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

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.

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.

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).

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 Exhibit 1.

Exhibit 1

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 medical 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 the payment 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 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 Exhibit 2). 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). Exhibit 3 demonstrates the disconnect occurring between how hard the orthopedic surgeons are working and the current income generated from the practice.

Exhibit 2

Exhibit 3

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 wRVU rate targeting compensation just above MGMA’s 50th percentile per FTE physician is established at $63.00, as shown in Exhibit 4. (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).

Exhibit 4

Potential upsides and downsides. Exhibit 5 identifies potential upsides and downsides of a PSA arrangement from a hospital and health system leadership perspective.

Exhibit 5

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