

FEATURE STORY

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physician-hospital integration without hospital employment

A full-service professional services agreement can ensure that a hospital's interests are aligned with clinical services.

Physician employment models can offer hospitals and health systems an effective option for addressing key medical staff concerns. The models provide the ability to attract and retain high-quality physicians by compensating physicians at competitive compensation rates. Although market competitive compensation rates are a “no-brainer” starting point for recruiting new physicians to any community, today's reality is that many independent physician groups on any given medical staff may be economically challenged and unable to offer existing or incoming physicians rates that are competitive regionally or nationally.

AT A GLANCE

- > Hospitals can use a full-service PSA to achieve physician-hospital integration without the downsides of an employed practice.
- > Under a PSA, a hospital would serve as provider of service and responsible billing party.
- > A PSA contractually obligates a group to defined responsibilities.

Although employment may offer some economic advantages to physicians, many physicians perceive employment as a significant reduction in their autonomy, including their ability to influence the culture of the group practice. What can hospital leaders do if physician groups are unwilling to pursue the single strategy that offers the highest probability of achieving competitive compensation rates and building a medical staff of the depth and breadth needed by the patient population?

A wait-and-see approach to addressing struggling independent practices will only exacerbate a growing problem as economics worsen and existing physicians age and retire and/or ramp down their practices without additional physicians coming along to replace or expand capacity within their specialty. Although consolidation of the physician community through acquisition and subsequent employment is increasing (over and above the integration that occurred years ago during the wave of primary care employment), a need exists for integration models that address physician concerns over hospital employment. One model that provides many of the benefits of physician-hospital integration while avoiding at least some of the perceived downsides of employment is a full-practice professional services agreement (PSA).

Full-practice PSAs are increasing in prevalence and serving as a vehicle to achieve full hospital-physician integration.

What Is a Full-Practice PSA?

At its most basic level, a full-practice PSA is a fully integrated model where the hospital or health system owns and operates a physician clinic and contracts with an independent physician group to provide professional services. Typically, because all professional services (e.g., office visits, hospital procedures, and hospital consults) are included in the contract for professional services, the physician group no longer bills patients and payers for any services. Instead, a physician group assigns its claims to a hospital, which takes on the roles of provider of service and responsible billing party.

Full-practice PSAs are increasing in prevalence and serving as a vehicle to achieve full hospital-physician integration (and a potential midstep between independent practice and full employment models). From the physician group perspective, a PSA contractually obligates the group to defined responsibilities, which can include the number of physician clinics, call and coverage responsibilities, the number of physician FTEs,

and access/availability requirements. A full-practice PSA is depicted in the exhibit below.

In return for the physician group delivering defined services to the hospital-owned clinic, the practice is paid (contractually) based on professional services. Multiple alternatives exist for defining the payment between the purchaser (the hospital) and the physician group, including base salaries, per diem payments, production models, or some combination of multiple approaches. Because a 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 needs to account for all revenue sources (professional and technical) to be competitive in the market. PSAs typically also compensate groups for defined professional expenses, including fringe benefits and malpractice insurance. However, a PSA provides the flexibility to include more or less practice infrastructure depending on the shared goals and capital positions of the physician group and hospital partner.

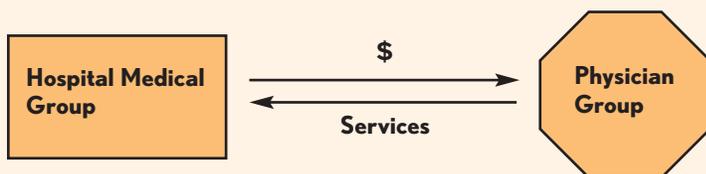
There are three potential structural scenarios.

Scenario 1. The hospital “leases” physicians’ services only, and the group receives a fair market value payment from the hospital for physician compensation, fringe benefits, and malpractice insurance.

Scenario 2. The hospital “leases” physicians’ services and nonphysician staffing (including compensation and benefits), and the group receives a fair market value payment from the hospital for all physicians’ services and staff-related overhead.

Scenario 3. The hospital “leases” physician services and all practice infrastructure (nonprovider staffing, building and occupancy, and equipment), and the group receives a fair market value payment from the hospital for all physicians’ services and all related overhead. Under this scenario, by avoiding the purchase of the physician group’s property and equipment (which instead can be leased by the hospital), the hospital partner is able to make a lower up-front capital investment

FULL-PRACTICE PROFESSIONAL SERVICES AGREEMENT



- > Owns and operates a physician practice(s)
- > Employs nonphysician staff
- > Assumes operational/financial risk for clinic performance

- > Maintains independent physician practice
- > Assigns all professional claims to hospital
- > Reimbursed for physician services provided to Hospital Medical Group

PROFILE OF SAMPLE ORTHOPEDIC GROUP

Total FTEs	8.00
Total compensation	\$3,360,000
Compensation per FTE	\$420,000
Production wRVUs	72,000
wRVUs per FTE	9,000
Compensation per wRVU	\$46.67

than would be required under the previous two scenarios.

A variety of factors can negatively affect an independent physician group’s ability to compensate physicians at market competitive rates. For groups experiencing difficulty, most share some or all of the following characteristics:

- > Limited access to ancillary service income
- > Markets/specialties with disproportionate governmental payer penetration
- > Depressed payment rates for commercial contracts
- > Locations in markets with an extremely high cost of living

In these instances, the market rate paid to physicians under a full-practice PSA may lead to improved physician compensation, allowing for the development of robust physician groups and specialties. Indeed, both groups and markets absolutely must have competitive physician compensation rates to attract and retain the high-quality physicians to serve the communities going forward.

It should be noted that a PSA should not be pursued as a means to address poor practice management or overhead deficiencies unless both parties (hospital and physicians) agree in advance. Culturally, it will be difficult for a physician to sign a PSA to only then have her or his practice operations turned upside down.

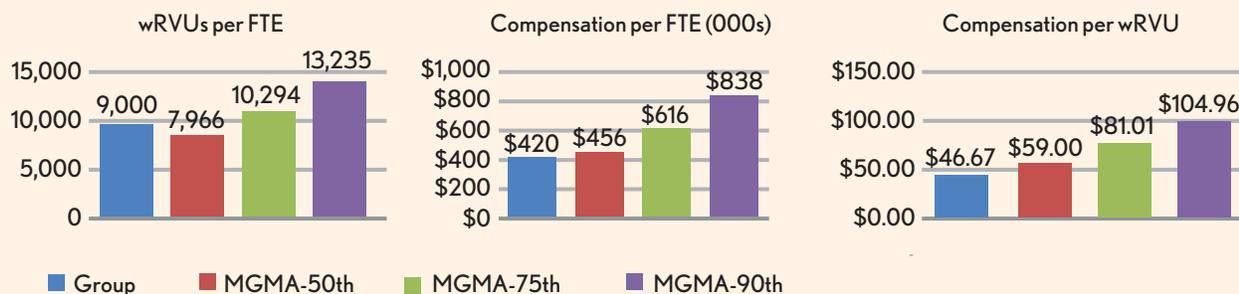
Case Study: Sample Orthopedic Group

A highly productive, eight-person orthopedic group generates compensation from professional and technical services of \$46.67 per work relative value unit (wRVU). (See group profile at left). This amount equates to total cash compensation (not including fringe benefits or malpractice) in the group of approximately \$3.4 million with weighted average productivity of 9,000 work wRVUs per FTE physician. The group has developed an on-site physical therapy service but does not offer magnetic resonance imaging. Also, the physicians do not have any investments in ambulatory surgery centers (ASCs). The exhibits below demonstrate the disconnect occurring between how hard the orthopedic surgeons are working and the current income generated from the practice.

The group’s wRVU production is significantly greater than the 50th percentile (per MGMA’s Physician Compensation and Production Survey, 2009 report). However, corresponding compensation figures are well below the MGMA 50th percentile (regardless of whether productivity is measured on a per wRVU or FTE physician basis).

Let’s assume that the group integrates with a hospital via a full-practice PSA, and a payment per

PHYSICIAN WORK EFFORT COMPARED WITH INCOME GENERATED



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wRVU rate targeting compensation just above MGMA's 50th percentile per FTE physician is established at \$63.00, as shown in the exhibit at right. (This rate is conservative when using the compensation per work RVU schedule.) Using this rate, total cash compensation to Sample Orthopedic Group would increase to nearly \$4.5 million, a net increase of approximately \$1.2 million (or \$147,000 per FTE physician). Again, in markets where orthopedic surgeons have access to ASC investments, the compensation rate used in this analysis would be below market (unless surgeons were allowed to retain outside investment opportunities).

Potential upsides and downsides. The exhibit below identifies potential upsides and downsides of a PSA arrangement from a hospital and health system leadership perspective.

Implications. The PSA, if structured, implemented, and managed appropriately (a significant *if*), offers health systems another vehicle for achieving

CASH COMPENSATION TO SAMPLE ORTHOPEDIC GROUP

	Practice Income		
	Current	PSA	Change
Total Group	\$3,360,000	\$4,536,000	\$1,176,000
Per FTE Physician	\$420,000	\$567,000	\$147,000
Per wRVU	\$46.67	\$63.00	\$16.33

physician-hospital integration. Both parties should work toward a final structure that promotes integration and performance while retaining the best characteristics of an independent practice. This model differentiates itself from full employment in that the "physician group" is maintained, including the ability to influence group culture, by determining the group's physician compensation methodology. In the above example, the Sample Orthopedic Group would receive a check for professional services in the amount of \$4.54 million, from which the group's pay plan determines compensation at the individual physician level. In

UPSIDES AND DOWNSIDES OF A PROFESSIONAL SERVICES AGREEMENT (PSA) FOR HOSPITALS

Potential Upsides

Technology. The group practice no longer has an incentive to duplicate services/investments.

Appropriate physician resource allocation. The PSA makes it possible to allocate physician resources to the geographies where they are needed. PSA rates offer a tool for hospitals/health systems to protect physicians from the lost productivity associated with travel/staffing outreach clinics.

Specialty-specific issues. The PSA gives hospitals the ability to address unique concerns/issues associated with key specialties (versus employment models/structures that may have been originally designed to effectively address concerns associated with small primary care practices).

Front-end flexibility. The PSA enables the hospital (depending on the final structure of the PSA) to avoid large capital outlays for equipment and/or real estate.

The ability to "date" before marriage. A PSA can be a good "test run" of how a full employment model would eventually function.

A defined "out." A PSA offers a predefined "out" for both integration partners if the PSA approach fails to meet expectations or cultures/vision are incompatible.

Compatible with other employed physicians. Because the clinic is hospital-sponsored, contractually aligned physicians technically are part of the "aligned medical group."

Potential Downsides

Ongoing contract management. A PSA becomes another contract in the file drawer that needs to be monitored on an ongoing basis and renegotiated on a periodic basis. If the PSA is one of 15 separate PSAs that the organization has in place, ongoing management could be difficult.

Branding issues. The integration partners will need to come to agreement on how the hospital/health system will brand physician services provided through the hospital-operated clinic.

Cultural issues. Although the physicians may continue to own and operate a professional corporation, they may have difficulty transitioning to an integrated model in which they are physicians functioning within a different provider organization. From a patient and a referring physician perspective, the PSA relationship should be undetectable.

addition to decisions regarding physician compensation, the group maintains its governance and management model on physician-related matters according to its bylaws. For organizations that have experienced a steep growth curve in their employed physician practices, the ability to retain a strong culture within an integrated group practice should have significant appeal.

PSAs Provide Mutual Benefit

Although many markets are experiencing consolidation through traditional physician employment, there remains a need for hybrid models and alternatives that are creative and stop short of full “employment.” If implemented correctly, a full-practice PSA provides mutual benefit to both hospitals and their physician group partners. With appropriate alignment through a PSA, hospitals will be more willing and able to invest capital in programmatic development, bricks and

mortar, and technology. More important, a PSA can give a hospital the assurance that its interests are aligned with the clinical service, allowing it to make strategic decisions to benefit the community without fear of limited physician resources hindering programmatic development. ●

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