Professional Services Agreements:  
A Physician-Hospital Integration Model  
Structuring Contracts and Complying With Stark Law and Anti-Kickback Statute

WEDNESDAY, SEPTEMBER 19, 2012
1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

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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
PSAs: Introduction

- Professional Services Agreements
  - Powerful tool
    - To staff existing Hospital cancer center or develop new hospital facility
    - To convert existing group sites to Hospital licensed facilities paid at hospital outpatient payment rates
    - Integrate and align Hospital and Group to improve quality, efficiency and operations of Hospital’s oncology service line
PSAs: Introduction (cont.)

- Potential economic win-win
  - Group paid fair market value compensation on an aggregate fixed fee or work relative value unit (“wRVU”) basis
    - Eliminates risk of reimbursement reductions and collection risk (free care/bad debt)
    - Other: purchase of equipment, management services, employee lease?
  - Hospital establishes new satellite sites or facility and new book of oncology business
    - Good contribution margin due to combination of hospital rates and physician office cost structure
    - Potential 340B pricing opportunity

- Potential economic losers
  - Payors—higher rates for “same” services
  - Higher patient co-pays
Professional Services Agreement

Hospital provides:
- License
- Provider-based status
- 340B pricing

Oncology Sites/Service Line

Payors

Professional Services Agreement

$/wRVU

Oncology Group

Group provides:
- Physician/NP/PA staffing

Hospital provides:

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PSA Transaction

- Avoid U/A transaction—Group cannot “perform the service”
  - Hospital could take assignment of Group leases from landlords
  - Hospital could purchase Group’s FFE and inventory at fair market value
  - Hospital would need to employ nurses/techs at off-campus locations (to meet Medicare provider-based status rules)

- Group can provide all other staff
  - Physicians/NPs/PAs
  - Non-clinical staff at all sites
  - Nurses and techs at on-campus sites
Professional Services Agreement

Hospital provides:
- License
- Provider-based status
- 340B pricing
- Space/equipment
- Nurses/techs (off-campus)

Oncology Group provides:
- Physicians/NPs/PAs
- Non-clinical staff
- Nurses/techs (on-campus)
- Administrative services?

Notes:
- FMV for assets and group retains cash and A/R
- PSA on fair market wRVU basis
- Employee lease on a fixed fee or cost plus fair market mark-up basis; or, administrative services as a percentage of collections with a FMV floor and cap
- Billing services at fair market percentage of collections or fixed fee per claim?
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 wRVU 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 years 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 wRVU) for their clinical services.

- The wRVU rate payable to the physician group is often 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.
PSA Conversion Models (cont.)
(or “Synthetic” Employment Agreements)

- 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.
PSA Conversion Agreements
Various Approaches (cont.)

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

- 90th percentile cash compensation - $825,000
- 90th percentile wRVUs – 13,867
- 90th percentile compensation per wRVU - $95.48

Where is this going?

- 90th percentile wRVUs x 90th percentile compensation per wRVU = $1,324,000 (i.e., 160% 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

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?)
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

- Payor pushback
- Role in governance of service line
- wRVU valuation issues
  - Relation to existing physician compensation/margins on drugs, imaging, labs, etc.
  - Benefits/other continuing expenses
  - New physicians/NPs/PAs
  - Anti-dilution protection
  - Harmonizing with alternative payment arrangements
- No overlap of duties/double payment
- Timing of 340B eligibility/cost report/HRSA registration process
Other Key PSA Issues (cont.)

- USP 797 standards and state pharmacy rules
- Staffing Issues
  - Split staff (off-campus) and salary/benefit differentials
  - Union issues
- Unwind rights
  - Asset repurchase
  - Lease assignment/real estate repurchase
  - Solicitation of employees
  - Data/records access/transfer
  - Systems issues
  - Non-compete exception
Hybrid PSA/Service Line Co-Management Arrangements
What Is a Service Line Co-Management Arrangement?

- At core, it is also an independent contractor relationship
- 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**

**Hospital-licensed services**

- **Medical Group I**
- **Medical Group II**
- **Other Group(s)**

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

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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
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 2-4% of service line revenues
  - Fixed, fair market value; independent appraisal advisable

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PSA with Service Line Co-Management Agreement

Notes:
• Same as PSA arrangement, plus
  - Service Line Co-Management Agreement
    (2-4% of Service Line revenue)
  - PSA component – wRVU rate equal to aggregate current physician comp/benefits
  - Employee Lease/Mgmt Agreement – FMV fixed fee or 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

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Professional Services Agreements
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
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 (cont.)

- 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 (cont.)

- 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
Addional Legal Considerations: Stark

- 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
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 2% to 4.5% (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 generally 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
Other Key Service Line
Co-Management Issues

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