

ACG GI Practice Toolbox

Alignment but NOT Employment: Professional Service Agreements with a Hospital System

AUTHORS:

Stephen T. Amann, MD, FACG, Digestive Health Specialists, Tupelo, MS

James C. DiLorenzo, MD, New York Associates at Montefiore and New York GI Center, LLC

INTRODUCTION:

An evolution of the physician to hospital relationship is ongoing. Changes are being driven by the need to provide value and quality, the economic pressures on private practices, and the need for physicians to protect the valuable resource of time. Hospital employment is not the preferred option for many due to a desire for autonomy and personal stewardship. An alternative contractual vehicle, the professional services agreement (PSA), offers an avenue to advance alignment with your hospital system and remain independent while acquiring financial support for direct services provided. PSAs provide an option open to practices of any size.

BACKGROUND:

Radically different reimbursement paradigms, rising expenses, and uncertainty of future revenue have pushed private practice physicians to consider new ways to economically relate to hospital systems. Full hospital employment can provide security and frees the physician of many of the burdens of private practice. However, the loss of autonomy experienced when moving from a private practice to a larger facility is significant. A PSA may be a more attractive option to foster alignment without employment. These agreements are typically fostered through an Internal Revenue Service (IRS) 1099 payment structure (rather than a W-2). Through a PSA, the physician is still employed at their practice corporation, but agrees to provide services at the hospital as an independent contractor. PSAs are fundamentally flexible and customizable. While there are a variety of different types of PSAs, the most common types are discussed below.

Entering into a PSA can confer several advantages - enhanced compensation, strategic planning, including joint development of clinical programs, installation of the electronic health record systems, data sharing, joint recruiting of new physicians, and bridging participation in clinically integrated networks (CINs) or accountable care organizations (ACOs). Through PSAs, physicians receive fair market value (FMV) compensation for any clinical or administrative services provided.



Key Benefits of a PSA vs. an Employment Agreement:

- Physician independence from hospital
- Greater flexibility
- Physicians can keep their existing benefits structures
- Stability for the physician-hospital relationship
- Easing implementation into a hospital CIN or ACO
- Easier to terminate
- Increased leverage to re-negotiate

General Risks of a PSA vs. an Employment Agreement:

- Pressure from hospital to expand services provided
- Easier for hospital to terminate
- Easier for hospital to non-renew

What are the most common PSA types? What are the key components?

1. Global PSA

- Hospital pays all practice overhead, along with work relative value unit (RVU)-based compensation for the physicians. Support staff remain employees of the practice.
- A joint-management committee with hospital and physician representation manages the practice.
- Physicians remain directly involved in running their practice (practices must be capable of management and reporting to the hospital's professional services and finance department).
- Hospital owns accounts receivable, establishes fee structures and contracts with payors.
- Ownership of ancillary revenue, real-estate, billing and collections are negotiable.
- As the practice infrastructure remains intact, at dissolution, physicians can return to their original practice format with minimal disruption.
- The duration of this type of agreement is typically short (1-2 years) and will likely need to be renegotiated based on the outcome of the contract term.

2. Traditional PSA

- Hospital employs all support staff, assumes and manages the practice through their practice entity. This frees the physicians from the responsibility over the typical day-to-day practice management.
- Hospital contracts with the physicians through the existing practice entity.



- Physician compensation is based on a work RVU formula.
- Physicians remain employees of the practice entity.
- Hospital owns accounts receivable, establishes fee structures and contracts with payors as well as billing and collections.
- Ownership of ancillary revenue and real-estate are negotiable.
- Significant changes may be developed at your practice, depending on the nature of the work culture that the hospital establishes for its employees. Once the contract expires, re-entering private practice typically requires hiring an entirely new office staff.
- Hospital employment may prove advantageous to support staff.
- The productivity and financial data acquired during the PSA contract term can provide transparency to the process of negotiating to full-time employment at the end of the contract term.

3. Practice Management Arrangement (PMA)

- Hospital employs the physicians directly (W-2 type payment).
- Physician group-practice management (MSO) and administrative structure is independently preserved, but contract with the hospital for these services.
 - i. Hospital pays fair market value (FMV) for management services.
- Lacks flexibility of a typical PSA, but eases transition to employment and can simplify dissolution or transfer completely to hospital.

4. Carve- Out PSA

- Physician groups can agree to provide specific services or needs, such as call coverage, endoscopy services or various combinations of services.
- This is a limited provision for specific services provided, that is tailored to the needs of the hospital and the practice.
- Physician services are paid based on FMV and are typically work RVU-based.
- Related administrative costs would be carved out and reimbursed by the hospital separately.
- This is limited in scope and does little to advance strategic initiatives for either the hospital or the practice but can provide specific services in need without higher levels of integration by the practice to the hospital.

5. “Wrap – arounds” to PSAs

- Can be a part of some aspects of PSAs to add focus on quality and value. This includes: cost saving initiatives, administrative duties, teaching functions, or medical directorships.



- Can be simple incentive payments, or up to and including, “at-risk” compensation for demonstrating quality of care and cost-efficiencies.
- Becoming more common, as the focus on quality and value for services increases.

Key concerns for the practice when considering a PSA:

- Does the agreement fit into applicable Stark Law and anti-kickback statutes?
- Does the proposed agreement provide a fair compensation package based on FMV?
- Is the intended hospital partner or MSO capable of running your practice as efficiently as you or your current staff?
- Will the new management structure allow a sufficient degree of shared decision-making?
- Is the contract long enough to make it worthwhile? Ability to renegotiate over time?
- Will the hospital seek to push you to full employment?
- What happens to your practice with non-renewal?
- Are there hidden costs in the overhead which do not exist in your current practice?
- How does your practice value moving forward with reimbursement changes?
- How are physician extenders factored into the FMV calculation?

Depending on how you answer these questions, one type of PSA may be a better fit for your practice’s specific needs.

Suggestions and Comments:

1. Evaluate your practice's current status and review all available options. While the focus of this article is practice alignment and retaining independence through PSA arrangements with hospital partners, other options to consider include full independence, full employment by a hospital/system, or employment within a large group corporate model.
2. Evaluate the PSA models and choose which best suits your goals. Work with the proposed hospital partner to provide raw data that can be used to devise a compensation plan, and address operational issues and human resources concerns.
3. Expert legal guidance is recommended to ensure any agreement meets requirements for FMV, Stark, anti-kickback statutes, and state-specific laws.
4. Work together as a group to choose and devise the best long-term arrangement. Do not be afraid to get creative! Find ways to help your group and make it attractive to your partners, such as a cohesive approach to GI care and other possible value-added services.



5. Many of these structures are relatively new and have not yet been tested legally to the fullest degree. **Thus, consult with an experienced healthcare attorney before entering into any arrangement.**
6. Ensure that the appraisal and valuation approaches are done by an experienced third-party valuation company. The hospital system internal valuation will not be adequate or impartial.
 - a. See Attachment 1: The Valuation Process and Fair Market Value
7. Use the Employment Checklist from the “White Paper: A contemporary options for alignment and integration. The Coker Group¹ “to review key discussion topics as you explore your options.”
 - a. See Attachment 2: Employment Checklist from the White Paper: “A contemporary option for alignment and integration.”

RESOURCES:

1. PSAs as an alternative to employment: White Paper: A contemporary options for alignment and integration. The Coker Group; Reiboldt M, Greeter A, Khan M, Harrison T. March 2016; 3-31.
2. Safreit SM, Hutzler AC. HealthCare Appraisers, Inc. The ABA Health Law Section. The Health Lawyer. Feb 2012; 24(3):1-33.
3. Allen JJ, Kaushal N. New Models of Gastroenterology practice. Clin Gastroenterol Hepatol 2018; 16:3-6.
4. <https://www.healthcareappraisers.com/insights/valuation-of-professional-services-arrangements>



Attachment 1. The Valuation Process and Fair Market Value

Keys to The Valuation Process:

- The valuation process is complex process and nearly all transactions between hospitals and referring physicians implicate the Stark Law.
- Stark Law definition of FMV is different than for the IRS.
 - Stark requires that NO compensation is based on volume or value of referrals.
 - Stark Law requires the valuation be at “arm’s length” in which all parties are independent and on equal footing.
- Value based upon personally performed productivity is the most commonly used (and likely most supportable) metric. Therefore, work relative value units (wRVU) are preferred to total RVU. Remember to include relative values for practice expense and malpractice risk.
- Ensure that the appraisal and valuation approaches are done by an experienced third-party valuation company.
- The valuation should include multiple approaches for valuation which are weighted. The final valuation should include rationale for the approach chosen.
- Valuation Approaches:
 - Cost approach: use of historical data made to be comparable to the present PSA agreement
 - Income approach: This is the most used. This is based on future cash flow and a valuation multiple (based on risk of that future cash flow). Detailed industry knowledge required for that risk assessment and growth rates.
 - Market approach: Use of “comparable” to another PSA agreement. It is difficult to find a truly comparable agreement, so errors can occur. Comparable or surveys may include other sources of income above wRVU and weaken the strength of this approach.
- You must have the valuation reviewed by an appropriate legal team to advise the practice on the agreement and valuation process.



Attachment 2. Employment Checklist from the White Paper: “A contemporary option for alignment and integration.” (The Coker Group)*

- What does the practice prefer regarding overall structure relative to its alignment? For example, does the practice believe that the hospital’s management structure is lacking and, further, are there questions in the minds of the practice about the sustainability of the hospital management structure? Currently, does the hospital provide adequate support services for their aligned practices?
- Is there a strong preference among the parties (i.e., both the practice and the hospital/health system) for the staff to be employees?
- What is the gestalt of the parties relative to ancillary services? What are the applicable state (and federal) legal requirements and parameters surrounding the issue? Is it essential for the hospital/health system to own the ancillary services going forward?
- How are leadership and governance addressed? What are the voting rights and reserved powers the health system may require? What will be the effect of ethical and religious directives, if applicable?
- What value-based criteria are to be considered, and how will they affect the PSA model going forward? Will a portion of the compensation plan include consideration of such non- productivity-based (i.e., value based) criteria?
- Is compensation comparable under both PSA and employment? Are fair market value/commercially reasonable rates under consideration, regardless of the structure? Has an independent valuation expert provided an opinion?
- What assurances are given the physician group that the hospital/health system will allow a level of independence and governance, particularly if the structure is the Practice Management Arrangement or Traditional PSA model?
- What is the term of the agreement? More importantly, what are the rights for early termination (with or without cause)?
- How much security, both financial and otherwise, will the hospital/health system provide to the practice? What guarantees of income may exist?
- What leadership duties and responsibilities will be assigned to the physicians? These may include medical directorships as well as non-clinical leadership positions.
- What service line responsibilities, if any, will be assigned to the physicians?
- Does the PSA include any “wraparounds?” For example, are there any clinical co-management or service line management responsibilities? What about medical directorships? Are these enveloped within the PSA or subject to a separate agreement?
- Have the strategic, relational, economic, and functional advantages or disadvantages been articulated between the hospital/health system and the practice? Does the employment lite structure allow for full alignment as well as a high level of partnership?



- What is the status of the staff and their security, as well as compensation, assuming the Traditional PSA is the model of choice? Will there be a guarantee of employment for a period, post-transaction?
- What are the restrictive covenant/non-compete terms and conditions? Are they different than what an employment model entails?
- What are the terms of the employment lite agreement in the context of a changing reimbursement paradigm? For example, if a shift from productivity- to value-based reimbursement occurs, would the increase trigger an automatic change in the compensation structure from productivity to value?
- Under the Global Payment PSA, how is the overhead reimbursed? Is the amount a budgeted total? A fixed amount that is only adjusted upon mutual agreement through a governance committee? Or is it a combination of fixed budgeted total to be reimbursed and certain variable expenses tied to wRVUs?
- Is the employment lite model a precursor to employment? Is this matter specified in the definitive agreements?

* “PSAs as an alternative to employment: Contemporary options for alignment and integration”. The Coker Group; Reiboldt M, Greeter A, Khan M, Harrison T. March 2016; 3-31.

