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Hospital-based physician staffing industry outlook:

The forces of COVID-19, NSA and inflation

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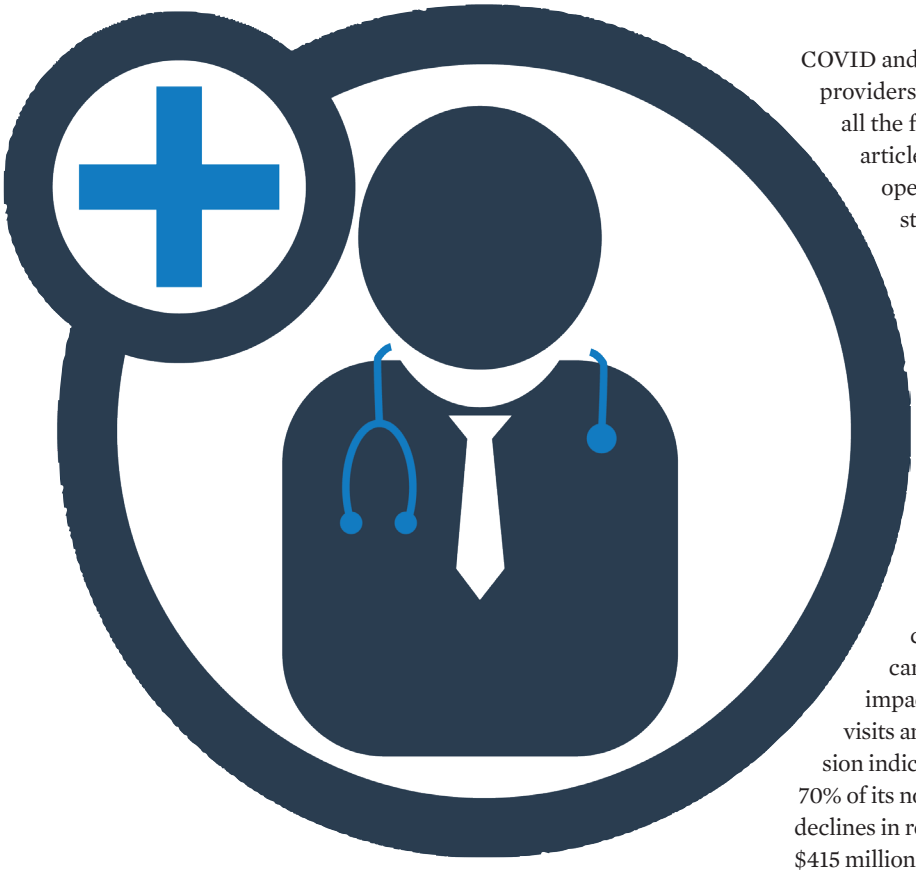
Due to the administrative burden associated with employing the clinical resources needed to cover hospital-based service lines (e.g., anesthesiology, emergency medicine, hospitalist medicine, intensive care, and various surgical specialties), hospitals and health systems routinely enter hospital-based clinical coverage arrangements ("HBCCAs") with independent physician groups. Because hospital-based providers frequently generate collections from professional services that fail to cover their costs in providing those services, HBCCAs usually involve some form of financial support from the hospitals.

The market for hospital-based physician services is experiencing a period of extreme disruption. On their recent earnings calls, hospitals and health systems have indicated that they are paying higher support payments to physician groups, and are increasingly looking for opportunities to reduce spend and/or increase the utility of their professional services arrangements. Despite increasing support payments, however, two of the largest hospital-based physician services staffing companies recently declared bankruptcy. In particular, Envision Healthcare Corporation ("Envision") and American Physician Partners ("APP") both filed for Chapter 11 protection in 2023 as a result of numerous industry headwinds including COVID-19, the No Surprises Act ("NSA"), and elevated inflation. One of the largest anesthesia groups in the country is facing a challenge from the Federal Trade Commission ("FTC") over certain business practices, which could have implications for the industry overall. This article discusses the recent bankruptcy filings, the industry headwinds, and the outlook for hospital-based services providers and their hospital and health system partners.

CHAPTER 11 FILINGS

Envision Healthcare Corporation filed for Chapter 11 protection in May 2023, with aggregate debt obligations totaling more than $6.4 billion. At the time of filing, Envision directly or indirectly employed approximately 17,000 healthcare professionals and provided services to more than 1,200 clinical departments. Of these employees, 44% were involved in care provision, and 55% were involved in administrative roles.

Among the key terms of the restructuring, Envision's ASC portfolio ("AmSurg") is being separated from the physician services business and is under ownership by holders of certain debt obligations secured by AmSurg assets. Envision explored a sale of AmSurg in February 2023, but elected to pursue restructuring despite receiving two indications of interest from outside acquirers. Prior to restructuring, Envision designated certain AmSurg assets as unrestricted subsidiaries, enabling it to engage in a debt exchange capturing $600 million in discount as part of a recapitalization. This resulted in Envision effectively owning 17% of AmSurg post-recap. Under the restructuring, this 17% was sold to the AmSurg debt holders for $300 million and the waiver of $1.4 billion of intercompany debt. The remaining Envision debt was equitized (primarily among first and second lien debt holders) or otherwise forgiven, and Envision



will continue operations. Envision completed its restructuring and emerged from bankruptcy in November 2023.[1]

American Physician Partners filed for Chapter 11 protection in September 2023, although the company ceased operations in July 2023. APP utilized more than 2,500 physicians to provide hospital-based services at more than 100 hospitals and free-standing emergency departments. Unlike Envision, which restructured but continued operations, APP is being liquidated and its contracts are being transferred to its health system partners or to other service providers (i.e., other staffing companies). APP transitioned approximately 150 ED and hospitalist contracts by the end of July 2023 (discussed in more detail later).[2]

HOSPITAL-BASED PHYSICIAN STAFFING INDUSTRY HEADWINDS

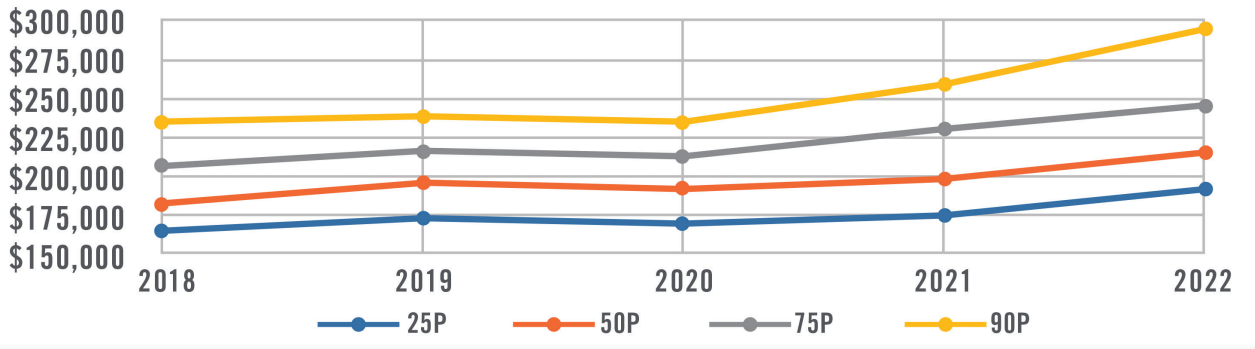
The bankruptcies discussed above were precipitated, in part, by several headwinds facing the hospital- based physician staffing industry. These headwinds include the COVID-19 pandemic, elevated inflation, the No Surprises Act (NSA), and potential challenges from the FTC. While COVID and inflation have impacted healthcare providers industrywide, the combination of all the factors discussed throughout this article represent a significant challenge for operators in the hospital-based provider staffing space.

COVID-19 PANDEMIC

The COVID-19 pandemic had dramatic short-term and longer-term consequences for healthcare providers, including hospital-based physician staffing companies. In the short-term, non-emergent visit volumes declined drastically as hospitals and health systems focused almost exclusively on COVID patients and others requiring lifesaving care, while any elective or deferrable care was put on hold. These immediate impacts resulted in dramatic declines in visits and revenue for many providers. Envision indicated that it lost approximately 65% to 70% of its non-emergency visits, and experienced declines in revenue of $1.1 billion and EBITDA of $415 million in 2020, followed by another negative $380 million revenue impact in 2021.[3] APP cited the COVID-19 pandemic as a significant contributor to its deteriorating financial position. Other hospital-based provider staffing companies suffered as well, including Pediatrix Medical Group, Inc. (formerly Mednax, Inc.) which sold its radiology and anesthesia businesses in 2020.

The losses of revenue had a direct impact on a medical group's ability to continue to pay and employ its physicians and advanced practice providers (APPs). For anesthesiology and surgical arrangements, groups had to contest with a loss of volumes, and having to reduce or lay off staff. When the non-emergent volumes returned, these groups often sought additional financial assistance from the facility to assist with costs associated with recruiting providers to replace those previously in the roles. For critical care and emergency medicine, groups had to contend with massive surges in volume, and sought financial assistance for additional providers, hazard pay, and overtime. Exhaustion and burnout were the obvious outcomes for the providers working in critical care units. The losses of revenue, losses of staff, and the effect COVID-19 had on certain specialties put the

FIGURE 1. SUMMARY OF CRNA CASH COMPENSATION, 2018 TO 2022



larger, national practices in a difficult financial and operational position.

The longer-term effects of COVID-19 are playing out throughout the healthcare industry. One impact that continues to affect hospitals and hospital-based provider staffing companies is the accelerating shift of care from the inpatient to outpatient setting. There are numerous factors contributing to the migration of care to the outpatient setting, including improvements in technology, implementation of value-based care models, increasing prevalence of high-deductible health plans, patient preferences, and payer policies, among others. COVID-19 accelerated this trend as patients either opted out of going to the hospital ED or were restricted from doing so.

The effects of COVID-19 and the shifts from inpatient to outpatient undoubtedly created challenging circumstances for any medical staffing group. However, smaller, local and regional medical groups (typically those without a corporate parent) may have been less equipped to deal with the losses of revenue and provider turnover. In addition, despite the obvious hardships presented to larger national practices, this period also proved to be an opportunity for those seeking to expand via acquisition. The Physicians Advocacy Institute (PAI) reported a stark increase in corporate entities acquiring physician-owned and other smaller practices. From 2019 through the end of 2021:

- 50,500 additional physicians became employees of corporate entities, 32,000 of which occurred after the onset of COVID-19, which was a 43% increase over the three-year study; and
- Corporate entities acquired 31,300 additional physician practices, an 86% increase.[7]

As the healthcare landscape slowly emerged from the pandemic, it became clear that the larger, national practices were better equipped to weather the storm. As a result, several smaller, local and regional groups were forced to close their doors and/or sell. In numerous regions, states and marketplaces, larger practices were ultimately able to absorb groups that were competing for the same contracts and medical providers. In some marketplaces, there are only large, national providers present and able to staff key hospital-based service lines. Hospitals and health systems in these areas are faced with the reality of dealing with a monopoly in the provider staffing space.

Advisor insight: Rising CRNA costs

COVID-19 was a disruptive force for anesthesiology coverage, and this was especially the case for certified registered nurse anesthetists (CRNAs). An American Association of Nurse Anesthesiology (AANA) study reported that 17.4% of CRNA respondents were furloughed and another 47.9% of respondents experienced a reduction in hours during COVID-19.[4] Additionally, AANA reported that CRNAs were often redeployed to critical care units and other non-anesthetizing service lines to assist with patient care stemming from COVID-19.[5]

In the post-COVID-19 landscape, hospitals found themselves trying to grow staffing back to pre-pandemic levels. The disruption of employment, coupled with the flexibility and cost savings of CRNAs compared to anesthesiologists, saw hospitals seek to rebuild their anesthetizing service lines with more CRNAs. As a result, the cost to employ CRNAs has greatly increased in the past two years, as shown in Figure 1.[6]

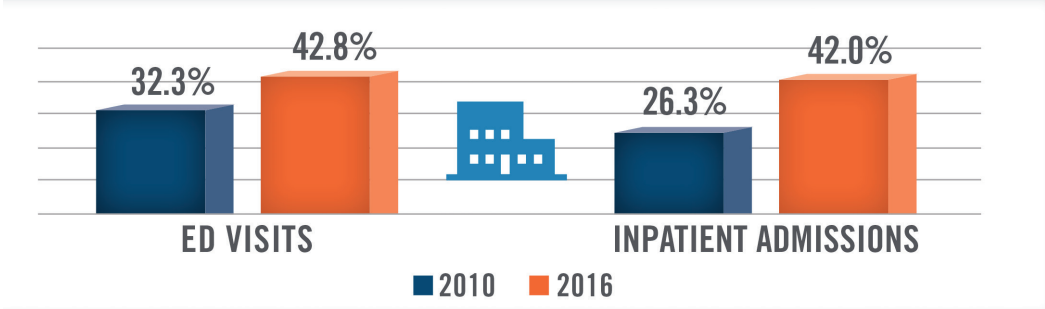
The competition for CRNAs between medical groups and hospitals alike is intense, and keeping CRNAs under contract is becoming difficult. Our clients represent that: (1) The medical group they are engaged with requires additional financial assistance to increase CRNA salaries; or (2) Their employed CRNAs are requesting additional compensation.

More often than not, CRNAs will provide job postings from other hospitals or positions and request commensurate compensation.

INFLATION

Inflation, largely a direct or indirect result of the pandemic, has represented a significant

FIGURE 2. HOSPITAL VISITS RESULTING IN A SURPRISE BILL



headwind for hospital-based physician staffing companies and providers. Staffing companies faced rising costs in connection with clinical staff, non-clinical staff, and other operating expenses. Envision reported a $330 million increase in clinical staffing expense compared to 2019. Hospital expenses per discharge increased 22.5% from 2019 through 2022, with labor expense driving a significant portion of this increase.[8] Much of the increase in labor expense is related to higher utilization of contract labor (e.g., locums tenens, travel nurses, etc.), which has been declining in recent quarters. In addition to higher labor costs, staffing companies (and other providers) faced higher costs for personal protective equipment (PPE) and other supplies during the pandemic.

More broadly, the pandemic exacerbated the shortage of providers, which, in turn, made it more difficult and expensive to staff hospitals. While the short-term trend of higher contract labor to deal with physician shortages may be on the decline, the longer-term trend of physician burnout and early retirement caused (or made worse) by COVID-19 is likely to impact the provider landscape for years.[9]

NO SURPRISES ACT (NSA)

In 2021, the federal government issued several regulations with the intent of curtailing surprise billing, and these rules went into effect in 2022. In the context of the hospital-based physician staffing industry, surprise billing was defined as receiving care from an out-of-network (OON) provider at an in-network facility. Within the text of the regulation, the government cites numerous statistics surrounding the practice of surprise billing. Figure 2 illustrates the increase in surprise billing from 2010 to 2016.[10] These surprise medical bills frequently cost patients hundreds or thousands of dollars more than if the provider had been in network, and typically don't count toward the patient's deductible or max out-of-pocket.

Prior to the NSA, several large staffing companies, including Envision, were already working to reduce their OON revenue due to backlash from the public, payers, and hospitals. According to some estimates, Envision's OON billing accounted for more than 60% of total billings from 2011 to 2015, before the company started reducing its exposure.[11] The company indicated in 2017 that it had made substantial progress and was targeting OON revenue to represent 5% of total company revenue by the end of 2018. TeamHealth, another large staffing company, had approximately 13% of its billings from OON claims according to a study published in 2017 that analyzed claims data from 2011 through 2015.[12]

The NSA furthered the need for these large staffing companies to move in-network but changed the dynamics in important ways. Without the ability to go OON with payers, staffing companies lost significant negotiating leverage. This was further exacerbated by the NSA's implementation of the Qualifying Payment Amount (QPA), which capped the patient's responsibility at the median contracted rate for like services provided in the same geographic market. According to the staffing companies, these dynamics have made it difficult to negotiate favorable rates with payers.

> *Now the payers have really relied on the implementation [of] the QPA and look at that in relationship to what the median in-network rate is … they're utilizing what we call ghost contracting, where they're taking all providers outside the specialty, including pediatricians, and taking those prevailing rates, which is lowering the QPA to 100% of Medicare or in some cases lower.*
>
> **— PEDIATRIX MEDICAL GROUP**

> *[S]ome payers (including Envision's single largest payer) have used the No Surprises Act and its implementing regulations as an excuse to avoid payment to medical groups like Envision and affiliated entities. Moreover, payers have aggressively denied, delayed, and reduced payment terms, often below the direct cost of delivering care. This has left Envision, other medical groups, and healthcare providers to deal with the negative financial consequences. Although the legislation included an arbitration process intended to provide a forum for providers and payors to settle disputes, the process has proved highly ineffective.*
>
> **— ENVISION BANKRUPTCY FILINGS**

TABLE 1. TOP 10 INITIATING PARTIES, OCT. 1 - DEC. 31, 2022

INITIATING PARTY OR THEIR REPRESENTATIVE	NUMBER OF DISPUTES, 4Q 2022	PERCENT OF ALL DISPUTES, 4Q 2022
SCP HEALTH	31,027	30%
R1 REVENUE CYCLE MANAGEMENT	14,563	14%
TEAMHEALTH	8,256	8%
SINGLETON ASSOCIATES, P.A.	3,923	4%
SONORAN RADIOLOGY	3,666	4%
ENVISION HEALTHCARE	3,052	3%
CALLAGY LAW	2,704	3%
SPECIALTYCARE	2,402	2%
ROUNDTABLE MEDICAL CONSULTANTS	1,914	2%
HCA HEALTHCARE	1,885	2%

TABLE 2. TOP PLACE OF SERVICE FOR IDR DISPUTES, OCT. 1 - DEC. 31, 2022

INITIATING PARTY OR THEIR REPRESENTATIVE	2022 Q4	PERCENT OF DISPUTES
23: EMERGENCY ROOM – HOSPITAL	75,463	73%
21: INPATIENT HOSPITAL	16,789	16%
22: ON CAMPUS – OUTPATIENT HOSPITAL	12,339	12%
24: AMBULATORY SURGICAL CENTER	3,844	4%
19: OFF CAMPUS – OUTPATIENT HOSPITAL	1,445	1%
81: INDEPENDENT LABORATORY	232	<1%

To resolve disputes between payers and providers regarding what the payment for services should be, the NSA created the independent dispute resolution (IDR) process. The IDR is effectively an arbitration hearing in which each party to the dispute (i.e., the provider or facility and the payer) submits a proposed payment and the arbitrator selects the appropriate amount from the payments submitted by each of the two parties. While the outcomes of IDR hearings have largely been favorable to providers, with the initiating party (i.e., the provider or facility) prevailing in approximately 71% of disputes as of March 31, 2023, CMS has reported a significant backlog due to the high volume of disputes.[13] As a result, even when favorable rulings are achieved, the delay between the provision of services and the collection of payment has increased significantly and caused material delays in cash collections and a lengthening of the cash conversion cycle. This delay in cash receipts contributed to deteriorating finances for staffing companies, although we note that OON claims also typically take longer to collect on. CMS reported the top 10 initiating parties to IDR disputes, outlined in Table 1.[14]

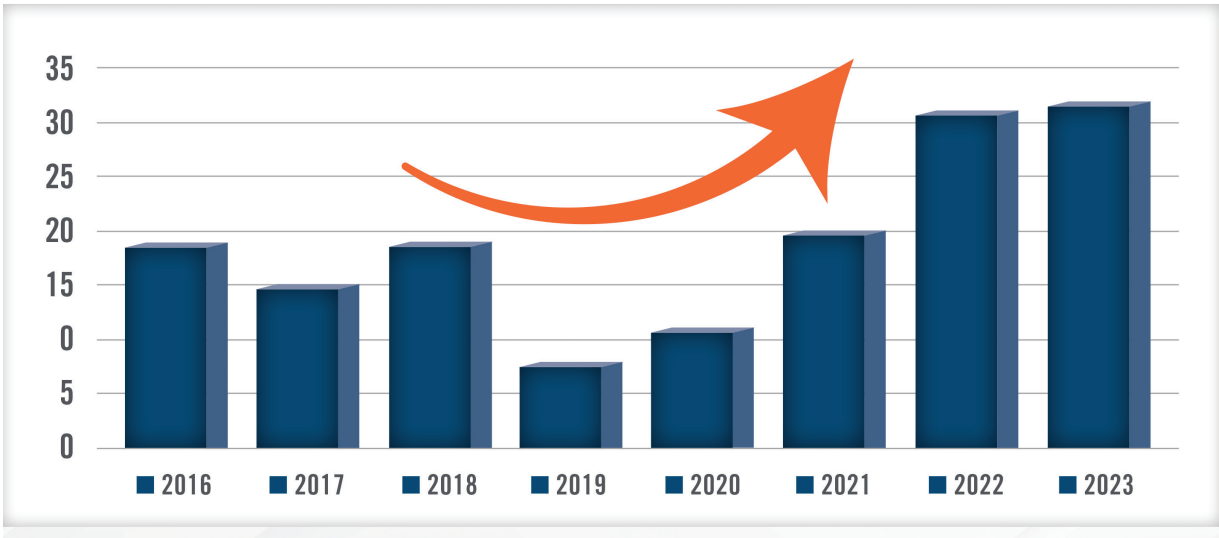
As highlighted in Table 1, several of the largest initiating parties in the IDR process were hospital-based provider staffing companies, including SCP Health, TeamHealth, and Envision. We also note that Singleton Associates, P.A. is majority owned by Radiology Partners, while R1 Revenue Cycle Management provides RCM services for staffing companies as well as hospitals and health systems.

CMS also provides data on the place of service for each IDR dispute. In the fourth quarter of 2022, 73% of disputed payments were from services provided in the ER, with an additional 16% from inpatient services. The place of service data from the fourth quarter of 2022 is presented in Table 2.

As a result of the NSA and its impact, Envision and other hospital-based staffing companies have implemented certain strategies to mitigate the headwinds. Envision moved 55% of its OON business in network, and extended offers to payers to go in network on more than 80% of its OON business. The company indicated it has submitted more than 117,000 claims through the IDR process, but despite its high win rate (more than 80%) the significant delays caused by the IDR backlogs has led to less revenue and cash on hand. Envision also restructured arrangements with health systems to share the risk associated with underpayment from payers. This likely has meant shifting many of their fixed stipend arrangements to arrangements where a hospital pays the actual difference between a group's desired level of revenue and their actual professional collections. Envision also divested assets to raise capital. Other large staffing companies have implemented many of these same strategies, including exiting certain markets and selling assets.

While the IDR process has been a source of many challenges for hospital-based provider

FIGURE 3. HEALTHCARE APPRAISERS VALUATIONS FOR HOSPITAL-BASED CLINICAL RADIOLOGY COVERAGE ARRANGEMENTS



staffing companies, the current outlook for the process is uncertain. The IDR process was suspended in August and September 2023 as a result of certain court rulings, before being partially reopened on Oct. 6, 2023.[15] During the period of suspension, CMS encouraged disputing parties to continue negotiations, but this will likely further exacerbate problems for the staffing companies and other providers who are most likely to be the initiators of IDR disputes.

As alluded to earlier, medical groups providing hospital-based services frequently require financial support from hospitals. Assuming no changes in patient volume, a medical group benefitting from OON billing would have seen a reduction in professional collections. This means that groups that historically did not receive any financial support may have started to seek such support, whereas groups already receiving financial support may have requested increases to account for the loss in revenue.

HealthCare Appraisers has performed more advisory engagements for radiology HBCCAs in 2022 and 2023 when compared to previous years. In some instances, hospitals and health systems requesting the advisory and consulting services spoke to changes in the group's annual professional collections as a result of NSA. Specifically, we are performing in-depth reviews and analyses as outlined in Figure 4.

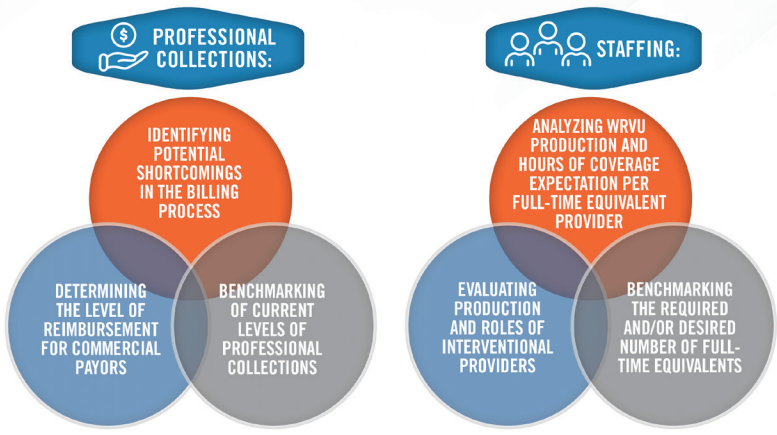
All too often, medical groups practicing OON billing have not had to negotiate rates with commercial payers. As a result of NSA, hospitals and health systems need to perform their due diligence when it comes to updating financial support payments.

Advisor insight: Radiology billing and coverage

HBCCAs typically require exorbitant levels of coverage when compared to patient volumes. However, radiology coverage arrangements can mitigate some of these challenges through remote staffing. A radiology group may be able to have minimal on-site coverage for emergent interventional radiology procedures. The remainder of the physicians can be remotely available, or able to perform reads and interpretations as needed. Furthermore, the use of teleradiology and nighthawk services after hours can further alleviate staffing costs. As a result, radiology groups can be staffed with high levels of utilization (e.g., high amounts of billable activity per provider hour), which can greatly reduce the need for financial support. In contrast, for example, laborist or OB hospitalist medicine coverage arrangements typically have high staffing costs (as a result of 24-hour, on-site coverage) and relatively more limited opportunities to bill and collect for professional fees.

In analyzing our historical advisory engagements,[16] we have identified a relationship between NSA and financial support paid to radiology groups.

FIGURE 4. OPERATIONS ASSESSMENT



FEDERAL TRADE COMMISSION

In September 2023, the Federal Trade Commission (FTC) sued U.S. Anesthesia Partners (USAP) and its private equity sponsor Welsh, Carson, Anderson & Stowe (WCAS) over allegations that USAP violated antitrust law. USAP is one of the largest anesthesia providers in the country, with more than 4,500 anesthesia providers performing approximately 2.5 million procedures at 1,100 healthcare facilities.[17] WCAS founded USAP in 2012, although by the time of the lawsuit it was a 23% shareholder. Despite being a minority shareholder, the FTC alleges that WCAS exercised control over USAP with respect to the alleged violations and thus was included in the lawsuit.

The lawsuit includes allegations that USAP (at the direction of WCAS) consolidated the anesthesia market in Texas to gain enough market share that it could negotiate higher rates with payers. The lawsuit also alleges that USAP entered into "price-setting arrangements" with independent practices wherein USAP would bill and collect for services provided by an independent group (that had lower reimbursement rates) and split the mark-up. Essentially, USAP entered into administrative services agreements with other practices wherein USAP would provide billing and collecting services, but would bill the payers under USAP's tax ID. In addition, USAP allegedly negotiated with a large competitor to keep it out of USAP's markets, which would restrict competition.[18]

Market participants do not believe that the lawsuit will slow down private equity-sponsored physician practice management (PPM) activity.[19] We note that two of the allegations ("price-setting arrangements" and negotiating with large competitors not to compete in certain markets) are not directly related to traditional PPM consolidation strategies. Consolidating to gain market share and leverage with payers has been happening for decades all across the healthcare landscape (and was accelerated by the Patient Protection and Affordable Care Act) and is not exclusively a PPM phenomenon.[20] This consolidation trend is pronounced within the payer market as well. More broadly, many of the specialties being consolidated by PPMs are clinic driven with significant ancillary services and are fundamentally different than anesthesia. Depending on the outcome of the case, we may see PPMs and their private equity sponsors doing more diligence around their market share in certain geographies and comparing their reimbursement rates to others in the market. To the extent this case has further impacts on the PPM space, we expect it to be limited to the hospital-based physician staffing PPM companies.

OUTLOOK FOR HOSPITAL-BASED PHYSICIAN STAFFING COMPANIES AND HOSPITALS

The ongoing disruption in the market should continue to affect hospitals and staffing companies going forward. Hospitals and health systems have experienced a variety of impacts including the need to insource or consolidate certain previously outsourced provider services, and/or paying higher support payments to contracted providers. For example, HCA Healthcare, Inc. recently consolidated its Valesco joint venture with Envision, which staffed many of its hospitals. In its third quarter earnings call with investors, HCA discussed Valesco's poor performance relative to expectations, citing weaker revenue. While HCA had initially anticipated no EBITDA impact from consolidating Valesco, following the third quarter, the company now anticipates approximately $50 million in losses from Valesco each quarter until mitigation efforts can improve performance. Community Health Systems recently insourced more than 500 hospital-based providers as a result of the APP bankruptcy, and has approximately 25% of its hospital-based provider contracts in-house.

> *This [Valesco] result was not what we are expecting as we are experiencing revenue shortfalls compared to what we originally modeled. The Valesco operating results had a negative impact on adjusted EBITDA margins of approximately 80 basis points in the quarter and 40 basis points on a year-to-date basis Going forward, we anticipate the loss from this venture to approximate $50 million a quarter.*
>
> **— HCA HEALTHCARE ON OCTOBER 24, 2023**

> *...as you likely know, American Physician Partners, or APP, has ceased operations effective July 31, amidst severe financial challenges. APP was contracted for ED and hospital provider services in a number of our markets. As it became likely that APP would not be able to continue operations, our team moved swiftly to transition the employment of more than 500 APP hospital-based providers working in our hospitals to affiliates of our company.*
>
> **— COMMUNITY HEALTH SYSTEMS, OCT. 26, 2023**

The transactions and processes to reduce spend on HBCCAs (for example, by bringing hospital-based provider groups in-house or starting a request for proposal process) can be challenging. We have advised and consulted on a variety of transactions wherein a health system was contemplating a change in provider and/or bringing a hospital-based provider group in-house. In some cases, these transactions were the result of a failed renegotiation of existing coverage arrangements (e.g., due to an increase in the requested support payment, dissatisfaction with the level of service and care being provided, etc.), necessitating the need for the transaction to close quickly to maintain coverage. These transactions are frequently structured as a buyout of the existing noncompete agreement between the platform and its providers. In certain cases, the sellers (i.e., the staffing company) have valued their provider noncompetes based on a multiple of the provider salaries (e.g., 1.5x salary) to release them from noncompete agreements. For hospitals or health systems that require dozens of providers to staff their facilities, this can result in a hefty purchase consideration, and the hospital will likely still be generating a loss on the service.

Advisor insight: Critical care and the focus on quality

Several operating characteristics, metrics, and data are considered when developing appropriate staffing and compensation models for hospital-based service lines. Additionally, the market is slowly beginning to incorporate aspects of quality into the equation. Today's Hospitalist reports that 100% of the hospitalist respondents have compensation plans where at least 5% of total compensation is paid in the form of bonuses and incentives.[22]

The Hospital Value-Based Purchasing (VBP) Program adjusts Medicare payments and funding to participating hospitals based on patient care quality, efficiency, safety, and overall patient experience. Specifically, 2% of a participating hospital's base operating Medicare DRG payments are withheld. The total of such reductions for all participating hospitals is then redistributed back to participating hospitals based on respective VBP performance results, such that a participating hospital can earn back a value-based incentive payment percentage that is less than, equal to, or more than the applicable 2% withhold for the respective year. In short, when assessing a hospital-based service line, the overall efficiency of the service line affects a hospital's Medicare funding.

For example, two key quality metrics associated with the VBP program relate to Central-Line-Associated Bloodstream Infections ("CLABSI") and Catheter-Associated Urinary Tract Infections ("CAUTI"). Since the vast majority of these procedures are performed in intensive care units ("ICUs"), quality of care and patient outcomes are paramount when assessing the efficiency of this service line.

In the hypothetical example in Table 3, a hospital is exploring the viability of different staffing models from two independent medical groups for purposes of providing exclusive clinical services coverage of its ICU.

TABLE 3. EXAMPLE RFP RESPONSE

DESCRIPTION	GROUP 1	GROUP 2
AVERAGE DAILY CENSUS	36	36
ON-SITE PHYSICIAN HOURS PER DAY	36	24
ON-SITE PHYSICIAN HOURS PER NIGHT	12	12
FTE PHYSICIANS	10.0	8.0
ON-SITE APP HOURS PER DAY	0	24
ON-SITE APP HOURS PER NIGHT	0	12
FTE APPS	0.0	8.0
TOTAL PROVIDER HOURS PER 24-HOUR PERIOD	48	72
ANNUAL PROVIDER STAFFING COSTS	$4,780,000	$4,968,000
PROFESSIONAL COLLECTIONS	$2,760,000	$2,760,000
HOSPITAL FINANCIAL SUPPORT	$2,020,000	$2,208,000

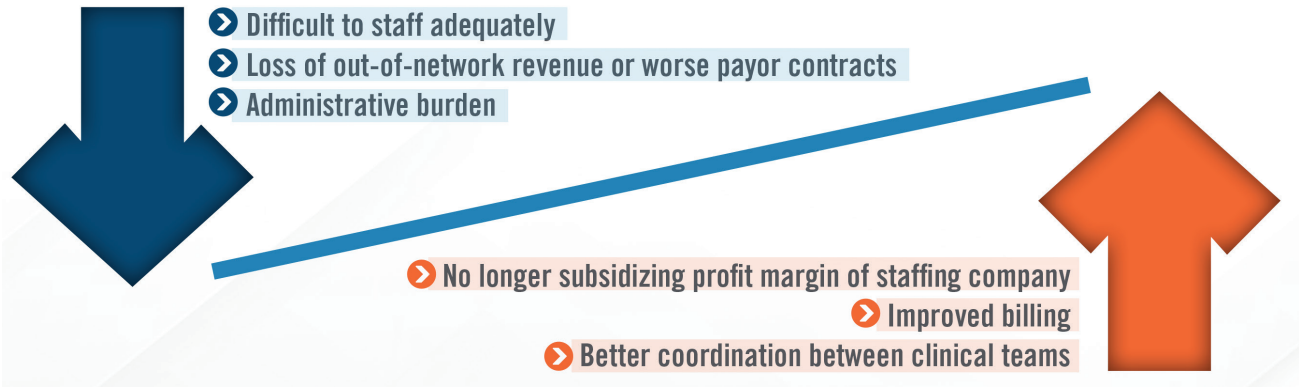
Advisor insight: Critical care and the focus on quality (continued)
At first glance, Group 1 may appear to be the more cost-efficient option since the hospital's financial outlay (i.e., the financial support required for Group 1 is $188,000 less than that of Group 2). However, Group 2 may be the better option for the hospital for the long term. While Group 2 may not provide the most cost-effective solution initially, it may provide a better patient-to-provider ratio, which, all things being equal, will likely yield better patient care quality outcomes. If Group 2 provides better patient outcomes which results in improved reimbursement, hospital's net cost for this service line over the longer term may be lower than if the hospital selected Group 1.

This high-level example does not consider the experience, skill level, and standard operating procedures of either group. More providers does not necessarily lead to better outcomes. An in-depth review of the underlying operations, financials, and other intangibles of any hospital-based service line is necessary to make a fully informed staffing structure selection and provider/contractor decision. Regardless, with critical care providers almost directly affecting a hospital's Medicare funding, it may make sense to compensate for more coverage than to risk losing Medicare funding.

When hospitals and health systems bring their hospital-based provider services in-house, there are several impacts to the financial statements. Once in-house, the hospital will bill and collect for the physician services, which increases revenue. The hospital then pays the physicians a salary, which increases payroll expense, but the support payment to the group goes away. Since salaries and the overhead expense associated with managing a physician group frequently exceed the revenue generated from the group, the hospital is losing money on the service (thus the need for the support payment to the independent contractor group). However, the amount of the loss can be impacted by a variety of factors that may change with the service being in-house versus independently contracted. Most support payments inherently yield a profit margin for the staffing company, which goes away when the hospital brings the service in-house. Reimbursement rates charged to payors by the hospital may be different than those charged by the independent group, which could also impact the economics once the service is brought inhouse. Figure 10 outlines the various potential pros and cons of bringing hospital-based provider services in-house.

Hospitals and health systems have been publicly discussing the higher support payments they have been paying for physician services on recent earnings calls (for more detail, see our recent Quarterly Insights articles). These higher support payments are driven by the lost OON revenue, reduced in-network revenue the physician groups receive from payors (driven by the NSA), and rising staffing costs. As revenue for the staffing companies declines, they generate higher losses and request larger support payments when their hospital contracts come up for renewal.

FIGURE 5. SHIFTING HOSPITAL-BASED PHYSICIAN SERVICES IN-HOUSE



There is a lot of uncertainty in this ever-changing HBCCA landscape. HBCCAs can be complex and daunting to value. In providing FMV opinions, we far too often encounter HBCCAs that are auto-renewed year after year, or are sent for FMV review at the eleventh hour, which hinders the negotiation and a party's ability to amend and improve a contract.

Staffing companies and medical practices, large and small, will continue to face financial and operational challenges. As a result, hospitals and health systems will be brought to the negotiating table to help alleviate the financial burden borne by the medical groups. We predict medical groups will ask for more financial assistance and/or more favorable compensation terms that mitigate downside risk. ■

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