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Alignment Without Servitude: Leasing the Practice to the Hospital

By Alice G. Gosfield

In the mad dash for alignment between hospitals and physicians in response to the new demands for a different value proposition—improved quality with controlled costs—employing physicians often has been the major strategy that hospitals have proffered. In all fairness, much of the wave of recent hospital employment was instigated by specialists, including a large number of cardiologists. Faced with decreased reimbursement for expensive technologies, they turned to their hospital partners in hopes of gaining financial security with continued autonomy. Many hospitals responded with expensive, long-term employment relationships, hoping to solidify their market share for the service line, as well as get control over the physicians whose patients they covet.

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Many of these transactions have no core content to them, have been motivated based on mutual delusions, and fail to recognize the potential drastic changes in hospital reimbursement in a quality driven environment. With Medicare's move to value-based hospital payment,[1] no payment for preventable readmissions within 30 days,[2] expanded conditions for which there will be no Medicare payment for hospital-acquired conditions,[3] and a hoped for revitalization of community-based primary care to keep chronically ill people out of the hospital,[4] the financial future of these institutions will likely be very different.

Against this background, it is important to recognize that there is another strategy that can accomplish the same goals of alignment without direct employment.

The Basic Transaction

Under a practice ''lease'' arrangement, the physicians remain within their corporate structure (e.g. professional corporation, professional limited liability company) and enter into a professional services agreement (PSA) with the hospital. The physicians reassign their right to payment to the hospital which bills all payers for their services. This approach preserves group cohesion, whereas employment is an individual relationship of master-servant with the employer. For both parties, if the transaction does not work, the unwind is far

[1] Section 3001, Affordable Care Act, 76 Fed. Reg. 26,490, May 6, 2011.

[2] Section 3025 of the Affordable Care Act, 42 CFR § 412.150 through § 412.154.

[3] www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/HospitalAcqCond/Index.html?redirect=/HospitalAcqCond.

[4] Innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html.

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easier than where there has been an acquisition of assets and employment of the group's personnel.

The fundamental basis for the relationship is a collaboration to accomplish results that will benefit both sides. The primary agreement often includes other forms of alignment as well (see below). Well drafted PSAs have at their foundation the goals of physicians improving quality, both in their practices and at the hospital, with compensation to recognize the economic value that they bring to the hospital in these new arrangements. While hospitals sometimes take the position that these transactions do not give them sufficient ''control'' over the physicians, most hospitals are doing relatively little to clinically integrate those whom they do employ[5] and have often struggled to merge the cultures of disparate factions of employed physicians, maintaining them in their own separate pods for compensation purposes.[6] This will not improve results in a value driven world, with increasing transparency of performance by all providers.

Base Compensation

In most of these transactions, the parties calculate work relative value unit (wRVU) based compensation for all the physicians in the practice, taking into account historical productivity levels. This calculation is multiplied by a conversion factor of dollars per wRVU which is constructed based on the historical payer mix. The total becomes the base compensation, which is paid monthly or bimonthly to the group. While in many transactions, the hospital drives this calculation, I advise my physician clients to have their own valuator tell them what the conversion factor should look like based on their data. Often, the resulting negotiated payment basis falls between the two.

In a multi-discipline context, such as where cardiovascular surgeons and cardiothoracic surgeons are in a group with cardiologists, there would need to be separate calculations for the relevant conversion factors as well as for wRVUs. Sometimes in the calculation of the expected wRVUs, physician administrative leaders of the group are recognized for their contribution in managing the group by attributing wRVUs (e.g. 4,000 a year) incorporated in the base compensation.

Depending on the practice, nonphysician mid-level practitioners who can be billed on their own numbers must be taken into account (e.g. nurse practitioners, physician assistants, physical therapists, and clinical nurse specialists) also considering which payers recognize the independent billing of these clinicians. Still further, services which are ''incident to'' physicians under Medicare's rules will appear as personally performed on claims forms but actually will be performed by other clinicians in the practice. They must be captured, too.

One of the critical elements in the transaction is for how long the agreed upon conversion factor and wRVU expectations will remain in place. In today's world, physicians are looking for multi-year commitments. Wary hospitals are concerned about impending changes that remain speculative. These are matters that reasonable parties can negotiate without much difficulty. The key is to develop a methodology to address the problem when the parties find themselves at loggerheads over fair market value for the services rendered (see below).

Because there can be variability in productivity for reasons beyond the physicians' control such as maternity leave, short-term disability, and occasional sickness, it is fair to establish a corridor, typically between 8 percent and 15 percent, where the base compensation remains the same despite fluctuations in production. Above the specified threshold, additional wRVUs for extremely productive behavior should be recognized with additional payment. However, since wRVUs are a fee for service concept where payment models are changing, and overuse is increasingly targeted for reduction, it is sometimes worthwhile to peg additional wRVU payments to quality metrics. In addition, it is legitimate to cap the total aggregate wRVUs that will be paid so as not to incentivize rampant improper behavior. Many hospital lawyers initially propose that if the wRVUs fall below the pre-established threshold that this is grounds for termination. One would think a more logical approach would be to recalculate the base compensation to reflect the lowered productivity, rather than to lose the group.

Since the group remains the employer of the physicians, during the term of the PSA the group may want to add additional physicians. Some transactions require a triggering event, as established in the documents, to permit the addition of a physician. This can include exceeding a targeted level of wRVUs, meaning the practice is busier and needs help, or the loss of a physician to retirement, relocation, or disability. If the mid-levels are also billed on their own numbers, then many of the same issues arise with regard to hiring additional mid-levels. Of course, for larger groups that have relationships with multiple hospitals, the only physicians at issue with regard to hiring would be those physicians performing services pursuant to the PSA. I have had transactions where larger groups have entered into multiple PSAs affecting different physicians at different hospitals but in the same group.

In adding more people, generally speaking there is a ''ramp-up'' as their practice is integrated into the pre-existing group. Unless the group merges with another group or hires a physician who brings a significant patient load, which could be the subject of an amendment to the PSA to take into account the additional calculable productivity, it is useful to establish a base compensation and benefits for the new physician that will be included in the group's compensation for a defined period of transition, say two years, to establish the practice. To the extent that an expected level of wRVUs is exceeded by the newly recruited physician, a conversion factor that is typically much lower than the conversion factor for the established physicians applies to those wRVUs.

Sometimes the new physician brings a new subspecialty to the practice (e.g. robotics) which has a very different wRVU profile. Under those circumstances, a recalculation may be necessary. With the addition of a new physician comes additional overhead as well. Therefore, agreeing on a pro rata addition to the overhead budget can be important, too (see below).

Losing people from the practice can be handled by bringing in a new physician to take over the position of the departed physician. Partial disability is more of a

[5] Gosfield and Reinertsen, ''Informed Consent to the Ties that Bind,'' *The Physician Executive* (January/February 2010), pp. 6-13, http://www.gosfield.com/PDF/Informed%20Consent..pdf.

[6] Cantlupe, ''Convincing Rival Docs to Become Partners,'' *Health Leaders Media* (Feb. 2, 2012), http://www.healthleadersmedia.com/page-1/PHY-276081/Convincing-Rival-Docs-to-Become-Partners##/.

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problem. Some agreements account for partial disability by assuming that the other physicians in the group will pick up the additional workload for a defined period of time. If, however, a physician becomes partially disabled so that he or she can no longer produce at the full-time equivalency, there are several options: (1) recalculate the base compensation; (2) hire another part-time person to fill in the FTE equivalence; or (3) terminate the physician.

Beyond Base Compensation

Under the practice lease model, the physicians are working for the hospital, in the sense that the hospital bills for their services. This is purely for the clinical work that the physicians previously rendered in their practices. As indicated above, the base compensation also can take into account the administrative work of the group leadership in managing the practice, which is now being managed for the benefit of the hospital. These agreements also can include other forms of compensation (non-CPT generated) such as medical directorships, on call coverage, and co-management.[7]

If these transactions are to overcome some of the problems with straight W-2 employment, they should be tied to additional bonuses for quality. Some transactions characterize the additional payments as a true bonus with quality targets established in advance with financial rewards based on achieving them. Here, the key is fixing accountability at the locus of control so the metrics reflect improvements the physicians can actually affect. Where the physicians now are operating their clinical practice so that it performs to a higher quality level, the hospital likely is seeing additional financial impact from that improved performance. In addition, as in a co-management agreement, if the physicians contribute to improvement of quality in the hospital's services, this is an additional source of potential bonus compensation to the group.

Some transactions capture and set aside this pool of money and withhold from it for failure to meet the quality targets. The practical realities are very much the same as the bonus, no matter how the money is characterized. In some transactions, if the group achieves a 100 percent score on established performance objectives for pre-determined consecutive quarters, they are entitled to a once annual ''super bonus'' of a fixed dollar amount (e.g. $200,000).

Other sources of money that must be addressed in the agreement include meaningful use and e-prescribing payments, Physician Quality Reporting System (PSRS) dollars, pay for performance bonuses from commercial payers, and medical home payments where those are available. When the Medicare value-based modifier is applied to the Medicare Fee Schedule, this will also require a review of base compensation if the physicians perform well.

Under this model, the hospital takes the risk of billing. The physicians get paid if they produce wRVUs regardless of collections. Often, the physician group is much better at billing than the hospital. In some transactions, the physician group gets paid by the hospital to do the billing on the hospital's behalf. This provides an additional fee to the group for providing the billing services.

Because the group now is managing the practice on behalf of the hospital, it is legitimate for the group to be paid for management services. Sometimes this is in a separate management agreement. One of the issues is whether the group's personnel become employees of the hospital. I generally recommend against this, since the point of remaining as a group is to be able to go back to independent practice if the transaction does not work. If the hospital is holding the personnel, that becomes much harder.

In some arrangements, the hospital employs some personnel, as in cardiology practices where the high end diagnostic testing is taken over by the hospital. Even where the hospital does not employ the group's personnel, often they will require that the personnel be subject to similar human resource screening and policies as applied to their employed staff.

One of the issues that arises is whether when the hospital gets access to the group's locations, under the PSA or in a formal sublease, the hospital converts the practice to a ''provider-based'' arrangement. As has been recently highlighted in the popular press,[8] one of the fundamental problems here is that the copays associated with hospital services conducted under the hospital's license as provider-based, at least for Medicare and most commercial payers, are considerably higher than those that apply in the office. The patients, seeing the same clinicians, with the same staff, and the same equipment in the same location, now are paying a higher rate for the same services. I usually suggest that the PSA state the hospital may not make the location provider-based without the agreement of the group.

Because the wRVUs generally reflect only the clinical effort of the physicians, there are a variety of approaches to how the hospital pays for the overhead of the practice. Sometimes, the wRVUs are calculated high enough to cover the overhead as well. This is far more complicated than is necessary. Sometimes, the overhead is a pass through, subject to the hospital's due diligence and the parties' agreement for changes in the overhead in advance. Sometimes, overhead is handled on the basis of a budget, with threshold variations permitted but special approval required above a certain number. Future capital expenditures can be a problem in these transactions and should be addressed at the outset.

Increasingly, as health system competition intensifies in certain markets, the physicians who are leasing themselves to one hospital may have their offices in the medical office building of another health system. Depending on the lease arrangements, there can be some significant problems with subletting to the landlord's competitor. These lease arrangements need to be confronted very early on in the transaction.

Given the fast developing innovations in payment models, the PSA should account for the role of the group in designing, accepting, and working with such new models. If alternative models implicate the wRVU assumptions and the hospital's revenue stream, depending on the market share of the relevant payer, problems can arise. By the same token, if the hospital gets additional dollars based on the fruits of the physi-

[7] Gosfield, ''A Physician's Perspective on Co-Management: Opportunities and Pitfalls'' (Sept. 18, 2012), http://www.gosfield.com/teleconference/index.htm.

[8] Mathews, ''Same Doctor Visit, Double the Cost,'' *Wall Street Journal* (Aug. 27, 2012), p. B1.

cians' labors, it is only fair that the physicians share in that increase. The role of the physicians in accepting and implementing new models should be addressed at the outset, as well.

Termination and Dispute Resolution

Many physician groups seek very stringent termination clauses that are restrictive on the hospital because they are looking for financial security. Hospitals are concerned that they get the productivity they are looking for and that their payment models are consistent with the transactions at hand. It is important to confront Change of Law provisions, which can be a source of dispute if the ''adverse consequences'' that are produced by a change in law, include financial impact.

Many of these transactions have noncompetes that operate during the term, but if the group is one that splits its services among several hospitals, these kinds of clauses can be problematic, especially if the group is leasing to a tertiary care hospital while they relate to community hospitals elsewhere. When those community hospitals engage in co-management strategies and the like in *their* alignment efforts, how those dollars get handled has to be addressed in the PSA. Sometimes the other hospital's confidentiality clauses are a problem.

With respect to post-termination noncompetes, many of these transactions are done with no post-termination noncompete. Others say that the group cannot affiliate with another system for a year post-termination, but they can go back to being who they were before and that subgroups can filter off and practice on their own as long as they do not affiliate with another system. Post-termination noncompetes should not apply if the hospital breaches the agreement, nor should they apply if there a dispute over payment models or future compensation that cannot be resolved.

Some hospitals are extremely focused on the confidentiality of the rates that they have negotiated with payers, which can be significantly higher than those paid to physician groups. In one transaction where I was involved, the lawyers for the hospital initially proposed a $1 million liquidated damages clause for any release of their confidential rates, even if inadvertent, and tried to impose an acknowledgement by people as low as the billing staff to be liable for the liquidated damages if their rates became known in any way. Of course, this was completely unreasonable and negotiated away, but it demonstrated the real concerns the hospital had in this arena. Once the group got in and saw the rates, they were so significantly higher that they understood the hospital's concern. It is these dislocations of rates that are contributing to the increasing costs in health care and likely will not be sustainable in the future.

Most of these transactions use confidential arbitration for dispute resolution. Besides typical contract issues that can lead to disputes, in these settings, agreement on the conversion factor in later years, on the totality of the aggregate wRVUs, on whether quality targets have been met, agreement on the overhead budget, and handling of alternative innovative payment models could end up in arbitration. Usually, breaches of confidentiality or breaches of the restrictive covenant are excluded from arbitration.

In a number of transactions on which I have worked, fair market value disputes are handled differently from all other disputes. Depending on the timeframe for the base compensation set forth in the agreement, and depending on the scope of the Change of Law provision, fair market value can be raised particularly by the hospital going forward as an excuse to lower the payments to the physicians. One model that we have used is that each party names a valuator and if the valuations by both are within 5 percent of each other, the parties agree to split the difference. If the valuations are disparate, then the parties select a third valuator whose determination is final. If the group cannot accept the determination of the valuator, they do not have to go through regular dispute resolution but can walk away from the transaction and terminate the agreement on 30 days notice. Whether the restrictive covenant applies under these circumstances is a matter of negotiation.

Conclusion

The dynamic nature of the hospital-physician alignment landscape is a challenge. While employment may be the answer in some settings, for many, a looser affiliation with stronger alignment principles to produce improved value can be a win-win.

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