How can you achieve more competitive compensation for your group and avoid the downsides of hospital employment? Consider a full-practice professional services agreement.

TOGETHER... yet separate

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How your medical group can achieve integration with a hospital — without hospital employment

As a medical group administrator, you are expected to maintain and even increase your physicians' incomes at the same time that they may resist pursuing the strategy that offers the highest probability for significant economic improvement: hospital employment. Administrators and physicians alike often fear employment models that will reduce their autonomy — including their ability to influence group culture. However, in many instances this independent mindset conflicts with the economic reality of private practice. You probably don't have an arsenal of strategies that will significantly improve — or even maintain — practice economics. If you did, you'd be using it.

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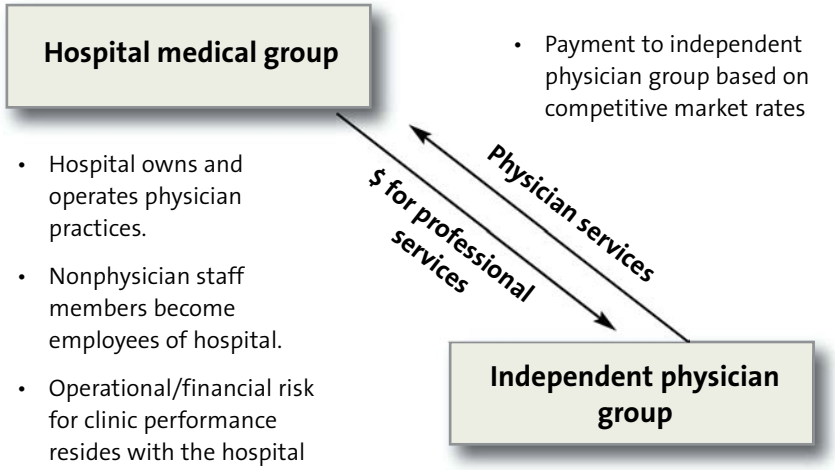
Together

Full-practice PSA



Although we're seeing more consolidation of the physician community through practice acquisition and employment by hospitals and integrated delivery systems, we see a need for alternative integration models that address administrator and physician concerns about hospital employment. One model that provides you an opportunity to achieve more competitive compensation for your group while avoiding some of the perceived downsides of employment is a full-practice professional services agreement (PSA).

Independence within an integrated physician-hospital arrangement

In a PSA, physicians can retain some of their independence within an integrated physician-hospital partnership. Basically, a full-practice PSA is a fully integrated model in which the hospital owns and operates a physician clinic and contracts with an independent physician group to provide professional services to that clinic. As the name indicates, typically all professional services — such as office visits, hospital procedures and hospital consultations — are included. The physician group no longer bills patients and payers for any services. Rather, its claims are assigned to a hospital, which is the responsible billing party.

Historically, PSAs have served as "niche" arrangements between hospitals and physician groups (example: a hospital contracting for physician services to staff its part-time outreach clinics). Now, full-practice PSAs work as vehicles to achieve full hospital-physician group integration. A PSA contractually obligates a physician group to provide a defined level of services that often includes call and coverage responsibilities, physician full-time equivalents (FTEs) (i.e., how many physician FTEs?) and access requirements (i.e., outpatient office hours between 8 a.m. and 5 p.m.). The diagram at left depicts the structure of a full-practice PSA.

How a PSA operates

The hospital pays the independent physician group a professional fee for delivering defined services to its owned medical practice. While payment alternatives such as base salary and per diem exist, the contract is typically weighted heavily toward physician productivity, often based on work relative-value units (wRVUs). Because an independent group assigns *all* its claims to a partnering hospital under a full-practice PSA, the fair-market-value payment to the group for services provided must account for all revenue sources (professional and technical) to be competitive with other independent groups offering a full array of ancillary services. A PSA typically compensates a group for all physician professional expenses, that is, cash compensation, fringe benefits and malpractice coverage.

The market rate paid to physicians under a full-practice PSA often improves their compensation, especially for doctors in markets with disproportionate government-payer penetration, depressed commercial rates or high cost of living. Without competitive physician compensation rates, these groups will fail to attract and retain high-quality practitioners.

A PSA model will typically include the sale of tangible practice assets, such as equipment and leaseholds, at fair market value. Unless the practice owns real estate, the sale of assets to the hospital or health system is a less significant portion of the overall transaction than determining how the group will be compensated for providing physician services.

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Case study – Sample cardiology group

The financial of a highly productive, five-physician cardiology group looks like this:

Total FTEs*	5.00
Total compensation	$2,205,000
Compensation per FTE	$441,000
Production: wRVUs**	64,000
wRVUs per FTE	12,800
Compensation per wRVU	34.45

*full-time-equivalent
** work relative value units

The group generates physician compensation from professional and technical services of $34.45 per wRVU. This equates to cash compensation of approximately $2.2 million, with weighted average productivity of 12,800 wRVUs per FTE physician. The three graphs show the disparity between how hard the cardiologists are working vs. the income they generate — compensation levels below market on a national basis, using benchmarks from the Medical Group Management Association *2008 Cost Survey Report for Single-Specialty Practices.*

The group's wRVU production is greater than the MGMA 75th percentile. However, corresponding compensation figures are well below that figure, regardless of whether productivity is measured on a per-wRVU or FTE-physician basis. Assuming the group integrates with a hospital via a full-practice PSA, the parties establish a payment rate per wRVU targeting compensation just above MGMA's 75th percentile per FTE physician at $45. (You could argue that this rate is still conservative and below market, given that groups performing above the 75th percentile would be highly efficient, probably generating compensation per wRVU above the 75th percentile.) Using this rate, total cash compensation to the sample cardiology group would rise to nearly $2.9 million, a net increase of approximately $675,000 (or $135,000 per FTE physician) (See the income table on page 50.)

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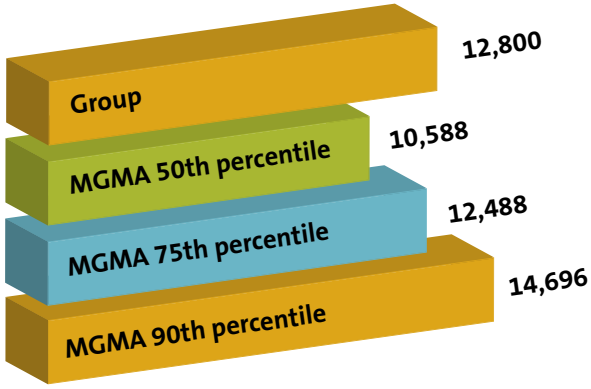
Cardiology group wRVUs* per FTE physician**

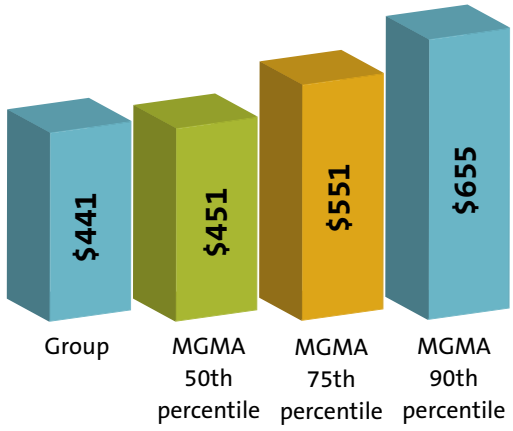
wRVUs per FTE



Cardiology group compensation per FTE physician**

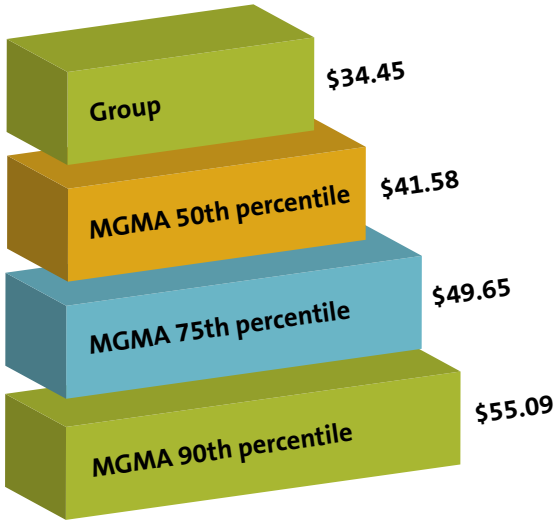
Compensation per FTE**

(000s)



Cardiology group compensation per wRVU*

Compensation per wRVU*



*full-time-equivalent
** work relative-value units

Income for sample cardiology group

Practice income			
Total group	Current	PSA	Change
	$2,205,000	$2,880,000	$675,000
Per FTE physician	$441,000	$576,000	$135,000
Per wRVU	$34.45	$45.00	$10.55

You can see that a full-practice PSA is a solution for groups experiencing less than optimal performance due to external factors such as commercial contract rates, payer mix and uncompensated care over which they have little control.

A PSA contractually obligates a physician group to provide a defined level of services that often include call and coverage responsibilities, physician FTEs and access requirements.

PSA implications for the group practice administrator

You, as well as your physicians, will experience some differences under a PSA:

- *Hospital name on your paycheck* – Staff members, including the practice administrator, are often employed by the partnering hospital. Wise hospital and group leaders recognize the importance of maintaining medical and administrative leadership of the existing group.
- *Different reporting relationships* – The reporting structure for the administrator changes with the design of the affiliation model. You are likely to report to a hospital executive and maintain an indirect reporting relationship to physician practice leaders. The hospital frequently establishes an advisory committee that may also provide strategic oversight for you.
- *A need to thoughtfully manage nonphysician staff* – A full-practice PSA will affect nonphysician staff as much or more than the physicians. Employees need to understand how their compensation and benefits may change and how new leadership affects them on a daily basis.

PSAs differ from hospital employment; come with caveats

The PSA model differs from full hospital employment of physicians: The PSA maintains the physician group. The group's physician compensation method influences its organizational culture. In our sample cardiology practice, the hospital writes a check for professional services to the group for $2,880,000. The practice's pay plan then divides the compensation among its physicians. In addition to decisions regarding physician compensation, the group maintains its governance and management model on physician-related matters according to its bylaws.

If your group is considering a PSA, recognize that it comes with potential disadvantages for a physician practice:

- *A difficult return to independence* – Should your group decide to return to private practice, the need for working and strategic capital may make the transition difficult. Nonphysician staff now employed by the hospital may find it hard to work for an independent group.
- *Potential additional costs* – The group will continue to have some external costs related to legal, tax and human resource functions.
- *A pathway to employment* – The PSA arrangement may lead to full employment of all physicians.

- *Market-based compensation might drop* – Physician compensation rates tied to a market-based figure will decrease if overall compensation rates for the specialty dip, as well. Although the PSA may continue to guarantee competitive compensation nationally and regionally, the hospital would most likely prevent a physician group unhappy with the rate from investing in business-development opportunities available to independent practices.
- *Culture change, loss of autonomy* – Do you have a job after the PSA transaction? You and your physicians might need to negotiate this from the start. As part of the hospital structure, your clinic's operation may now be subject to hospital rules and regulations. The physicians should realize the hospital will drive much of the decision-making for the practice.

As many markets see consolidation of health care service providers, there is a need for physician-centric models that stop short of employment by hospitals or health systems. Implemented correctly, a full-practice PSA can benefit both a hospital and a physician group. A PSA maintains a medical practice's anatomy but refocuses physician energy to patient care and strategic leadership (vs. the monotony of daily business operations). Unencumbered by an unsustainable business model and with a competitive pay plan, the group will be better positioned to compete for scarce physician resources. Physicians can pursue personal interests and develop subspecialty programs.

Similarly, a PSA gives a hospital the assurance that its interests are aligned with the clinical service, allowing leaders to make strategic decisions unhindered by limited physician resources. Aligned with medical groups through PSAs, hospitals will be more willing to invest in programmatic development, capital projects and technology.

In addition, properly structured PSAs can also provide significant, long-term benefits to local communities.

join the discussion: Is your group under a full-practice professional services agreement? Tell us at mgma.com/connexioncommunity or connexion@mgma.com

Characteristics of groups that may benefit from a full-practice PSA

Group characteristic	*Full-practice PSA implications*
Limited in-office ancillary services – Practice has chosen not to invest in ancillary services – currently performed at hospital	Full-practice PSA can achieve market compensation for physicians and enhance recruitment while benefiting the community by eliminating need for duplication
Poor patient demographics – Practice carries a disproportionate number of government payers and uncompensated care	Full-practice PSA can achieve market compensation if payment mechanism is tied to physician productivity, regardless of payer (consistent with hospital mission)
Inadequate commercial payer contracts – Practice unable to achieve competitive rates	Full-practice PSA corrects for market deficiency compared with other locales with competitive contracts
Poor management – Group has limited investment in management and difficulty controlling staff costs and general overhead	Full-practice PSA typically isolates the economic risk for clinic performance within the hospital. However, changes implemented by the hospital may affect physician productivity
Broad service area – Group is located in a market that requires significant investment in outreach activities, such as developing satellite clinics	Full-practice PSA will pay competitive rates, protecting physicians from lost productivity while in outreach clinics