AUGUST 2023

PA PULSE

MGMA PENNSYLVANIA

E-NEWSLETTER

MESSAGE FROM THE BOARD

As this summer quickly flies by, we want to provide you with recent exciting developments for the Pennsylvania MGMA.

- Welcome to our two new directors – **Lindsay Howerter**, Operations Manager for The Eye Center of Central PA, and **Emily Allen**, Practice Site Manager for Wellspan Health. Both have already made their mark on the association with their participation on our committees and

EVENTS

Leveraging Generative Artificial Intelligence (AI) in Medical Practices
August 18
12:30- 1:30 PM
Webinar

Protecting Primary Care: Practical Solutions to Address the

at our board meetings. We're excited to have them join us to serve you!

- Our website underwent a refresh! We are excited for you to experience the new user-friendly experience.

- At the June Board of Directors meeting, and after many discussions during recent Membership & Marketing Committee meetings, we have approved a new Mission Statement that remains aligned to our Articles of Incorporation yet reflects the changing healthcare environment. Our new Mission Statement is – *"To provide professional development and education to all healthcare professionals, in a collaborative environment."*

- Speaking of professional development and education, watch for an exciting multiple-part series to be offered this fall which will include finances and financial reporting, human resource management, and hands-on leadership training. We will host this series both virtually and with a one-day in-person session. You can register for one or all. We will unveil this special learning series on or about Labor Day.

As always, continue to participate in our collaborative webinar series with our wonderful partners with Virginia MGMA and West Virginia MGMA. We already have our webinars planned through October. These include ***August - Leveraging Generative Artificial Intelligence (AI) in Medical Practices***; ***September - Protecting Primary Care: Practical Solutions to Address the Workforce Shortage****;* and

Workforce Shortage
September 22
12:30- 1:30 PM
Webinar

The Consummate Call Center: People, Process and Technology
October 20
12:30- 1:30 PM
Webinar

View Events

***October - The Consummate Call Center: People, Process and Technology*.**

Regards,

Shelley Rine, CPC, COPC
Chair, Board of Directors

Peter Constantinou
Executive Director

INDUSTRY NEWS

CMS outlines 2.8% pay increase for outpatient facilities, ASCs in 2024 proposed rule

Reprinted from Fierce Healthcare

The Centers for Medicare & Medicaid Services (CMS) has released its proposed Medicare payment rates and policy updates under the Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

In the proposed calendar year 2024 rule, set to be published in the Federal Register, CMS floated payment rates for hospitals that meet applicable requirements for quality reporting at 2.8%, reflecting a projected 3% hospital market basket increase reduced by 0.2% percentage points for a required productivity adjustment.

Additionally, CMS proposed extending a productivity-adjusted hospital market basket update to ASC payment system rates for an additional two years due to pandemic interruptions on care services such as elective surgeries.

“This will enable us to gather additional claims data further removed from the COVID-19 [Public Health Emergency] to more accurately analyze whether the application of the hospital market basket update to the ASC payment system had an effect on the migration of services from the hospital setting to the ASC setting,” the agency wrote in a fact sheet.

Applying the proposed two-year extension yields a proposed productivity-adjusted hospital market basket update factor to the ASC rates for calendar

year 2024 of 2.8%, reflecting a 3% hospital market basket percentage increase and a -0.2% percentage point productivity adjustment.

Outside of top-line pay rates, CMS shined a spotlight on new hospital price transparency proposals included in the FY 2024 OPPS proposed rule.

The agency said changes included in the proposed rule would support its commitments earlier this year to clamp down on hospitals that are not compliant with the requirements.

It also proposed language changes that aim to increase the transparency of its enforcement process and is seeking public comment on whether its work aligns with other price transparency initiatives, such as the Transparency in Coverage regulation and the No Surprises Act.

Of particular note to the industry, CMS said its rule proposal includes a requirement that hospitals use a specific template when displaying the required standard charges in a machine-readable file—a frequent request among critics who said the initial requirements were too vague on formatting.

“Currently, hospitals have flexibility in form and format for display of the standard charges they have established as long as they are posted online in a single machine-readable file,” CMS wrote in a separate fact sheet. "While the hospital price transparency regulations take some steps to bring consistency to the way standard charges are presented, hospitals and users of the [machine-readable file] data have recommended improving standardization of the data required for display.”

In a statement released Thursday evening, American Hospital Association Executive Vice President Stacey Hughes said the industry group was "concerned" the proposed 2.8% payment update would be insufficient to offset financial headwinds hospitals faced in 2022 and beyond.

"Without a more robust payment update in the final rule, hospitals’ and health systems’ ability to continue caring for patients and providing essential services for their communities may be jeopardized,” she said.

As for the price transparency updates, Hughes said her organization would be "carefully reviewing" the proposed changes "to ensure they continue to advance our shared objective with CMS of making it easier for patients to access pricing and cost information while reducing unnecessary administrative burden and costs on hospitals and health systems.”

Other major components of the proposed OPPS and ASC Payment System rule outlined by CMS included:

- Establishment of the “Intensive Outpatient Program” (IOP) under Medicare, a benefit that would furnish several services delivered in hospital outpatient departments, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers, and Rural Health Clinics. CMS said the IOP proposals could “address one of the main gaps in behavioral health coverage in Medicare and promote access to needed behavioral health care”
- Update Medicare payment rates to for partial hospitalization program services furnished in hospital outpatient departments and at CMHCs
- Changes to CMHCs’ Conditions of Participation that would reflect provisions of the Consolidated Appropriations Act, 2023
- Payment rate updates for tribal and Indian Health Service hospitals converting to Rural Emergency Hospitals that CMS said is expected to “bring further stability” to facilities that decide to convert
- Continuation of the statutory default rate (average sales price plus 6%) for drugs and biologicals acquired through the 340B program
- Changes to and a request for public comment on, reporting measures of outpatient care within the Hospital Outpatient Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program and the Rural Emergency Hospital Quality Program
- Request for public comment on separate payment under the Inpatient Prospective Payment System (IPPS) to help facilities establish and maintain access to a stockpile of essential medicines, an adjustment which CMS noted could then come to OPPS in “future years”
- A request for public comment on payment for high-cost drugs and services outside of the Indian Health Service All-Inclusive-Rate

The FY 2024 OPPS and ASC Payment System Proposed Rule will be up for public comment until Sept. 11. CMS said it will issue the final rule in early November.

Share of physicians working in private practice continues to dip

Reprinted from HealthCareDive

The percentage of physicians working in private practices across the U.S. continues to decline as hospitals, private equity firms and payers acquire physician practices.

Dive Brief:

- The share of physicians working in private practices, or those wholly-owned by physicians, fell by 13% between 2012 and 2022 — from 60.1% to 46.7%, according to a survey released this week from the American Medical Association.
- The percentage of physicians working in practices at least partially owned by a hospital or health system increased by almost 8% during that time frame, while the share of physicians working in hospitals increased by 4%.
- Four out of five physicians surveyed who sold their practice cited a need to negotiate higher payment rates with payers as a main driver for their decision, while others pointed to a need to manage administrative and regulatory requirements.

Dive Insight:

Over the past decade, independent physicians in the U.S. have become increasingly scarce as hospital systems, private equity firms and payers have acquired individual practices — a trend that accelerated under financial stresses from the COVID-19 pandemic. In 2021, the Physician Advocacy Institute estimated nearly 70% of all U.S. physicians were employed by hospitals or corporate entities.

Now, factors including complex payer relationships, rising costs and labor shortages continue to make practice buyouts an attractive option for physicians, experts told the New York Times.

Financial pressures for physician practices have increased over the past twenty years, AMA researchers noted. Physician payment in the Medicare program declined after adjusting for inflation in practice costs, and a majority of physicians describe associated burden as “high or extremely high,” the report found.

“The shift away from independent practices is emblematic of the fiscal uncertainty and economic stress many physicians face due to statutory payment cuts in Medicare, rising practice costs and intrusive administrative

burdens," AMA President Jesse Ehrenfeld said in a statement. "Practice viability requires fiscal stability."

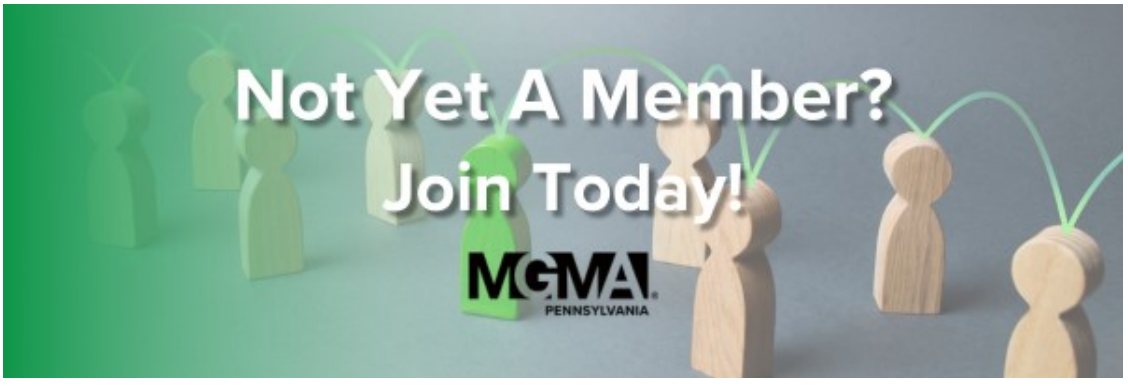
However, even if buyouts can offer financial benefits for practices, individual providers may not directly reap rewards.

Studies have found that consolidation can lead to decreased physician earnings and increased costs for patients seeking care.

A December 2021 study in Health Affairs analyzed physician compensation between 2014 and 2018 and found acquisition by hospitals was associated with a modest drop in provider compensation, even as hospital profits tended to expand.

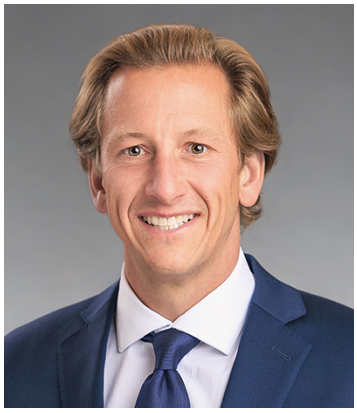
Patients are also likely to pay higher premiums for care when hospitals or PE firms acquire practices. A 2018 analysis published in Health Affairs found that prices for services at a facility integrated with a hospital system were 5% higher for primary care and 9% more for specialty services. Another analysis, published by the Petris Center this week, found that when PE firms controlled more than 30% of the market, cost for some specialties increased — in some cases by double digits.

In response to concerns about possible anti-competition effects of acquisitions, the FTC announced a multi-year study investigating healthcare mergers in 2020. Multiple watchdog groups, including Public Citizen and Brookings, have called upon Congress to take a closer look at PE's role in the healthcare industry and possibly introduce procompetitive reform legislation.



INDUSTRY ARTICLES

4 Ways Landlords Benefit When Healthcare Providers Don't Have Representation



By Christopher Peffall, CARR

Real estate is typically the second highest cost for a healthcare practice, so hiring a healthcare specific real estate agent is a must. Unfortunately, finding a suitable property at the best possible price and negotiating a lease rate that fits your budget isn't as simple as just reviewing listings and visiting a few spaces. Consider these ways landlords benefit when you're not represented:

1. It's Easier for Landlords to Convince You They're on Your Side

Remember: Financial gain is the end goal. Even the friendliest landlord—he or she might even be your patient—intends to make the most amount of money possible, renting or leasing a space. Just like the nicest tenant seeks the lowest lease rate. Without representation, convincing tenants that the landlord is looking out for them, that they're on the same side, becomes much easier—and can create costly financial mistakes for the tenant. Landlords are no more likely to voluntarily reduce lease rates in a renewal or give up extra cash through concessions in a new lease negotiation as you would be to voluntarily pay more for equipment or increase your costs on utilities.

2. It's Easier to Keep Lease Rates Above-Market

The idea that a lease renewal is not negotiable is a tactic many landlords employ. Any landlord who says the terms for a renewal can't be negotiated is most likely testing to see how ignorant you are and doing so to make more money. Or, when you exercise the option to renew, instead of negotiating new terms or specific concessions, they win.

Annual increases in lease rates typically compound year over year, and more often than not, they outpace inflation and cost of living escalations. So, when you go to renew your lease, you're typically paying an above-market lease rate—higher than what a landlord might have listed the space for if it was vacant. Similarly, a landlord is not going to suggest you negotiate concessions

when renewing, but a lease renewal negotiation *should* always contain concessions similar to what you would ask for as a new tenant.

To be certain your lease terms and concessions are the most competitive, understanding market availability and comps is vital. How will your renewed lease rate compare to *current* market rates? How does your current space compare to other top available options in the market?

3. Landlords Don't Have to Worry About Accurate Market Evaluation

Landlords know that without market knowledge, tenants have no baseline against which to compare a lease offer. Whether you're renting a new space or renewing your lease at your current location, market knowledge is key to a successful negotiation. Healthcare real estate agents are generally experts on the local commercial market and compile available vacancies, any recently completed transactions in the area, and future available spaces—often properties that are never listed in online databases. Having information about other properties (What are they charging? How do they appeal to you? How does their value compare to others?) will not only help healthcare tenants decide on a new property vs a lease renewal, it's also vital to the negotiation process.

The only way to effectively negotiate is to ensure the landlord knows you're pursuing (or have the option to pursue) a variety of spaces on the table. If you're renewing, you'll also want to know the lease terms and concessions that new tenants in your building are receiving from your landlord. Creating this type of posture will ensure any terms thrown out to the tenant are truly competitive.

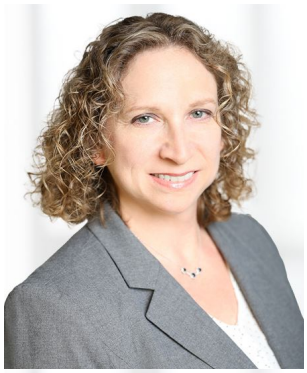
4. Landlords Have the Upper Hand in Negotiation

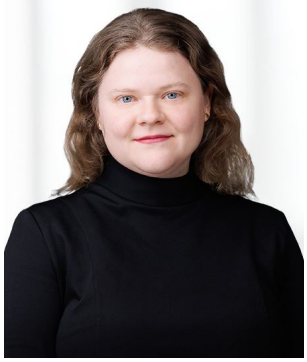
The first question a landlord asks its agent is whether the tenant is being represented professionally, and if not, whether they appear to have market knowledge (or in a renewal situation if they're willing to leave). If the answer is no, the landlord's negotiation strategy changes immediately. When working with an unrepresented tenant, landlords will often make an offer that contains margins they're comfortable with. That way, when a tenant inevitably counters, the landlord doesn't lose much. But the tenant walks away thinking they've successfully negotiated, even at an over-market price point.

Without representation, no one is protecting a tenants' interests. If any of the above sounds daunting, healthcare tenants always have the option to hire an experienced commercial real estate professional at the landlord's expense. And as a practice owner or manager, tens of thousands of dollars are on the

line, which means it makes the most financial sense to have a professional represent your interests in negotiations and help you find a space that meets your needs and saves you significant money.

Healthcare Organizations Face Increased Antitrust Risk from FTC and DOJ Proposals





By Carrie Amezcua and Abigail Cessna

Carrie Amezcua, counsel at Buchanan Ingersoll & Rooney, and Abigail Cessna, associate at Buchanan Ingersoll & Rooney, focus their practices on antitrust and trade regulation counseling and transactions.

It has been a busy month for the Federal Trade Commission (FTC) and the Department of Justice Antitrust Division (DOJ), which released proposed revisions to the Hart-Scott-Rodino Act (HSR Act) premerger filing rules, draft merger guidelines, and completed the full withdrawal of healthcare policy statements in the past month. The healthcare industry is not immune from the Biden Administration's aggressive antitrust enforcement agenda. The healthcare industry is replete with antitrust risks, and companies should incorporate these risks into business plans.

Proposed HSR Rules Revisions. Some transactions are subject to premerger filing requirements pursuant to the HSR Act. In early July, the FTC and DOJ released the first proposed overhaul of the HSR form and instructions since their introduction 45 years ago. These proposed changes will require organizations filing to produce substantially more information to the FTC and DOJ and increase the burden and time required to prepare a premerger filing, up to 222 hours. In particular, parties must provide all agreements they have with each other, employee information, and certain ordinary course strategic documents. Documents produced during merger antitrust investigations have

already spawned separate investigations into antitrust violations. Organizations should consider a careful review of documents when considering transactions. And, organizations pursuing a reportable transaction will need to allow a much longer lead time to prepare HSR filings.

Policy Statement Withdrawals. Also in July, the FTC followed the DOJ and withdrew policy statements relating to antitrust enforcement in healthcare. Those statements provided safety zones for healthcare mergers, participation in exchanges of price and cost information, accountable care organizations, joint purchasing arrangements, and guidance for activities that fell outside of the safety zones. The withdrawal of these statement increases the uncertainty around collaborations with other healthcare entities and forces companies to weigh the risks and benefits in each potential collaboration or exchange.

Proposed Merger Guidelines. The draft merger guidelines are a dramatic shift from how courts currently analyze merger cases, and they contain significant changes relevant to the healthcare industry, including lower market share thresholds for presumptive harm for horizontal and vertical mergers, focus on labor markets as an independent analysis, and targeting serial acquisitions.

***Lower market share thresholds*.** All healthcare organizations pursuing mergers and acquisitions will be affected by the lower market share thresholds for presumptive harm in horizontal and vertical mergers. A horizontal merger would be presumed illegal if, combined, the parties have a market share greater than 30%. This is much lower than what courts currently view as a high market share and shifts the burden to the merging parties at a lower threshold. The threshold of presumptive harm for vertical mergers (merger or acquisition with a company downstream or upstream in the supply chain) is 50% of a relevant market. Merging organizations will need to be prepared to argue why other market dynamics rebut this presumption.

***Labor Markets as Independent Harm*.** The antitrust agencies' focus on labor markets, including an analysis as to whether a merger will substantially lessen competition for workers, impacts hospitals, physician practices, and insurers. Even if organizations have a vertical relationship or do not compete for services, healthcare organizations may compete for labor. The agencies' assessment would include whether the transaction could suppress wages or degrade working conditions. Unlike today where harm to employees is a secondary consideration in a merger analysis, with the new guidelines, the agencies may consider it a primary reason to block a transaction.

***Serial Acquisitions*.** The proposed guidelines also emphasize that the DOJ and FTC will scrutinize organizations making serial acquisitions, assessing whether an overall pattern or strategy of serial acquisitions is illegal. This guideline targets private equity firms that are rapidly acquiring physician practices and hospitals. The DOJ and FTC have raised concerns about so-called private equity "roll-ups" in the healthcare industry. Indeed, the agencies' recent proposed revisions to the HSR filing would require additional information from both parties to a transaction regarding previous acquisitions. This information would more easily allow the FTC and DOJ to assess whether an organization is pursuing a serial acquisition strategy.

Conclusion. The agencies have stated that problematic mergers should die in the boardroom. Issuing these revised merger guidelines may chill merger activity, at least temporarily, as organizations assess how the agencies will pursue enforcement actions against mergers and how successful the agencies are in their aggressive enforcement push. Healthcare organizations pursuing transactions should be prepared for aggressive antitrust scrutiny and increased merger challenges when the proposed changes become final.

Create and Sustain a Successful Leadership Development Institute

Reprinted from MGMA

In a world where talent and innovation reign supreme, investing in leadership development has become a crucial strategic move for organizations across industries. Research conducted over the past year reveals staggering statistics that highlight the significance of nurturing and empowering leaders. By delving into these findings, we gain valuable insights into the importance of leadership development, as well as the barriers preventing organizations from fully embracing this transformative practice.

The results of these research findings might be surprising to some more cynical individuals, including the 11% of senior executives surveyed by McKinsey & Co. who felt their leadership development initiatives had a clear business impact.

Leadership coach Susan Aloi, PhD, FACMPE, interim assistant program director and professor for the Doctor of Health Sciences (DHSc) Population Health program at Thomas Jefferson University, thinks she understands why

there might be doubters around the return on investment for assessing leadership competencies and growing them.

“In all of my research over the past 24 months,” Aloi noted during her 2023 MGMA Summit presentation, “I found that 80% of health systems believed … the investment in leadership development is a strategic imperative, [yet] only 20% of them actually invest in leadership development.”

The impact of leadership development

As professionals strive to find fulfillment in their work, it’s no surprise that, as Aloi noted from her research, 25% of employees express a desire to engage in tasks aligned with their strengths — this aspiration has far-reaching implications for employee satisfaction and overall productivity. Additionally, Aloi pointed to the important role of development to fuel higher worker satisfaction: Gallup workforce polling has found that 87% of millennial workers rate development opportunities and professional/career growth as important in their job, and nearly 6 in 10 (59%) rank those opportunities as “extremely important” when applying for jobs.

And in a continually competitive market for healthcare workers, these types of opportunities can help stave off staff departures in an era when more than 70% of high-retention-risk employees will leave their company to advance their career. Employee engagement studies from Deloitte support the rationale for doing more in leadership development, as their findings point to retention rates being 30% to 50% higher in companies with strong learning cultures.

---

4 ways boards can influence quality and safety, per MGH's former chief quality officer

Reprinted from [Becker's Hospital Review]

Hospital boards are responsible for plenty of high-level duties, and while their overall role may vary depending on an organization's size and type, quality and safety should be infused into all of the areas they oversee, according to the former chief quality officer at Massachusetts General Hospital in Boston.

MEMBER LINKS & RESOURCES

Handouts

Helpful Links

Practice Tools Resources

"With today's financial and workforce challenges, it's easy to see how boards might focus on the most urgent issues, but quality and safety issues are always important," Elizabeth Mort, MD, former senior vice president of quality and safety and chief quality officer at MGH, said in an interview with the AHA.

All hospitals are in the business of patient care, and it's up to boards to set the tone and communicate their organization's commitment to high quality, safe care.

"It starts at the top," Dr. Mort said. "[The board's] role can be to shape the vision, purpose and support management in the required operations and in setting the culture, a culture of safety, a just culture and a culture that supports inclusion and psychological safety. That's the big picture."

Four ways boards can positively influence quality and safety at their organizations, as outlined by Dr. Mort:

Consider whether your organization's mission statement clearly mentions quality and safety, whether there are safety and quality experts on the board, whether board agendas include updates on quality and safety, and whether there is a quality committee on the board to oversee work with the senior team.

Have each board committee make investment and management decisions with the potential effects on quality and safety in mind.

Ensure quality and safety goals are set annually, "in the same way institutions have financial and operational plans," she said.

Understand the key quality and safety metrics and indicators hospitals are judged on for leading ranking and rating calculations, such as Leapfrog safety grades and CMS star ratings. At the same

time, don't solely rely on these measures. Additional information to consider include safety reports, serious reportable events and safety culture surveys.

"These scores are often easier to grasp, but I would caution any board from being comfortable with high marks on one or two, as there may be important performance gaps that are not visible," Dr. Mort said. "Even the top-rated institutions have opportunities to improve quality and reduce patient harm."

Join PA MGMA for member benefits like exclusive access to the Washington Connection issued by National MGMA!

CALL FOR ARTICLES

We invite you to share your medical group management expertise and submit an article for the PA Pulse!

Here's what we need for your article's consideration:

- The article must be timely and relevant.
- It must be 750 words or less.
- Include full name, headshot, short bio, and link if applicable (LinkedIn or website).
- Email your article in original format (accessible web link or Word).

Submit an Article