

# Professional Services Agreements: Emerging Hospital-Physician Integration Model

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# Why PSAs?

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- ❑ 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

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- ❑ Medical Director Agreements
- ❑ Coverage Agreements
- ❑ Hospital-Based Service Agreements
- ❑ Leased Employee Agreements
- ❑ Foundation Model Arrangements
- ❑ **PSA Conversion Agreements**
- ❑ **Co-Management Arrangements**

# **PSA Conversion Agreements**

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# PSA Conversions: Introduction

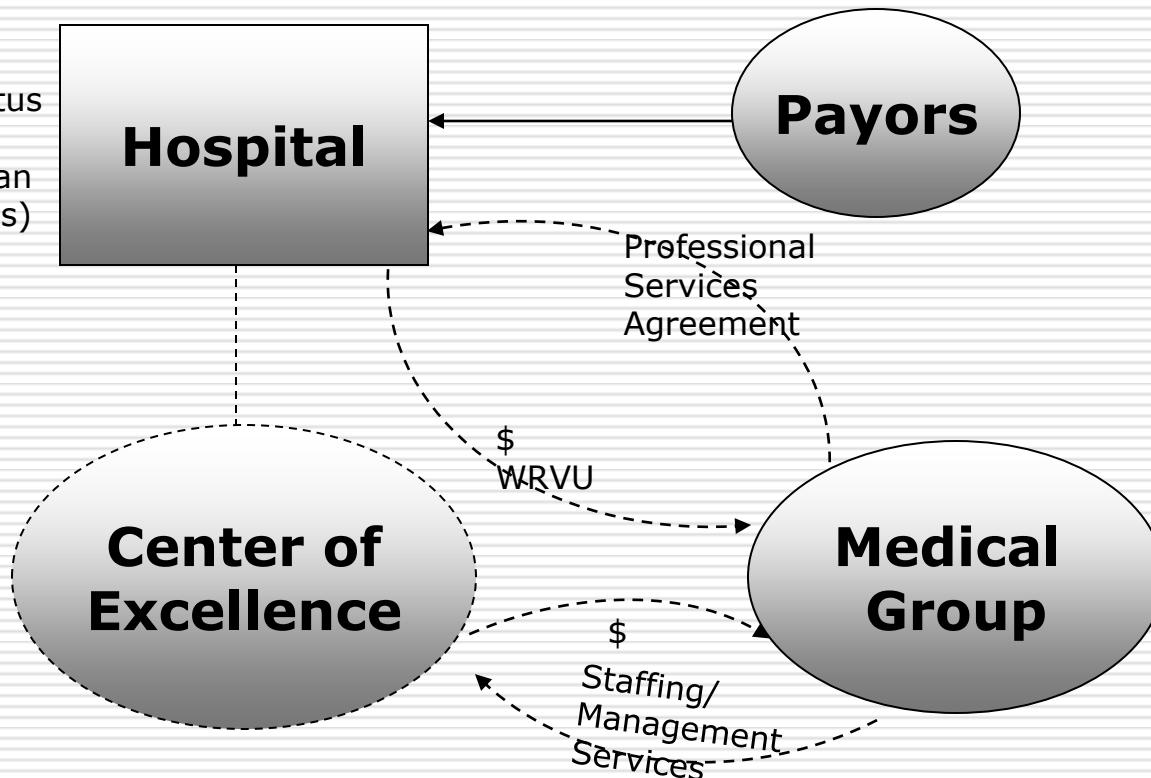
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- ❑ Conversion of existing group practice facility/ambulatory care center
- ❑ Clinically and financially integrate and align
- ❑ Hospital license and payment rates
- ❑ Medical group stop loss: hospital bears risk of reimbursement reductions and nonpayment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

# Principal PSA Legal Issues

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## 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.)

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## □ 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.)

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- 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.)

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## □ 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.)

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- 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**

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# PSA Conversion Models

## (or “Synthetic” Employment Agreements)

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- 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)

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- 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.

# PSA Conversion Models (cont.) (or “Synthetic” Employment Agreements)

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- 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

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### 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.

# PSA Conversion Agreements

## Various Approaches (cont.)

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- 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.

# PSA Conversion Agreements

## Various Approaches (cont.)

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- 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.)

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- ❑ 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

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- 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

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### **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

# PSA Conversion Agreements

## Perils of wRVU Models

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**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

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**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.)

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- 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”

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**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

# Other Key PSA Issues

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- ❑ 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.)

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- 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**

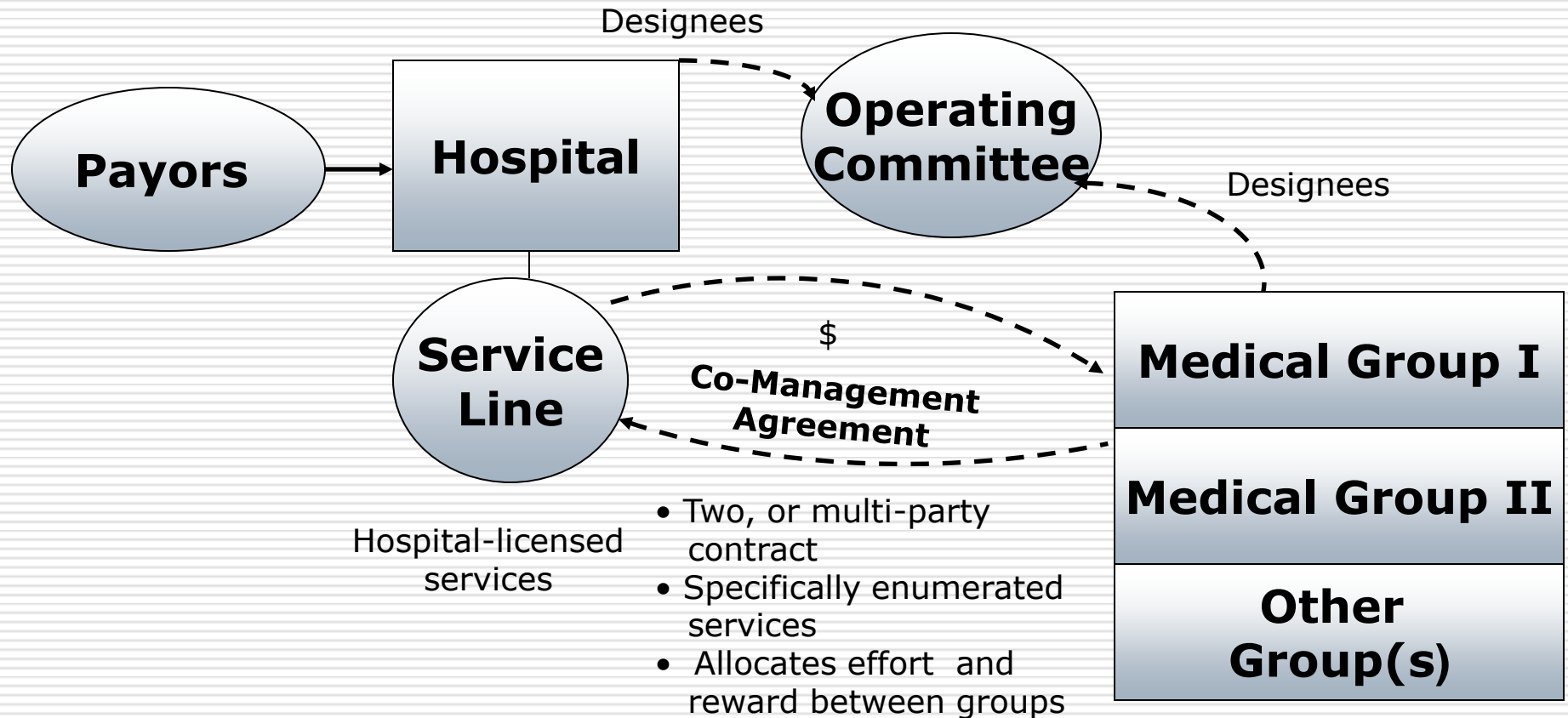
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# What IS a Service Line Co-Management Arrangement?

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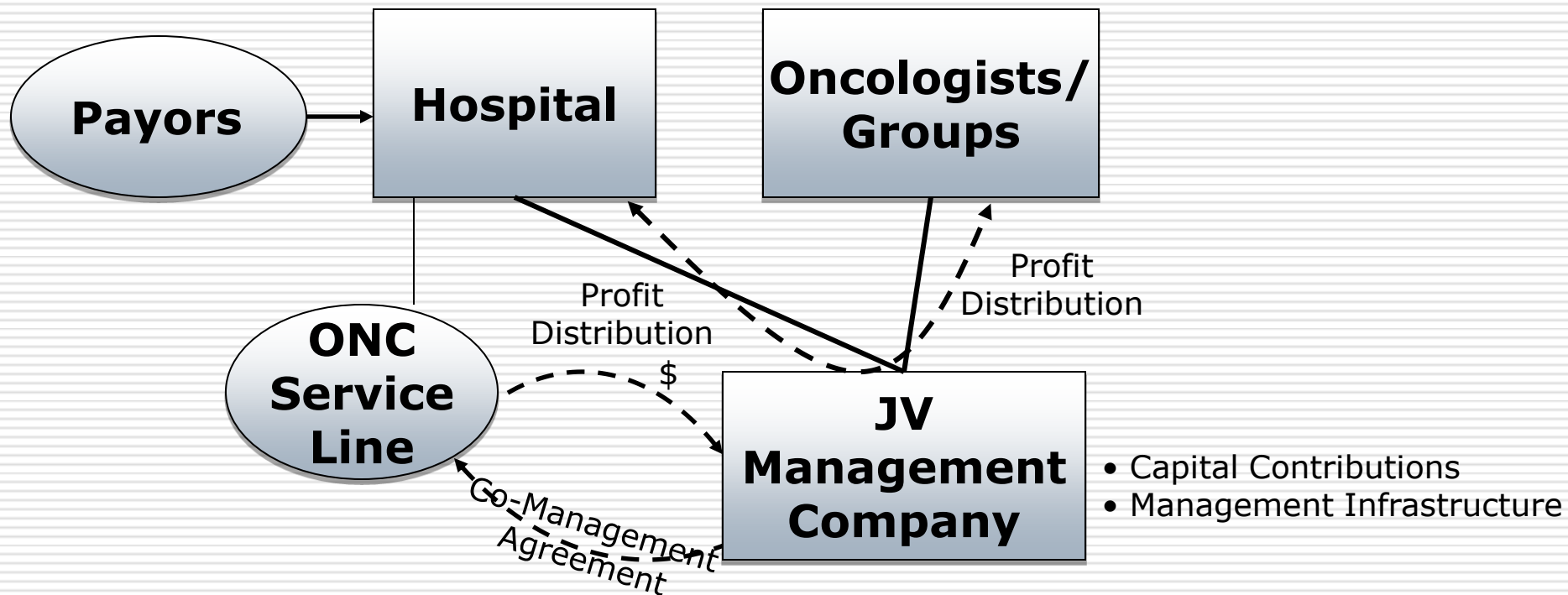
- ❑ At core, it is also a contractual relationship.
- ❑ Between a hospital and physicians, or between a hospital and a joint venture comprised of the hospital and physicians
- ❑ Focused on a hospital service line
- ❑ To engage physicians as a business and clinical partner in managing, overseeing and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

# Service Line Co-Management Direct Contract Model



# Service Line Co-Management Joint Venture Model

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# Service Line Co-Management Arrangements

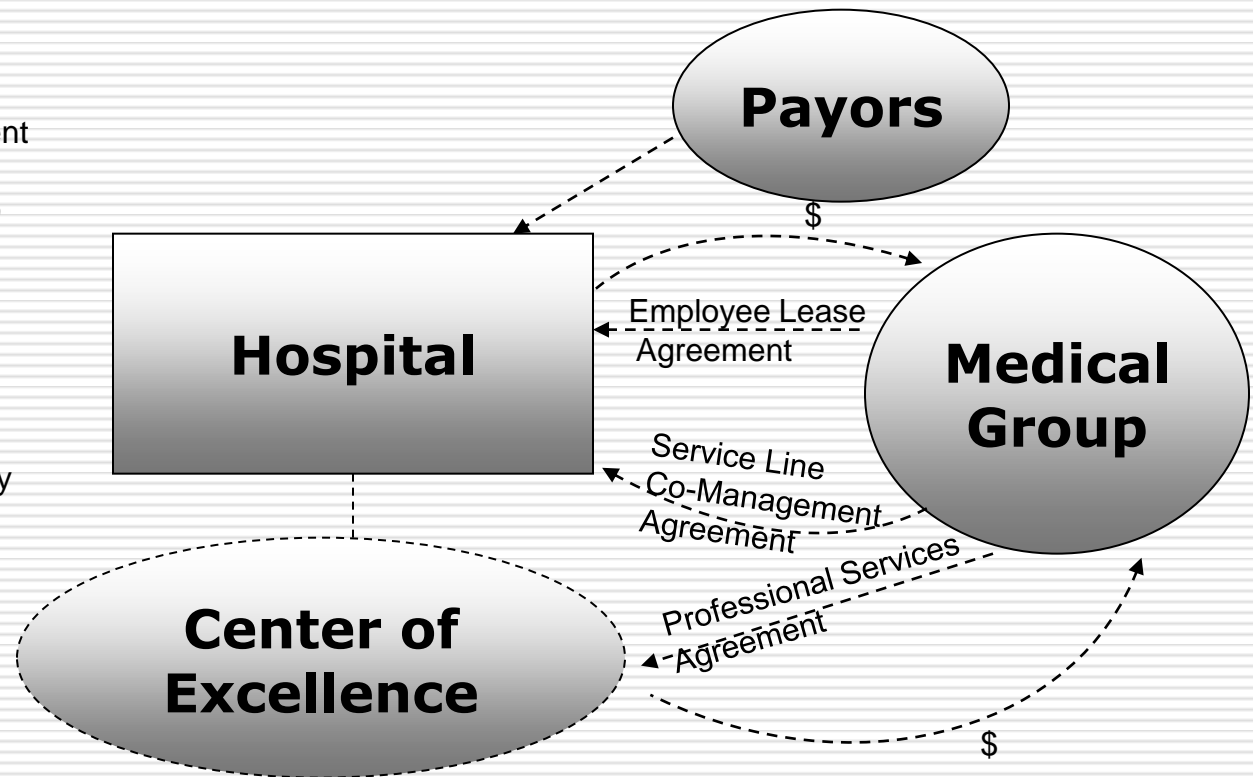
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- Typically two levels of payment to physician managers:
  - Base fee – a fixed annual base fee that is consistent with the fair market value of the time and effort participating physicians dedicate to service line development, management, and oversight
  - 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

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## **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

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- ❑ 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

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- ❑ 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

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- 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

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- 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

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- Proposed Incentive Payment and Shared Savings Regs
  - 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**

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# Typical Features of a Co-Management Arrangement

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- 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

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**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

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- 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

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- ❑ 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

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- 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

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- 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?

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- 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.)

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- 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

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- 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.)

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- ❑ 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

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- 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

# Other Key Service Line Co-Management Issues

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

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