Health Capital Topics
Volume 13
Issue 4
April 2020
Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang MBA, MHA, CVA, ASA, FACHE, Publisher

How Will COVID-19 Change Healthcare Delivery?

Spurred by how unprepared the American healthcare system was for a pandemic, the current COVID-19 emergency may present the conditions necessary to commence a healthcare delivery model paradigm shift.[1] In response to the public health emergency, the federal government, which has a record of reducing regulatory "*burdens*" under the Trump Administration,[2] has taken aggressive actions to create regulatory flexibilities for healthcare providers and suppliers.[3] At least some of the various actions taken to reduce provider burden as they treat COVID-19 patients are likely to stay intact following the end of this pandemic, potentially revising the fundamental tenets of U.S. healthcare delivery. This *Health Capital Topics* article will discuss some of the ways in which the pandemic may change the healthcare delivery landscape going forward.

Accelerated Shift to Outpatient Settings

Healthcare delivery has been shifting toward the outpatient setting over the past two decades for several reasons, including patient convenience and lower cost of care (and not necessarily in that order). The *Centers for Medicare & Medicaid Services* (CMS) has promulgated agency regulations and guidance to incentivize the provision of care in these lower-cost settings; this shift may well be accelerated as a result of the pandemic.

Ambulatory surgery centers (ASCs) are uniquely capable of handling surgical overflow from hospitals, a characteristic that healthcare organizations may find more valuable post-crisis.[4] During the pandemic, ASCs have been allowed to coordinate with local hospitals to provide hospital services.[5] If these partnerships are successful, hospitals are likely to remember this coordinated response when making future transactional decisions. The post-COVID-19 transactional arena may consist of healthcare organizations with deeper interests in non-traditional sites of care, including ASCs, urgent care centers, or telemedicine companies, as these business lines may provide a way for healthcare organizations to diversify their revenue.

Further, the proliferation of concierge medicine, i.e., primary care providers who usually receive annual or monthly fees in exchange for providing patients 24/7 access, has gained significant momentum during the pandemic due to the desire to obtain treatment and testing outside of hospitals. Consumers may become accustomed to the priority treatment received from concierge providers, leading to growth in this form of outpatient treatment. Technologically-inclined concierge providers, such as *One Medical*, are ideally positioned to succeed because they had a strong telemedicine infrastructure in place pre-COVID-19.[6] In contrast, many traditional primary care providers will not survive the COVID-19 crisis because of the closures of physician offices due to stay-at-home orders; the wariness of patients entering a medical facility during a pandemic; and, the non-emergent nature of many primary care appointments.[7] Further, most primary care providers, who tend to have fewer technological and financial resources,[8] are unprepared to add telemedicine services to their practices; only 22% of family physicians used video visits in 2019.[9] Without massive support from the government, many primary care practices will not survive the pandemic,[10] providing an opportunity for concierge providers to gain significant market share. Healthcare organizations seeking to expand their outpatient footprint may find failing primary care facilities or successful concierge providers as attractive acquisition targets.

Expansion of Telemedicine Services

While relaxed regulations related to telemedicine across all aspects of healthcare, from hospice to primary care, were intended to be temporary when established, these regulatory changes may permanently shift how medical care is delivered and reimbursed. CMS has loosened site limitations and expanded the number of covered telemedicine procedures to 80, and is paying for these services at the same rate as their in-person counterparts.[11] Some Medicare COVID-19 reimbursement changes, e.g., allowing providers to see patients without a previously-established relationship and allowing patients to receive telehealth services regardless of the patient's or provider's location, may be allowed continue going forward.[12] In fact, on April 15, 2020, CMS Administrator Seema Verma announced that CMS is exploring how it can make the emergency telehealth regulation changes permanent once the pandemic is over,[13] and will be working with Congress to expand telehealth access to all Medicare beneficiaries post-COVID-19.[14]

In addition to Medicare, private insurers have also expanded their telehealth policies, with most shifting to cover telehealth visits of all kinds since the start of the crisis.[15] Multiple insurers, including Anthem, Cigna,

©HEALTH CAPITAL CONSULTANTS
(Continued on next page)

UnitedHealthcare, and Aetna, are waiving any cost sharing for telehealth visits[16] and/or reimbursing for telemedicine services at the same rate as in-person visits.[17] Significantly, several insurers own telemedicine services (e.g., Anthem's LiveHealth Online), which compete directly with providers.[18] Health insurers may be able to establish themselves as telehealth providers for their subscribers during this crisis, creating a competitive advantage post-COVID-19. Moreover, commercially-insured patients will likely become much more accustomed to telehealth services as a result of having to use the technology during the crisis,[19] Patients may consequently opt to continue receiving medical services in this manner post-crisis, which means that providers who do not offer telehealth services may find it difficult to convince commercially-insured patients to come into the office for visits that can be provided virtually. This reliance on commercial reimbursement is primarily because of the significant price discrepancy between Medicare payments and commercial insurance payments; on average commercial insurance reimburses hospitals at 241% of Medicare rates.[20]

From a broader policy perspective, this forced overnight shift to telemedicine is more efficient for the healthcare delivery and payment system overall. Increased utilization of telemedicine will reduce unnecessary (and costly) emergency room visits and help physicians prioritize patients with complex conditions, including allowing them to spend more in-person time with those patients and more frequently monitor their conditions through telemedicine technology. Thus, those providers who choose not to adapt to this healthcare delivery "*sea change*" may jeopardize revenue and market share.

Increased Delivery of Healthcare in the Home

As alluded to above, the COVID-19 crisis has not just shifted services to the outpatient setting, but is also shifting certain services from being provided by a physician in the hospital to being provided by a nurse in the patient's home.[21] While this trend toward providing more care in the patient's home began in earnest over the past couple of years due to the CMS expansion of payment for home healthcare services[22] and the overall shift to value-based reimbursement, this change may become much more prevalent, as the expansion of these services during the crisis are affirming that some services do not, in fact, need to be performed by physicians or in a hospital setting. Because patients treated in the comfort of their own homes require less testing, have fewer readmissions, and report higher satisfaction with the care received,[23] taking certain services out of the hospital setting will not just reduce long-term costs for insurers, but will also reduce healthcare costs for patients. Going forward, hospitals may face significant pushback from patients if providers insist the services received in the home during the crisis must now be returned to the hospital setting, especially if the patient was satisfied with the care received in-home. This shift may allow home health providers to capitalize on the newfound need for home healthcare post-COVID-19.[24]

The Final Blow to Rural Providers

Rural hospitals were already in a precarious position pre-crisis, with many rural providers teetering on the brink of closure with "*razor-thin*" operating margins.[25] COVID-19 has changed the risk of closure into a reality – seven rural hospitals have closed since the beginning of the pandemic.[26] Before the crisis, approximately 25% of rural hospitals were at risk of closing unless financial conditions improved.[27] The elimination of elective procedures will further negatively affect the long-term viability of many rural providers, as evidenced by the *American Hospital Association* (AHA) requesting additional emergency funding for that very reason.[28]

Pre-crisis, rural hospitals were already a victim of their circumstances, due to an older and less healthy patient population,[29] rural outmigration, payor-mix degradation,[30] clinician shortages, and an overall lack of capital.[31] The current pandemic may be the final blow. The federal stimulus efforts, in their current form, are likely not sufficient to prop up rural hospitals for the duration of the public health crisis.[32] Closures of rural hospitals could significantly change the healthcare delivery landscape in much of the country. This may force the expedited adoption of telehealth in rural regions at a time when broadband networks, even in rural America, appear to have sufficiently handled the surge in traffic from the pandemic, indicating that rural broadband networks can support the use of telehealth in rural areas post-COVID-19.[33]

Ameliorated Healthcare Worker Shortages

The critical state of the physician workforce shortage has been highlighted by the pandemic, compelling the relaxation of Medicare licensing restrictions that has allowed for an influx of physicians and other healthcare clinicians.[34] Regulations loosened by the *Department of Health & Human Services* (HHS) include allowing hospitals to use non-physician providers (NPPs) to the fullest extent possible.[35] Current Medicare standards of care regulations, which require Medicare patients to be under the care of a physician, have been waived for the duration of the crisis.[36] Other changes related to NPPs include the following:

(1) The *Coronavirus Aid, Relief, and Economic Security (CARES) Act* permanently authorizes NPs and physician assistants (PAs) to order home healthcare services for Medicare patients;[37]

(2) CMS waivers allow all providers to practice across state lines (via telehealth technology) at the top of their license authority;[38]

(3) CMS waivers allow NPPs to perform some medical exams at skilled nursing facilities;[39] and,

(4) A number of those states that do not currently allow full practice authority have relaxed their scope of practice standards.[40]

(Continued on next page)

These expansions in NPP scope of authority and state licensure could theoretically remain in place going forward with minimal adverse consequences. Such changes may serve to alleviate physician manpower shortages not just during a public health crisis, but over the next few decades, as the aging *Baby Boomers* population will require more healthcare services than the current physician population can provide. Because CMS has shown a willingness in the past to expand NPP practice authority, more states have been expanding NPP scope of practice,[41] and the federal government has explicitly endorsed expanding NPP practice authority,[42] there is a strong possibility that at least some of these changes related to NPP practice authority will become permanent.

In addition to expanding NPP practice authority, many states have also substantially decreased licensing requirements for foreign physicians and medical students, which may further alleviate physician shortage problems long term.[43] Foreign physicians (who are already living in the U.S.) will likely stay in the U.S. post-crisis due to the higher physician salaries,[44] which would significantly increase the supply of physicians.[45] Additionally, many states have allowed nearly-graduated medical students to commence practicing immediately.[46] Thousands of medical students have joined the ranks to fight COVID-19, with some in special services roles, but many through early residency start.[47] The push to graduate medical students early could finally move medical schools in the direction of graduating more medical students based on *competency-based medical education* (wherein students are judged on competency, not on years in medical school), which would significantly reduce physician shortage problems in the long run because many medical students could graduate after three years, in contrast to the current four-year curriculum.[48]

The Future is Still Unwritten

As the ultimate impact of COVID-19 is unknown, it will likely take a significant amount of time before healthcare consumer behavior returns to previous trends, if ever. Moreover, what characteristics will define the "*new normal*" of healthcare consumer behavior remain tentative at best. Health policy experts have argued that this unprecedented moment in the nation's history is the ideal time for Congress to transform the U.S. healthcare delivery system.[49] However, policy experts may overestimate the appetite of congressional lawmakers for bipartisan healthcare reform, especially considering the impending presidential election. While Congress has acted swiftly and cooperatively thus far to alleviate the economic and healthcare crisis, further bipartisan agreement on contentious healthcare issues seems improbable.[50] While healthcare crises such as COVID-19 may highlight the inadequacies of the healthcare delivery and payment system, and accordingly spark healthcare reform conversations, the reality is that Americans traditionally have only had the appetite for small incremental changes to the healthcare system. Although a wholesale change of the healthcare system appears improbable, the changes highlighted above, such as patient care settings shifting away from traditional settings and the utilization of technology and other clinicians to increase healthcare access, could, in aggregate, result in the next paradigm shift in the U.S. healthcare delivery system.

1 Thomas Kuhn proposes in his book "*The Structure of Scientific Revolutions*" that crisis is a fundamental part of a paradigm shift. "What Is A Paradigm Shift, Anyway?" By Tania Lombrozo, National Public Radio, July 18, 2016, https://www.npr.org/sections/13.7/2016/07/18/486487713/what-is-a-paradigm-shift-anyway (Accessed 4/14/20).

2 "Tracking deregulation in the Trump era" The Brookings Institute, April 15, 2020, https://www.brookings.edu/interactives/tracking-deregulation-in-the-trump-era/ (Accessed 4/21/20).

3 "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers" Centers for Medicare & Medicaid Services, 2020, https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (Accessed 4/14/20).

4 "Surge Capacity" Ambulatory Surgery Center Association, March 25, 2020, https://higherlogicdownload.s3.amazonaws.com/ASCACONNECT/b42cd922-f859-443e-852e-27f187129ed1/UploadedImages/COVID-19/SurgeCapacity_ASCA.pdf (Accessed 4/13/20).

5 "COVID-19: A Message to ASCs" Ambulatory Surgery Center Association, March 20, 2020, https://www.ascassociation.org/asca/resourcecenter/latestnewsresourcecenter/covid-19/covid-19-message (Accessed 4/13/20)/

6 A more comprehensive explanation of One Medical's business model is available in the February 2020 *Health Capital Topics* article entitled, "Healthcare "Disrupters" Continue to Attract Capital." "Healthcare "Disrupters" Continue to Attract Capital" Health Capital Topics, Vol. 13, Issue 2 (February 2020), https://www.healthcapital.com/hcc/newsletter/02_20/HTML/IPO/convert_ipo_hc_topics.php (Accessed 4/15/20).

7 "COVID-19 pushing primary care to brink of collapse" By Farzad Mostashari, Modern Healthcare, April 2, 2020, https://www.modernhealthcare.com/opinion-editorial/covid-19-pushing-primary-care-brink-collapse (Accessed 4/15/20).

8 "No More Lip Service; It's Time We Fixed Primary Care (Part One)" By Andy Lazris, Alan Roth, and Shannon Brownlee, Health Affairs, November 20, 2018, https://www.healthaffairs.org/do/10.1377/hblog20181115.750150/full/ (Accessed 4/21/20).

9 "Telehealth Index: 2019 Physician Survey" American Well, 2019, https://static.americanwell.com/app/uploads/2019/04/American-Well-Telehealth-Index-2019-Physician-Survey.pdf (Accessed 4/17/20), p. 4.

10 "Mostashari, April 2, 2020.

11 For a robust explanation of CMS's telehealth waivers, see: "COVID-19 Could Solidify Telehealth's Long-Term Future" Health Capital Consultants, Vol. 13, Issue 3, March 2020, https://www.healthcapital.com/hcc/newsletter/03_20/HTML/TELE/convert_telehealth_hc_topics.php (Accessed 4/14/20). "President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak" Centers for Medicare & Medicaid Services, March 17, 2020, https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak (Accessed 4/14/20); "Medicare Telemedicine Health Care Provider Fact Sheet" Centers for Medicare & Medicaid Services, March 17, 2020, https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet (Accessed 4/24/20).

12 Centers for Medicare & Medicaid Services, March 17, 2020.

(Continued on next page)

13 "Medicare Agency Weighing Permanent Telehealth Rule Changes" By Shira Stein, Bloomberg Law, April 15, 2020, https://www.bloomberglaw.com/product/blaw/document/XCBKPSCS000000?criteria_id=7e4dcba25fe223fbce3d0791e0deb911&searchGuid=c076cb34-a26c-42d8-846c-038c01a64f94&bna_news_filter=health-law-and-business (Accessed 4/15/20).
14 *Ibid.*
15 "Health Insurance Providers Respond to Coronavirus (COVID-19)" America's Health Insurance Plans, 2020, https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/ (Accessed 4/14/20).
16 *Ibid.*
17 *Ibid.*
18 *Ibid.*
19 "What Will U.S. Health Care Look Like After the Pandemic?" By Robert S. Huckman, Harvard Business Review, April 7, 2020, https://hbr.org/2020/04/what-will-u-s-health-care-look-like-after-the-pandemic?utm_source=BenchmarkEmail&utm_campaign=P4P_eNewsletter_-_4%2f16%2f2020&utm_medium=email (Accessed 4/15/20).
20 "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely" By Chapin White and Christopher Whaley, Rand Corporation, 2019, https://www.rand.org/pubs/research_reports/RR3033.html (Accessed 4/15/20).
21 Huckman, Harvard Business Review, April 7, 2020.
22 "Home Care Providers Look Ahead as Medicare Advantage Evolution Continues" By Robert Holly, Home Health Care News, April 7, 2019, https://homehealthcarenews.com/2019/04/home-care-providers-look-ahead-as-medicare-advantage-evolution-continues/ (Accessed 4/24/20).
23 "Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences" By Alex D. Federman, Tacara Soones, and Linda DeCherrie, JAMA Internal Medicine, Vol. 178, Issue 8 (August 2018), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2685092 (Accessed 4/17/20).
24 Huckman, Harvard Business Review, April 7, 2020.
25 "Rural Relevance 2017: Assessing the State of Rural Healthcare in America" By Michael Topchik, The Chartis Center for Rural Health, 2017, https://www.chartis.com/forum/wp-content/uploads/2017/05/The-Rural-Relevance-Study_2017.pdf (Accessed 4/20/20).
26 Counting all rural hospital closings in February through April 2020. "Rural Hospital Closure Data for Download" University of North Carolina, The Cecil G. Sheps Center for Health Services Research, available at: http://www.shepscenter.unc.edu/download/11619/ (Accessed 4/23/20).
27 "2020 Rural Hospital Sustainability Index" By Dave Mosely and Daniel Debehnke, Guidehouse, https://guidehouse.com/insights/healthcare/2020/rural-hospital-sustainability-index (Accessed 4/13/20).
28 "AHA statement on additional emergency funding for hospitals & health systems" American Hospital Association, April 13, 2020, https://www.aha.org/press-releases/2020-04-13-aha-statement-additional-emergency-funding-hospitals-health-systems (Accessed 4/21/20).
29 "Rural Aging" Rural Health Information Hub, 2020, https://www.ruralhealthinfo.org/topics/aging (Accessed 4/14/20); "Tobacco Use in Rural Areas" Rural Health Information Hub, https://www.ruralhealthinfo.org/toolkits/tobacco/1/use-in-rural (Accessed 4/14/20); "New Report Shows U.S. Obesity Epidemic Continues to Worsen" By Michael Devitt, AAFP, October 15, 2018, https://www.aafp.org/news/health-of-the-public/20181015obesityrpt.html (Accessed 4/14/20).
30 The poverty rate in rural areas is 17.2% compared to 14.3% in urban areas. "Poverty Rates/Median Household Income in United States by County Type: 2013-2017" United States Census Bureau, https://www.census.gov/library/visualizations/2018/comm/acs-5yr-poverty-type.html (Accessed 4/14/20).
31 "One in four rural hospitals were at high financial risk of closing even before coronavirus" By Jeff Lagasse, Healthcare Finance, April 8, 2020, https://www.healthcarefinancenews.com/news/one-four-rural-hospitals-were-high-financial-risk-closing-even-coronavirus (Accessed 4/14/20).
32 "Rural Hospitals Unsure Coronavirus Aid Is Coming" By Peg Brickley, The Wall Street Journal, April 9, 2020, https://www.wsj.com/articles/rural-hospitals-unsure-coronavirus-aid-is-coming-11586424601 (Accessed 4/14/20).
33 "Pandemic hasn't crushed broadband networks—even rural areas are doing OK" By Jon Brokin, Ars Technica, April 8, 2020, https://arstechnica.com/information-technology/2020/04/pandemic-hasnt-crushed-broadband-networks-even-rural-areas-are-doing-ok/ (Accessed 4/21/20).
34 "Immigrants With Foreign Medical Training Untapped in Virus Fight" By Genevieve Douglas, Bloomberg Law, April 13, 2020, https://www.bloomberglaw.com/product/blaw/document/XFU90VFS000000?criteria_id=e9f47350ece4a755d32413d954343041&searchGuid=dab88026-9379-4be7-bc6e-f8169e0fc3dd&bna_news_filter=health-law-and-business (Accessed 4/15/20).
35 Centers for Medicare & Medicaid Services, 2020, p. 4.
36 *Ibid*.
37 "Federal COVID-19 Emergency Legislation Authorizes PAs to Order Home Health Services" American Academy of Physician Assistants, March 27, 2020, https://www.aapa.org/new-central/2020/03/federal-covid-19-emergency-legislation-authorizes-pas-to-order-home-health-services/ (Accessed 4/14/20).
38 "Trump Administration Acts to Ensure U.S. Healthcare Facilities Can Maximize Frontline Workforces to Confront COVID-19 Crisis" Centers for Medicare & Medicaid Services, April 9, 2020, https://www.cms.gov/newsroom/press-releases/trump-administration-acts-ensure-us-healthcare-facilities-can-maximize-frontline-workforces-confront (Accessed 4/15/20).
39 *Ibid.*
40 "COVID-19 State Emergency Response: Temporarily Suspended and Waived Practice Agreement Requirements" American Association of Nurse Practitioners, April 23, 2020, https://www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements (Accessed 4/24/20).
41 "More States Pushing For Autonomy in Scope-of-Practice Battle" By Christopher Cheney, HealthLeaders, May 1, 2019, https://www.healthleadersmedia.com/clinical-care/more-states-pushing-autonomy-scope-practice-battle (Accessed 4/24/20).
42 In a March 2020 letter, HHS asked state governors to lift supervision requirements on and provide more flexibility to many NPPs. "HHS Secretary Letter to States Licensing Waivers" Department of Health & Human Services, March 24, 2020, https://www.ncsbn.org/HHS_Secretary_Letter_to_States_Licensing_Waivers.pdf (Accessed 4/20/20).
43 Most states are requiring physicians to be in good standing in their country of origin and have five years of experience to qualify. "Immigrants With Foreign Medical Training Untapped in Virus Fight" By Genevieve Douglas, Bloomberg Law, April 13, 2020, https://www.bloomberglaw.com/product/blaw/document/XFU90VFS000000?criteria_id=e9f47350ece4a755d32413d954343041&searchGuid=dab88026-9379-4be7-bc6e-f8169e0fc3dd&bna_news_filter=health-law-and-business (Accessed 4/15/20).
44 Many foreign physicians already reside in the country but do not practice medicine or below their capability due to state licensing restrictions. "Immigrants With Foreign Medical Training Untapped in Virus Fight" By Genevieve Douglas, Bloomberg Law, April 13, 2020, https://www.bloomberglaw.com/product/blaw/document/XFU90VFS000000?criteria_id=e9f47350ece4a755d32413d954343041&searchGuid=dab88026-9379-4be7-bc6e-

(Continued on next page)

f8169e0fc3dd&bna_news_filter=health-law-and-business (Accessed 4/15/20).
45 "Immigrants With Foreign Medical Training Untapped in Virus Fight" By Genevieve Douglas, Bloomberg Law, April 13, 2020, https://www.bloomberglaw.com/product/blaw/document/XFU90VFS000000?criteria_id=e9f47350ece4a755d32413d954343041&searchGuid=dab88026-9379-4be7-bc6e-f8169e0fc3dd&bna_news_filter=health-law-and-business (Accessed 4/15/20).
46 *Ibid*; ""Itching to get back in": Medical students graduate early to join the fight" By Gabrielle Redford, April 3, 2020, https://www.aamc.org/news-insights/itching-get-back-medical-students-graduate-early-join-fight (Accessed 4/15/20).
47 Redford, April 3, 2020.
48 *Ibid.*
49 "Will 2020 Be the Year That Medicine Was Saved?" By Ezekiel J. Emanuel and Amol S. Navathe, The New York Times, April 14, 2020, https://www.nytimes.com/2020/04/14/opinion/coronavirus-hospitals.html (Accessed 4/15/20).
50 "Will there be a second round of coronavirus stimulus checks?" By Doug Whiteman, Yahoo! finance, April 17, 2020, https://finance.yahoo.com/news/second-round-coronavirus-stimulus-checks-204420905.html (Accessed 4/23/20); "Next coronavirus aid package may not pass Congress until June as battle lines harden" By Victor Reklaitis, MarketWatch, April 22, 2020, https://www.marketwatch.com/story/next-coronavirus-aid-package-may-not-pass-congress-until-june-as-battle-lines-harden-2020-04-22 (Accessed 4/23/20).

FREE EBOOK DOWNLOAD
Health Capital Topics 2019
Visit www.healthcapital.com
This book reviews and discusses subjects in the ever-changing U.S. healthcare industry and how they may affect healthcare organizations. Topics include value-based reimbursement; the latest regulatory pronouncements; emerging healthcare organizations; and much more.
CLICK
GET IT NOW

 (Continued on next page)

(800)FYI - VALU

Providing Solutions in the Era of Healthcare Reform

Founded in 1993, HCC is a nationally recognized healthcare economic financial consulting firm

- HCC Home
- Firm Profile
- HCC Services
- HCC Experts
- Clients & Projects
- HCC News
- Upcoming Events
- Contact Us
- Email Us

HCC Services

- Valuation Consulting
- Commercial Reasonableness Opinions
- Commercial Payor Reimbursement Benchmarking
- Litigation Support & Expert Witness
- Financial Feasibility Analysis & Modeling
- Intermediary Services
- Certificate of Need
- ACO Value Metrics & Capital Formation
- Strategic Consulting
- Industry Research Services

Todd A. Zigrang, MBA, MHA, CVA, ASA, FACHE, is the President of HEALTH CAPITAL CONSULTANTS (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare – 2nd Edition*" [2015 – AICPA], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. In addition to his contributions as an author, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); American Health Lawyers Associate (AHLA); the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President & General Counsel of HCC, where she focuses on project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions, and research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. She has presented before associations such as the American Bar Association and NACVA.

John R. Chwarzinski, MSF, MAE, is Senior Vice President of HCC, where he focuses on the areas of valuation and financial analysis of healthcare enterprises, assets and services. Mr. Chwarzinski holds a Master's Degree in Economics from the University of Missouri – St. Louis, as well as, a Master's of Science in Finance Degree from the John M. Olin School of Business at Washington University in St. Louis. He has presented before associations such as the National Association of Certified Valuators and Analysts; the Virginia Medical Group Management Association; and, the Missouri Society of CPAs. Mr. Chwarzinski's areas of expertise include advanced statistical analysis, econometric modeling, and economic and quantitative financial analysis.

Daniel J. Chen, MSF, CVA, focuses on developing Fair Market Value and Commercial Reasonableness opinions related to healthcare enterprises, assets, and services. In addition he prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams. Mr. Chen holds the Certified Valuation Analyst (CVA) designation from NACVA.

Paul M. Doelling, MHA, FACMPE, has over 25 years of healthcare valuation and operational management experience and he has previously served as an administrator for a number of mid to large-sized independent and hospital-owned physician practice groups. During that time, he has participated in numerous physician integration and affiliation initiatives. Paul has authored peer-reviewed and industry articles, as well as served as faculty before professional associations such as the Medical Group Management Association (MGMA) and the Healthcare Financial Management Association (HFMA). He is a member of MGMA, as well as HFMA where he previously served as President of the Greater St. Louis Chapter.

© HEALTH CAPITAL CONSULTANTS