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Physician Affiliations With Hospitals: Practical Tips for the Physician Practice When Entering Into a PSA



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I. Introduction

Due to the continuing uncertainties surrounding the health care delivery landscape, physicians are increasingly looking at alternatives to secure their survival. Historically, physicians have turned to their local hospital for assistance, and such avenue of recourse holds true in the current health care climate.

Recent discussions between physicians and hospitals have focused on various forms of affiliation structures, and a frequently discussed structure is based upon the “professional services agreement” (PSA) model. In simplest terms, the PSA model retains the basic structure of the practice, but bifurcates the clinical from the non-clinical component. Typically, both clinical staff (including the owner(s), associate physician(s), nurse practitioner(s) and physician assistant(s)) as well as

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nonclinical staff (including administrative personnel) remain employed by, and on the payroll of, the practice entity. The clinical personnel continue to perform medical services, however, the right to bill and collect for these clinical services are assigned to the hospital (or an affiliate). As compensation, the hospital pays the practice for the clinical services, typically based upon work relative value units (wRVUs). In addition, the non-clinical component of the practice will operate pursuant to an agreed upon budget. Pursuant to the budget, the hospital will reimburse the practice entity for its overhead. Practice overhead includes the following types of expenses: compensation and benefits for staff, office rental payments, equipment, utilities, supplies and other items, and all must be identified in the budget. The hospital will either purchase or lease the hard assets (and possibly medical records) of the practice. Additionally, in some cases, the practice will be paid a management fee or stipend.

This article identifies several practical considerations that physicians must consider prior to entering into the PSA model.

General Considerations

Prior to entering into an affiliation with a hospital, the practice should understand and weigh the benefits and detriments of the affiliation in order to determine whether the affiliation is worthwhile.

Practices typically believe that the PSA model will provide greater financial stability. This is due to the structure of the PSA model, which alleviates the burden of the billing and collection function from the practice and replaces it with payment by the hospital for its professional services based upon wRVUs generated. This relieves the practice of the risk of payer reduced payments or nonpayment, as well as the billing lag between the time of billing and receipt of payment. The PSA model provides the benefit of being paid based upon the performance of the service at a fixed rate, irrespective of if, or when, payment is actually received by the hospital for the clinical service provided.

Additionally, practices also believe that the affiliation will reduce the administrative burden of managing the practice. Indeed, in some cases a portion of the administrative burden of managing the practice can be shifted to the hospital which typically has more administrative resources.

Sometimes the practice's beliefs do not materialize, so it is appropriate to analyze the competing factors. First, the practice's autonomy is compromised in the PSA model, as the nonclinical expenses are based upon a budget. In the absence of a budgeted amount, the hospital must agree to a proposed expenditure. Most practices do not follow strict budgets and physicians generally make these decisions unilaterally. However, the PSA model will now require an additional layer of hospital input and approval. Similarly, operational autonomy is affected, as managerial decisions, such as hiring and firing of personnel, will also need to be approved by the hospital.

Separately, practices must consider the time and cost of an affiliation. The practice will need to retain counsel and a financial advisor, which in addition to costs, might result in a loss of productivity when physicians are involved with negotiating, rather than spending time with patients. Also, a transition to the hospital's EMR system and procedures may create downtime at the practice, resulting in a negative economic effect. Additionally, it is not unusual to have a significantly long lead time (six to 12 months or longer), as the affiliation must first be negotiated and then pre-go-live activities must occur, such as credentialing and IT connectivity.

Sale or Lease of Assets

An initial discussion point when entering into a professional service affiliation with a hospital is whether the practice will sell or lease its hard assets to the hospital. In either case, the amount paid must be fair market value, and the hospital should have an appraisal of the practice's assets to support the valuation. Some hospitals may include the value of the active patient charts in such calculation, while other hospitals may not. Beyond patient charts (if paid at all), a hospital generally does not pay for the value of the practice's goodwill. With this in mind, most smaller practices often have a nominal value, despite the contrary hope or expectation of the physicians.

Financial Considerations—wRVU Component

The PSA model typically pays the practice based upon the wRVUs produced by the physicians (both owner and nonowner), and in some cases, other clinical personnel (such as nurse practitioners and physician assistants). As this is one of the most significant economic components of the affiliation, it must be fully understood by the practice and its physicians when negotiated. The most obvious item is the negotiated fair market value dollar amount per wRVU (sometimes called the "conversion factor"). Accordingly, when considering the PSA model, the practice must know its historically produced wRVUs in order to properly analyze the economic impact.

Notwithstanding an agreement on the conversion factor for the initial term, a hospital will often want the ability to periodically revisit, and adjust, the conversion factor to the then fair market value. Any potential downward adjustment in the conversion factor may significantly alter the practice's initial beneficial financial arrangement. Consequently, the practice should make efforts to lock-in the initial conversion factor for an extended period (three to five years). Additionally,

adjustments to the conversion factor should require sufficient prior notice (at least six months) and, if it would result in a downward adjustment beyond an agreed upon percentage, should give the practice the right to terminate the affiliation with a reduction to, or entirely free of, the restrictive covenants.

In order to insure proper cash management for the practice, the practice should request the wRVU payment in advance of each month based upon estimated wRVUs to be produced during the following month (rather than in arrears). There will be periodic reconciliations (such as quarterly) to "true-up" these estimated payments against actual production. Some hospitals will limit the advance to 80 percent or 85 percent of the estimated wRVUs. This creates a built-in delta in favor of the hospital (to subsequently be reconciled). Still other hospitals refuse to pay in advance, and will only pay in arrears based upon the actual wRVUs produced. Of course, from the practice's perspective, upfront payments are favored so that the practice does not have to wait to receive payment from the hospital.

Since a physician's "total compensation package" includes more than his or her salary, the practice also needs to consider the fringe benefits, such as health insurance, retirement plan contributions, continuing medical education allowance, auto allowance, and other items. The practice needs to consider whether wRVU payments will adequately capture the financial value of these benefits, or negotiate with the hospital to pay for, and/or reimburse, the practice for them. When doing this, make sure that the practice includes the employer-side payroll tax since the employees will remain on the practice's payroll.

Financial Considerations—Budget and Overhead Component

Another significant financial component of the PSA model is the reimbursement of overhead. Overhead reimbursement creates an additional stream of payments to the practice by the hospital, and reimburses the practice for budgeted overhead expenditures. Typically, the practice and the hospital negotiate an annual budget in advance of each contract year. The hospital will then pay the practice on a monthly basis pursuant to the agreed upon budget. If an expenditure is not in the budget, or exceeds a line item in the budget, the hospital generally is not required to reimburse the practice unless it otherwise agrees (typically on a case by case basis). Accordingly, the practice needs to focus on the mechanics of the budget process from the outset, which should be clearly set forth in writing so the practice is fully reimbursed for its expenses.

Prior to signing the documents, the initial budget should be fully vetted, prepared and attached as an exhibit. The practice needs to insure that all anticipated expenditures are accounted for. These expenditures include: personnel salaries and benefits, office and equipment lease payments, repair and maintenance costs, supplies, utilities, professional fees, marketing expenses, medical waste disposal, etc. We stress the integral role that the practice's financial officer or accountant should play in this process as he or she is typically the person most familiar with the finances of the practice. When preparing the budget, the practice should think long and hard about all possible expenditures, es-

pecially unexpected expenses. As subsequent budgets will need to be agreed upon annually, we suggest creating a sufficiently detailed initial budget, so it may serve as the template for future annual budgets. It is important to include a dispute mechanism to set forth a procedure should a dispute arise. In those situations, the prior year's budget should control with automatic adjustments to account for expenditures that will increase pursuant to pre-existing contracts or upon a cost of living adjustment or other mechanism, until the budget impasse is resolved.

Similar to the wRVU payment, the timing of the monthly budgeted payment is important to the practice, with the practice preferring to receive the monthly budgeted payment in advance. If expenditures fluctuate from month to month (rather than remain fairly steady), the budget should break down the month by month amount to properly account for such fluctuations.

Term, Termination and Unwinding

Under the PSA model, the term will typically range from one to five years, with smaller practices (one to two physicians) on the shorter side of the range, and larger practices on the longer side. Most include renewal terms which are generally one to three years. As indicated above, the practice should try to fix the initial conversion factor for the initial term (so that the conversion factor is not subject to change).

As with all relationships, the professional service relationship will contractually end at some point. We recommend spending appropriate time to fully walk through and address the inevitable "unwind" upfront. The unwind provisions will address exactly what happens upon expiration or termination of the affiliation and should provide that the physicians have the ability to immediately resume their private practice structure. Unwind provisions should address: permitting the practice to reacquire the assets which were initially transferred to the hospital (as well as any new assets used at the practice site); assigning all phone numbers to the practice; setting forth a process by which patient charts are transferred to the practice's possession; assigning the office lease(s), other leases, and contracts back to the practice; and reassigning staff to the practice to the extent any such staff have been moved to the hospital's payroll.

Of critical importance in any unwind is the ability of the practice to be in a position to bill payers immediately on the unwind. To speed up the credentialing process, we recommend that the practice negotiate upfront the ability to continue to bill and collect through the practice entity's taxpayer identification number a minimum number of claims for Medicare, Medicaid and pri-

vate payers on an annual basis, such that all physicians remain credentialed through the practice. Absent such *de minimis* annual billing, the practice will find itself needing to recredential, which may, depending on the payer, result in cash flow shortages.

Restrictive Covenant

In states that permit restrictive covenants for physicians, the PSA documents generally include a restrictive covenant which generally prohibits the physicians from affiliating with another health care system after expiration or termination of the affiliation. The restrictions must be carefully reviewed and vetted with the practice to ensure that they are fair and reasonable.

Typically, the duration of the restriction is between 12 and 24 months. Hospitals will often try and prohibit not only the affiliation with another hospital system, but also an affiliation with "large" private practices. If this is proposed by the hospital, the definition of a "large" private practice should be clearly defined (such as, a physician practice comprised of more than a specified number of physicians or locations). Even though the hospital will typically verbally reassure the physicians that it will not prohibit the physicians from re-entering private practice in the form that existed as of the go-live date, this carve-out should be included in the agreements. We suggest that the practice negotiate several other exclusions to the restrictive covenant, including a limitation on the restrictions should the hospital terminate without cause, or fail to renew the affiliation, or if the practice terminates "for good reason."

We also suggest the practice try to limit who is covered by the restrictive covenants. Typically, all owners should be subject to the restrictive covenant. However, it is important to determine whether associates should likewise be bound by the restrictive covenants. Keep in mind that practices with a significant number of associates, or associates that are part-time, may find it problematic to require the associates to sign off and abide by the restrictive covenant.

Conclusion

The PSA model is one of many current affiliation models utilized by physician practices and hospitals in order to weather the current health care climate. It is imperative that physician practices properly analyze all facets of the affiliation when contemplating such an arrangement. While no one knows for certain the path health care will follow in the long term, many practices and hospitals believe that the PSA model can be mutually beneficial in the short term to continue to provide quality patient care, while at the same time providing the physicians with some level of economic assurances.