Professional Services Agreements: Emerging Hospital-Physician Integration Model

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Why PSAs?

- Market imperative to integrate and align for quality and efficiency improvement
- Need for team approach to disease and population health management
- Aversion to employment of many historically independent physicians/medical groups
- PSA preserves a modicum of practice independence and future strategic options for physicians
Types of PSAs

- Medical Director Agreements
- Coverage Agreements
- Hospital-Based Service Agreements
- Leased Employee Agreements
- Foundation Model Arrangements
- PSA Conversion Agreements
- Co-Management Arrangements
PSA Conversion Agreements
PSA Conversions: Introduction

- Conversion of existing group practice facility/ambulatory care center
- Clinically and financially integrate and align
- Hospital license and payment rates
- Medical group stop loss: hospital bears risk of reimbursement reductions and nonpayment
- Potential economic win-win
PSA Conversion Transaction

Hospital provides:
- License
- Provider-based status
- Space/equipment
- Mid-levels other than NP/PAs (off-campus)

Group Provides:
- Physician staffing
- Non-clinical staff
- NP/PAs
- Management services

Professional Services Agreement

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Professional Services Agreements
Principal PSA Legal Issues

☐ Stark Law

- Under arrangements prohibition: cannot have investment interest in entity (including own medical group) that “performs” the DHS service
- Assign leaseholds/Sell equipment?
- “Stand in the shoes”
- Personal services, fair market value or indirect comp exception: fair market value/independent appraisal advisable
Principal PSA Legal Issues (cont.)

☐ Anti-Kickback Statute

- Personal services and management contracts and/or space or equipment rental safe harbor: fair market value/independent appraisal strongly advised

- Some irreducible AKS risk: aggregate compensation not set in advance if RVU based
Principal PSA Legal Issues (cont.)

- Provider Based Status Regulations
  - Within 35 mile radius
  - Hospital license requirements/Physical space standards
  - CON issues
  - Clinically, financially and administratively integrated
  - Hospital reporting lines
  - Hospital must directly employ mid-levels/techs at off-campus sites (other than NPs/PAs)
  - Medical group can lease non-clinical staff and NPs/PAs to Hospital
  - No off-campus joint venture with medical group
Principal PSA Legal Issues (cont.)

- **Tax Exemption Considerations**
  - No inurement/private benefit
  - No excess benefit transaction
  - Rebuttable presumption of reasonable compensation process
  - Rev. Proc. 97-13 and private use of bond financed space or equipment/duration limitations (3 years/2 year out)
Principal PSA Legal Issues (cont.)

- Reassignment exception
  - Joint and several liability for refunds
  - Individual physician assignment agreements

- Antitrust
  - Sufficient clinical and/or financial integration for joint pricing?
  - Exclusivity and market power
  - New antitrust guidelines for ACOs
PSA Conversion Model
Valuation Considerations
PSA Conversion Models (or “Synthetic” Employment Agreements)

- Instead of traditional employment, new arrangements are gaining traction whereby physicians retain their own practice and are compensated on a productivity basis (e.g., per work relative value unit (“wRVU”)) for their clinical services.

- The wRVU rate payable to the physician group is a “gross” rate that typically includes remuneration for:
  - Cash compensation
  - Taxes and benefits
  - “Retained” practice expenses (e.g., malpractice insurance, CPE costs, etc.)
PSA Conversion Models (cont.)
(or “Synthetic” Employment Agreements)

- FMV considerations – Generally the same as employment arrangements, with additional consideration given to the overall arrangement.

- FMV analysis should consider pre- and post-transaction compensation.
As previously mentioned, can involve the purchase of physicians’ tangible assets and/or an employee leasing arrangement. In either case, it is key that these two components are consistent with FMV as well.

Employment agreements have many moving parts...the “terms and features” are critically important.
PSA Conversion Agreements
Various Approaches

- Market Approach
  - Compares a physician/practice against available benchmark data
  - Commonly seen metrics:
    - Work Relative Value Units (i.e., wRVUs)
    - Professional collections
    - Median comp per wRVU
  - Through a “percentile matching technique,” align each productivity variable with the expected level of compensation.
Make a “weighting” determination based on the unique facts of the particular arrangement and credibility of data.

Depending on the specialty and/or sources of physician data, it may be that one market indicator is more appropriate than another.
Cost and Income Approaches

- Application of these two approaches can offset and mitigate limitations of the market approach.
- Provide view into local marketplace
- Allow analysis of full array of economic factors affecting physician compensation
- Provide a reality check
PSA Conversion Agreements
Various Approaches (cont.)

- Cost Approach
  - Normalized and adjusted historical compensation
  - Realistic numbers for the cost to recruit

- Income Approach
  - *Pro forma* based on hypothetical-typical employer basis
  - Reflects future market conditions

- Earnings Available for Physician Compensation
  (i.e., Calculate applicable overhead, deduct benefits and apply a cost of capital)

- Synthesize all three approaches
PSA Conversion Agreements
Using Survey Data

- Confucius Statistician say...If you torture the data long enough, it will confess to the crime it did not commit.
- Data from reliable sources can be misused in a variety of ways, including:
  - Cherry picking from among different tables (e.g., regional data vs. state data)
  - Failure to consider ownership/ancillary profits that may be inherent in all reported percentiles of compensation
  - Do regional compensation differences exist? The grass is always greener...
PSA Conversion Agreements
Caution Regarding Compensation per wRVU

Example of misuse of data, using MGMA for Orthopedic Surgery: General

- 90th percentile cash compensation - $876,000
- 90th percentile wRVUs – 13,977
- 90th percentile compensation per wRVU - $103.71

Where is this going?

- 90th percentile wRVUs x 90th percentile compensation per wRVU = $1,450,000 (i.e., 165% of 90thP compensation)
- MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU
- Median compensation (per wRVU) is a misnomer; no physician wants to be below the median!
- Evaluate comp by quartile of production data; comp per wRVU declines as wRVUs increase
Providers implementing wRVU models have been observed to make errors related to:

- “Total” vs. “Work” relative value units
- GPCI adjustments
- Assistant at surgery
- Multiple procedures
- Mid-level providers (i.e., “Incident to” or “at full rate”)
- Use of “blended” rate for multiple specialties
- CMS changes in wRVUs
- New or discontinued CPT codes
PSA Conversion Agreements
Physician Non-Salary Expense

Should certain payments be passed through or fixed, rather than as a component of a wRVU rate?

☐ Professional liability expense
☐ Benefits costs such as insurance coverage for medical, dental, vision or life insurance
☐ Benefits costs for what is normally an employer-contributed pension or retirement plan
☐ Employer’s portion of taxes for FICA Medicare and FICA Social Security
PSA Conversion Agreements
Physician Non-Salary Expense (cont.)

- Benefit plans are becoming more robust
  - Need to review and evaluate the components

- Since likely “baked” into the wRVU value, it is important to determine a “cap” on benefits
  - e.g., Tier out the wRVU value to accommodate the benefit ceiling

- Is it commercially reasonable to have a non-exclusive arrangement? (i.e., physician gets to maintain certain aspects of the practice?)
PSA Conversion Agreements
Perils of Compensation “Stacking”

Beware of existing agreements that preceded the PSA, as well as other new terms.

- Sign-on bonus
- Productivity bonus
- Medical directorship
- Co-management agreement
- Quality bonus
- Retention bonus
- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits

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Other Key PSA Issues

- Payor pushback
- Increased patient co-pays
- wRVU/compensation guarantees and anti-dilution protection
- Alignment of comp incentives with changing payment systems
- Adding new physicians/NPs/PAs
- Duration and durability
- Exclusivity and existing relationships
Other Key PSA Issues (cont.)

- Staffing Issues
  - Split staff (off-campus) with salary/benefit differentials
  - Union issues
- Unwind rights
- Post-termination restrictive covenants
- Breach remedies and dispute resolution
Hybrid PSA/Service Line Co-Management Arrangements
What IS a Service Line Co-Management Arrangement?

- At core, it is also a contractual relationship.
- Between a hospital and physicians, or between a hospital and a joint venture comprised of the hospital and physicians.
- Focused on a hospital service line.
- To engage physicians as a business and clinical partner in managing, overseeing and improving service line quality and efficiency.
Service Line Co-Management Direct Contract Model

- Payors
- Hospital
- Service Line
- Operating Committee

Designees

Hospital-licensed services

- Two, or multi-party contract
- Specifically enumerated services
- Allocates effort and reward between groups

Medical Group I
Medical Group II
Other Group(s)

Co-Management Agreement

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Service Line Co-Management Joint Venture Model

- Payors
- Hospital
- Oncologists/Groups
- ONC Service Line
- JV Management Company

- Capital Contributions
- Management Infrastructure

Co-Management Agreement
Profit Distribution
Profit Distribution

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Professional Services Agreements
Service Line Co-Management Arrangements

- Typically two levels of payment to physician managers:
  - Base fee – a fixed annual base fee that is consistent with the fair market value of the time and effort participating physicians dedicate to service line development, management, and oversight
  - Bonus fee – a series of pre-determined payment amounts, each of which is contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals
  - Aggregate payment generally approximates 3-6% of service line revenues
- Fixed, fair market value; independent appraisal advisable
PSA with Service Line Co-Management Agreement

Notes:
• Same as PSA arrangement, plus
  - Service Line Co-Management Agreement (3–6% of Service Line revenue)
  - PSA component – wRVU rate equal to aggregate current physician comp/benefits
  - Employee Lease – cost plus
  - Co-management component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard
Additional Legal Considerations

There are legal constraints on Service Line Co-Management Agreements (*i.e.*, CMP, AKS and Stark):

- No stinting
- No steering
- No cherry-picking
- No gaming
- No payment for changes in volume/referrals
- No payment for quicker-sicker discharge
- No reward for changes in payor mix, case mix
- Must be FMV; independent appraisal required
Additional Legal Considerations: CMP Law

- Civil Monetary Penalty Law prohibits a hospital from making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to a Medicare or Medicaid beneficiary who is under the direct care of the physician.
  - OIG maintains that the CMP Statute prohibits reducing medically unnecessary services or substituting clinically equivalent items.
  - Section 6402 of PPACA exempts from the definition of “remuneration” “any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (. . . as designated by the Secretary under regulations)”
  - Potentially broad authority, but requires regulations

- Proposed limited CMP waiver regulation issued on April 7, 2011 with respect to ACOs participating in the MSSP (76 Fed. Reg. 19655):
  - Protects distributions of ACO shared savings from a hospital to a physician if the payments are not made knowingly to induce the physician to reduce or limit medically necessary items or services
  - 15 favorable OIG Advisory Opinions on gainsharing—low risk of abuse
Additional Legal Considerations: CMP Law

- Cost savings metrics/incentives implicate Civil Monetary Penalty Law
  - Hospital cannot pay a physician to reduce or limit services to Medicare/Medicaid beneficiaries under the physician’s care.
  - Cannot pay for reduction in LOS or overall budget savings

- Can pay for cheaper not fewer items of equivalent quality?
  - Potential to incent verifiable cost-savings from standardizing supplies or reducing administrative expenses as long as quality is not adversely affected and volume/case mix changes are not rewarded
Additional Legal Considerations: Anti-Kickback Statute

- Volume/revenue-based performance measures implicate the Anti-Kickback Statute
  - Should not reward increase in utilization, revenue, or profits of service line
  - Should not reward change in case mix
  - Should not reward change in acuity
  - Should obtain independent appraisal of FMV to help negate inference of improper intent

- Advisory Opinions indicate that the AKS could be violated if the requisite intent is present, but that OIG would otherwise not seek sanctions.
Additional Legal Considerations: Anti-Kickback Statute

- Co-Management contract will not meet Personal Services and Management Contracts safe harbor if “aggregate compensation” is not set in advance.
  - Maximum and minimum compensation may be set in advance, but aggregate compensation may not be.
- Joint venture probably will not meet small investment safe harbor 40/40 tests.
  - More than 40% of interests held by persons in a position to refer
- Analyze under AKS “one purpose” test; some irreducible legal risk
Additional Legal Considerations: Stark

- Proposed Incentive Payment and Shared SavingsRegs
  - 2009 PFS Final Rule reopened and solicited comments on 55 specific areas
  - No exception anytime soon (if at all), except for ACOs participating in MSSP
  - Not necessary: fit into one or more existing exceptions
    - Personal service, fair market value, indirect compensation exception
    - Fair market value requirement/independent appraisal strongly advised
Co-Management Arrangements
Valuation Considerations
Typical Features of a Co-Management Arrangement

- The agreement stipulates a listing of core management/administrative services to be provided by the manager (for which the base fee is paid).

- The agreement includes pre-identified incentive metrics coupled with calculations/weightings to allow computation of an incentive payment (which can be partially or fully earned).
  - Usually tiered in terms of level of accomplishment and associated payouts.
  - Must demonstrate some level of improvement over “current state” in order to receive the “top tier” of compensation.
  - Can provide some level of compensation for maintaining current state, if at national benchmark or better.

- Compensation is directed towards accomplishments rather than hourly-based services.
Valuation Process
Riskiness of Co-Management Arrangements

Among the spectrum of healthcare compensation arrangements, co-management arrangements have a relatively “high” degree of regulatory risk if FMV cannot be demonstrated.

☐ By design, these agreements exist between hospitals and physicians who refer patients to the hospital.

☐ Available valuation methodologies are limited and less objective as compared to other compensation arrangements.

☐ The “effective” hourly rate paid to physicians may be higher than rates which would be considered FMV for hourly-based arrangements (since a significant component of compensation is at risk).
Valuation Process
Approaches to Value

☐ Available valuation approaches include:
  ■ Cost Approach
  ■ Market Approach
  ■ Income Approach

☐ In considering these valuation approaches, an income approach can likely be eliminated since the possible or expected benefits of the co-management agreement may not translate directly into measurable income.
The Cost Approach

- The Cost Approach can be used to estimate the “replacement” or “replication” cost of the management/administrative services to be provided by the manager.
- An analysis by “proxy,” or an approach that estimates the number of medical director hours required to manage the service line in the absence of a management arrangement, (which is then multiplied by an FMV hourly rate) yields one indication of value.
- However, within the framework of a joint venture management company, this approach does not consider the hospital’s contribution.
- Further, a key ideal of most co-management arrangements is to reward results rather than time-based efforts.
The Market Approach

- The Market Approach recognizes that each co-management arrangement is unique and may include and prioritize different market and operational factors.

- Therefore, within the framework of the Market Approach analysis, consideration must be given to the required management tasks.
  - Specific tasks and responsibilities of the managers must be identified.
  - On an item-by-item basis, the relative worth of each task/responsibility is “scored” relative to other comparable arrangements.
  - An indication of value of the management services is then established by comparing the “scoring” of the subject agreement to other service arrangements in the marketplace.
Valuation Synthesis

- The Cost and Market valuation methodologies should be reconciled to arrive at a final conclusion of value.
  - The Cost Approach may “underestimate” the value of the arrangement because in the case of joint ventures, the Cost Approach only considers physician participation (i.e., medical directors).
  - The Market Approach may “overestimate” the value of the arrangement because market comparables may not be exact.

- While it may be appropriate to give equal weighting to the two approaches, the valuator may conclude that one method should be weighted more heavily than the other.
  - Make an assessment regarding the split between the base fee and incentive fee components.

- The FMV of the base fee must encompass payment of any medical director fees or administrative services related to managing the service line.
What Drives Value?

- As a percentage of the service line net revenues, the total fee payable under a co-management arrangement typically ranges from 3% to 6% (on a calculated basis).
- The fee is fixed as a flat dollar amount, including both base and incentive components, for a period of at least one year.
  - Commonly, the base fee equals 50-70% of the total fee.
- The extent and nature of the services drive their value. Thus, the valuation assessment is the same whether the manager consists of only physicians or physicians and hospital management.
- Determinants of value include:
  - What is the scope of the hospital service line being managed?
  - How complex is the service line? (e.g., a cardiovascular service line is relatively more complex than an endoscopy service line)
  - How extensive are the duties being provided under the co-management arrangement? How many physical locations are being managed?
What Drives Value? (cont.)

- Size adjustments based on service line revenue:
  - Large programs may be subject to an “economies of scale” discount.
  - Small programs may be subject to a “minimum fee” premium.

- Consider the appropriateness of the selected incentive metrics:
  - Is the establishment of the incentive compensation reasonably objective?
  - Consider the split of base compensation and incentive compensation.

- Who is responsible for monitoring and “re-basing” the metrics?
Possible Pitfalls of Co-Management Arrangements

- The service line/revenue stream to be managed must be defined objectively, and there should be no overlap between multiple service lines which may be subject to co-management arrangements (e.g., surgery service line and orthopedic surgery service line).

- A co-management arrangement typically contemplates that no third-party manager is also providing similar services on behalf of the hospital or its service line.

- Care must be taken to ensure that employed physicians who are part of co-management arrangements are not double paid for their time.
  - Employment compensation based solely on wRVUs is self-normalizing.
Possible Pitfalls of Co-Management Arrangements (cont.)

- Medical director agreements related to the managed service line must be compensated through the base management fee.
- There can be no passive owners, active participation and significant time and effort are required by busy physicians.
  - Documentation requirements
Other Key Service Line
Co-Management Issues

- Performance standards and targets
  - Validation
  - Achievability
  - Reset
- Term/durability
  - Rev. Proc. 97-13 (5/3 years if 50%+ fixed)
- Dilutive effect of adding physicians due to fixed FMV fee for services rendered

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Other Key Service Line
Co-Management Issues

- Cost of independent monitor, valuation, security offering (for JV)
- Some irreducible legal risk
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