

PSAs as an Alternative to Employment:

A Contemporary Option for Alignment and
Integration

White Paper



Business Advisors for the Healthcare Industry

MAX REIBOLDT, CPA

President/CEO

AIMEE GREETER, MPH

Vice President

MADIHA KHAN, MPH

Senior Associate

TAYLOR HARRISON

Associate Consultant

March 2016

TABLE OF CONTENTS

Introduction and Overview.....	3
What Do Physicians and Hospitals Need and Want?.....	3
What is Employment Lite?.....	5
Professional Services Agreement	5
Global Payment Model PSA.....	7
Practice Management Arrangement.....	10
Traditional Model PSA.....	12
Carve-Out PSAs.....	13
Additional Services “Wraparounds”.....	14
PSA Structure Comparison	15
Reimbursement Trends.....	15
Legal Challenges Apply	16
Overall Benefits of Employment Lite Models.....	17
Is Employment Lite for You?.....	20
Case Studies	22
Case Study #1: Global Payment PSA.....	22
Case Study #2: Practice Management Arrangement.....	24
Case Study #3: Traditional PSA.....	25
Summary.....	26
Exhibits.....	28

INTRODUCTION AND OVERVIEW

Private practices and health systems alike continue to evaluate their options for working together during the continuing evolution of healthcare delivery. Over the past five years, many physicians from all specialties and practice structures (i.e., single and multispecialty, hospital-based, and others) have completed transactions with health systems. Many, if not most, of these arrangements are through employment vehicles. However, growing in prevalence are professional services agreements (PSAs), which are the model and structure of choice for thousands.

The movement from volume to value in reimbursement drives physicians to seek ways to align with hospitals and health systems. Moreover, thousands of “first generation” transactions that began three to five years ago are now expiring, and their initial terms and structures are under review. The arrangements that develop through revised alignment transactions are now in their second generation.

So, what is next? Integration of physicians and hospitals continues to be a major area of strategic and tactical consideration among both categories of providers. The complexity of the transactions continue to range from limited to moderate to full, depending on the structure that is the best fit for the parties. Exhibits I and II outline traditional alignment models and structures, categorized by limited, moderate, and full.

The basic premise of “one-size-fits-all” is not supportable in the case of PSAs (also called “employment lite” models). Given their varied structure, PSAs can be customized to fit the specific needs of the partners. Thus, PSAs present an alternative to employment that may be the best option for alignment for many organizations. Our foundation in considering the various components of PSA/employment lite structures is our extensive experience in completing hundreds of such transactions over the past five years, and it is supported by a projection of the emerging landscape of “volume-to-value” reimbursement.

WHAT DO PHYSICIANS AND HOSPITALS NEED AND WANT?

As the imperative to “do more with less” continues to exert its force on hospitals and private practices, both groups have many reasons to collaborate in the delivery of healthcare. Payers, patients, and providers are becoming more cognizant of the value proposition, defined as quality per unit of cost, within their respective areas. As a result, hospitals and physicians remain interdependent in the total provision of patient care, particularly with the focus shifting to *value-centric* initiatives, such as care coordination, data sharing, clinical and financial integration, and, ultimately, population health management. For hospitals to meet the needs of these activities, which eventually lead to the realization of economic gains under value-based payment models (i.e., bundled payments, shared savings/losses programs, etc.),

they must have a solid medical staff, and private groups must have a reliable partner. Regardless of the payment scheme in place at present, however, most players will benefit by embracing high levels of integration into the future (if they haven't already).

Common reasons why hospitals seek to employ physicians include specialty shortages and the difficulty in recruiting and retaining physicians, especially in more rural areas. Hospitals undoubtedly need access to physicians to be able to provide their services. Recently, however, hospitals prefer employment over other alignment structures to amass the physician strength to progress their clinically-integrated initiatives. These actions could include the development of clinically integrated networks (CINs) or accountable care organizations (ACOs). Physician support and a strong medical staff network are critical components to the success of such structures. The limited number of physicians in proportion to a population with increasing demands calls for hospitals and physicians to align to maintain their viability. While hospitals appreciate that physicians are the single greatest contributor to their success, they also realize their need to justify physician alignment on an economic basis.

From an independent physician's perspective, alignment can be an attractive option as they prepare a responsive strategy to the accountable care era. With alignment being "Stage I" of the overall accountable care era strategy, of which the ultimate goal is clinical integration (i.e., Stage II), every independent practice should consider viable alignment options for weathering the unprecedented challenges brought forth by the current and prospective healthcare landscape. This projection is not to say that the classic issues of running a private practice will cease to exist. For example, rising economic pressures coupled with increased regulatory demands, administrative needs, decreasing reimbursement rates, and the ongoing burdens of operating a business will remain amidst an uncertain healthcare backdrop. Fortunately, many, if not all, of these challenges that independent physicians typically face may be alleviated through alignment with a hospital.

Despite the existence of such pressures, by nature, a lot of private practice physicians desire to maintain as much independence as possible, both clinically and financially. Many have forfeited substantial independence, however, by embracing employment by hospitals. Although employment has since transformed to be more flexible than the traditional and long-standing Internal Revenue Service (IRS) W-2 model, these provisions still may be unsatisfactory for some physicians. In this case, could there be a different arrangement that meets the needs of both entities?

The purpose of this paper is to discuss a high level of alignment achieved through a professional services agreement; that is, employment lite. It is not a discussion of the numerous options for integration—limited, moderate, or full. *(Note: For a complete summary of the degrees of alignment, including the PSA employment lite model, refer to*

Regardless of the payment model, most parties benefit by embracing high levels of integration.

Exhibit I.) PSAs serve as an alternative to the primary structure considered under full integration, e.g., employment. In fact, PSAs provide a form of alignment that is growing in popularity with many physicians and hospitals as an employment alternative.

WHAT IS EMPLOYMENT LITE?

“Employment lite” is a term signifying a high level of physician-hospital alignment that falls just short of full employment. It is formalized by a Professional Services Agreement that is specific to this arrangement. The term PSA is not to be confused with other arrangements such as clinical co-management, directorship, or other professional arrangements. Technically, these arrangements may be considered professional services agreements but not in the sense of our definition in this paper. *(Note: There are various forms of physician/hospital integration. Many of these relationships involve a contract—a professional services agreement. Technically, PSAs encompass virtually any agreement wherein a physician provides professional services on a contractual basis. In the context of this paper, however, PSAs refer to the particular alignment relationship that entails many of the aspects of employment, i.e., full integration, without a “W-2” employee relationship; hence, the term “employment lite.”)*

While employment typically entails an “IRS W-2” relationship, most PSAs entail an “IRS 1099” relationship. The physicians remain employed by their practice entity and are under contract for the provision of professional services through a PSA by the hospital. *(Note: As described below, the Practice Management Arrangement entails physician employment by the hospital; however, the practice entity remains intact in this scenario and the physicians retain the ability to oversee the management of it.)* Numerous benefits and elements of employment are realized through such a structure. However, the independent contractor status comprises the “lite” portion of the model. The following section articulates the details of the various PSA arrangements that are available for implementation between hospitals and physicians.

PROFESSIONAL SERVICES AGREEMENT

A PSA between a hospital and a physician practice can fall into several scenarios as described at a high level below, but in greater detail in the subsequent sections. Although the nuances of each model are unlimited, the following models are highly recognized and the most commonly utilized variations on the professional services agreement model. We note that no alignment structure, particularly the PSA, is a “one-size-fits-all” strategy. For example, the specific terms and conditions of a Global Payment PSA for one set of providers could differ from that completed for another group of providers. While the key tenets will remain consistent, each PSA model allows for flexibility to address the various characteristics of different parties.

The following are the most common variants of the PSA model.

1. *Global Payment PSA.* The hospital contracts with the practice for professional services in exchange for a Global Payment rate (typically a rate per work RVU), which encompasses all physician compensation and benefits. The hospital also reimburses the practice for its fixed and variable overhead costs. The two parties work together through a joint management committee to adhere to annual budgets and oversee the overall relationship; however, the practice retains control of its practice entity and staff.
2. *Practice Management Arrangement.* The hospital employs the physicians; the practice entity is preserved and contracts with the hospital for management services; administrative management staff are not employed by the hospital, as the practice provides these services via a management contract (a corollary yet separate agreement from the PSA itself) and receives a corresponding fee set at fair market value.
3. *Traditional PSA.* The hospital contracts with physicians (vis-à-vis their historical practice entity) for professional services that are reimbursed through a rate per wRVU. The hospital assumes ownership of the administrative structure of the practice by employing all support staff, performing the billing and collection functions, owning the accounts receivable, etc.
4. *Carve-Out PSA.* Within any of the PSA models explained thus far, provider groups can opt to “carve-out” certain services, locations, specialties/subspecialties or practice physicians to fall under the PSA. For example, a hospital could contract with a private gastroenterology practice for the provision of endoscopies only. A PSA would be effectuated but only for a subset of the professional services. All related administrative costs will be carved out as well and reimbursed by the hospital accordingly.
5. *Hybrid Arrangements.* Countless variations of the models above are possible, allowing the prospective partners to mix and match the desired qualities of each within their PSA. For example, the hospital could employ or contract with physicians and the practice entity could spin-off into a jointly-owned MSO/ISO.

Of the five structures listed, the most prevalent in today’s markets are the Global Payment PSA, the Traditional PSA, and the Carve-Out PSA. The Practice Management Arrangement may be a viable option for some practices; however, it is applied less frequently than the other models. Hybrid scenarios abound, too, as the deal-making process and negotiations unfold, particularly as we move into second generation agreements.

GLOBAL PAYMENT MODEL PSA

According to our context and designation, the Global Payment PSA is a particular employment lite model that allows the physicians to remain an employee (or partner) of the practice. In turn, the practice contracts to provide professional services to the hospital or other entity that owns the revenue stream. As employees of the practice, the physicians receive the compensation, benefits, and all other personnel-related matters from their employer, i.e., the practice. Here, the hospital is no different than any other outsourced contractor in that the relationship falls under the IRS 1099 tax arrangement.

In these agreements, typically the practice receives payment for the physicians' professional services, calculated based on productivity, as defined by wRVUs.¹ This methodology predominates as the mode for determining compensation. However, the compensation landscape is moving toward value-driven compensation, just as the reimbursement landscape is moving toward value-based reimbursement. As such, some hybrid compensation models are now being used within the Global Payment PSA model that are based on something other than solely production (i.e., some agreements are now placing a portion of total compensation at risk for value-based tenets).

In the Global Payment PSA model, the revenue stream and the responsibility for it shift to the hospital (or other entity contracting the physicians for professional services). This entity, as opposed to the practice, is now responsible for the payer contract negotiations, billings, collections, and the entire revenue cycle.² In turn, the practice receives compensation for the services provided based on defined terms and conditions. Essentially, these terms are established based on the professional services that the physicians perform and are mostly productivity-based (using wRVUs), along with some non-productivity-based incentives (see below for further discussion of the compensation matrix).

The Global Payment PSA is a "full" alignment model, yet it stops significantly short of W-2 employment. Under the Global Payment PSA model, in addition to wRVU-based compensation for the services provided, the practice receives remuneration for its overhead, often on a budgeted dollar basis. That budgeted amount may have some consideration for variable

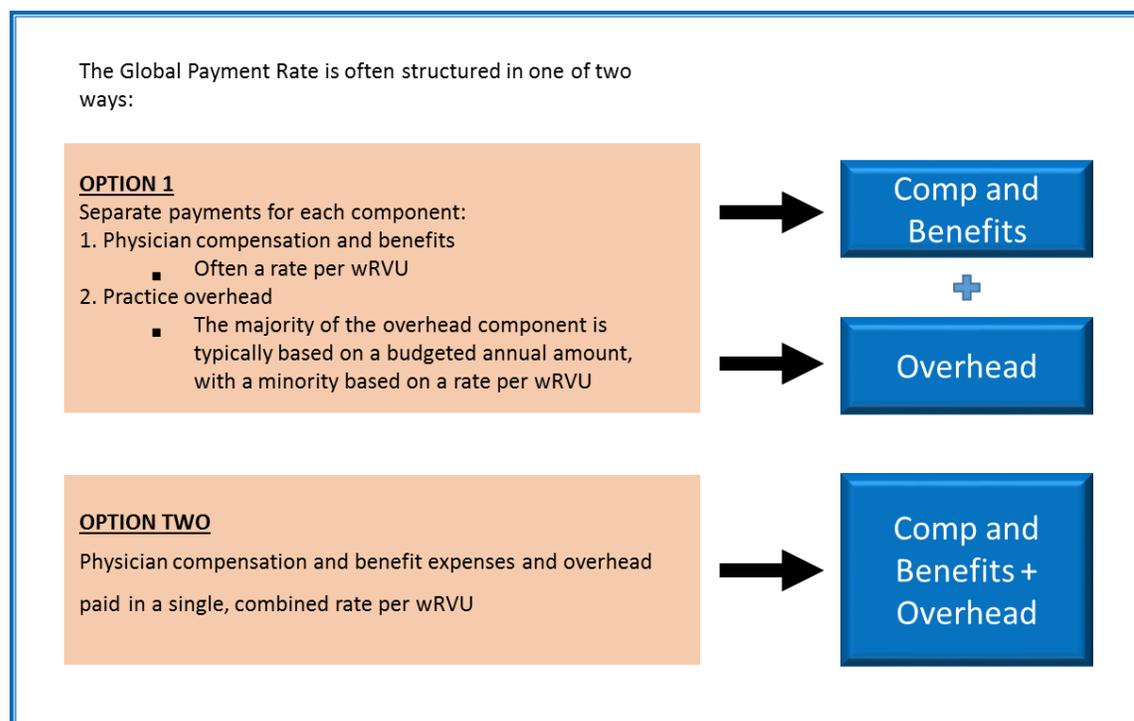
¹ A relative value unit (RVU) describes a unit of work (i.e., productivity) for each CPT™ code within that overall organized system of structure. For each CPT™ code, each of the three components of services rendered is assigned an RVU value and then summed to create the total RVU for that specific code. Thus, the sum of the work only component (i.e., wRVU), the practice expense RVU, and the professional liability insurance RVU equals the total RVU value for each CPT™ code. To derive reimbursement for Medicare purposes, the total RVU is multiplied by the then-current assigned conversion factor.

² While the billing and collection functions are the responsibility of the hospital, in some cases (such as the Global Payment PSA), the hospital may choose to outsource these functions to the practice as a third-party billing agent.

expenses (i.e., expenses that vary with revenue), which usually are based on a rate per wRVU. Nevertheless, since the vast majority of practice overhead is a fixed (or mostly fixed) cost, the Global Payment PSA reimburses the practice for the majority of its overhead on a fixed or budgeted basis.

Alternately, the practice can be reimbursed using a total rate per RVU. Although some early Global Payment PSA models were structured in this way, in recent years most arrangements are based on a budgeted overhead reimbursement basis as well as some limited amount of variable expenses paid on a rate per wRVU (see above). Figure 1, below, illustrates the potential payment methods to the practice under a typical Global Payment PSA model, with Option 1 currently the most prevalent methodology of the two.

FIGURE 1—PAYMENT ALTERNATIVES WITHIN THE GLOBAL PAYMENT MODEL



Other notable facets of the Global Payment PSA are that post-alignment, the hospital:

- owns the accounts receivable;
- establishes the fee structure, and;
- contracts with payers.

The ownership and assumption of the ancillaries are negotiable terms in the Global Payment PSA structure. However, usually the hospital takes the responsibility for delivering the ancillary services and attaining the subsequent revenue. Though the practice may either retain the

ownership of the assets that support the ancillaries and lease them to the hospital or sell them outright to the hospital, the stream of income and resulting accounts receivable shifts to the hospital. (This scenario is similar to employment and substantiates our references to this model as a form of employment lite.)

To drill down further on the integral components of the Global Payment PSA, Figure 2 summarizes the differentiation of ownership, assignment responsibilities, etc.

FIGURE 2—RESPONSIBILITIES WITHIN THE GLOBAL PAYMENT MODEL

Global Payment Model		
	Practice	Hospital
Employment of Physicians	X	
Employment of Staff	X	
Real Estate Ownership	*	*
Ownership of Ancillary Equipment and Staff	*	*
Payer Contracting		X
Tax ID Used		X
Reimbursement for Practice Overhead		X
Ongoing Management of Practice	X	X (through Management Committee)
Billing/Collections Functions	*	*
Recruitment of Physicians	X	
Capital Expenditures	Defer to Management Committee	Defer to Management Committee

*Depends on negotiated structure

In summary, the Global Payment PSA requires considerable objectivity and trust between the hospital and the physician group. However, the Global Payment PSA is quite logical and offers a prospective segue toward an ultimate agreement. Sometimes, the health system’s goal is for the practice to be aligned fully through employment. However, it may take time to reach employment; thus, the Global Payment PSA is a positive means for initiating a working relationship between the two parties. Conversely, many Global Payment PSAs are renewed

and extended with neither party expressing interest in converting to another model (i.e., employment or even the Traditional PSA). Indeed, the Global Payment PSA can be a useful and enduring model.

PRACTICE MANAGEMENT ARRANGEMENT

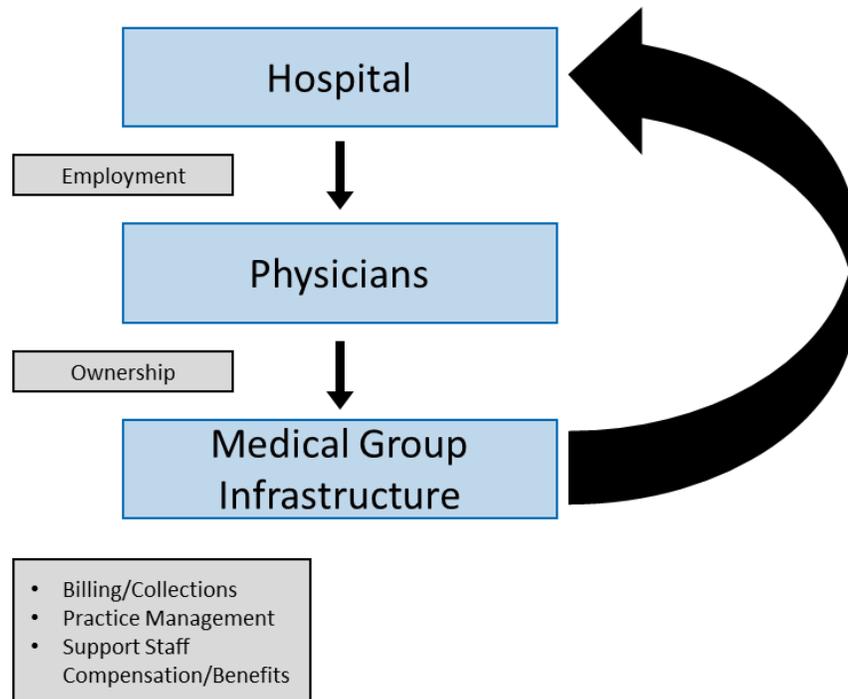
The practice management arrangement (PMA) model is another type of PSA. It is structured wherein the physicians (and potentially the allied professional providers [APPs]) are employed by the hospital. However, the infrastructure of the practice entity remains independent and the management and administrative structure of the practice continues to support the (now-employed) providers. Such a model allows for the physicians and practice that originally existed in a private setting to continue to possess an element of independence and autonomy in that their management structure is preserved. By preserving their practice infrastructure, it is easier for the practice to revert to a private practice setting or even align with another health system post-termination, assuming the restrictive covenant and/or non-compete terms allow for it.

It is also worth noting that the practice infrastructure of management and operations may be more efficient as well as better operated and managed when maintained independently, as compared to if it were acquired and subsequently managed by the hospital. This arrangement allows for an easier transition into a PSA. At some point in time, this infrastructure could still be transferred to the hospital.

As seen in Figure 3, under the PMA, the physicians operate as managers of the practice (which now functions as a back-office support structure, as opposed to a functional and comprehensive clinical practice), providing administrative services, space, equipment, and support staff. The hospital contracts with the practice entity for these services and pays a fair market value (FMV) management fee.³ The compensation structure for the employed physicians is structured in no different than if they were employed and did not provide the management services. In other words, the compensation to the physicians and APPs is consistent with any other W-2 employment arrangement. As such, it can include a base salary, both productivity and non-productivity-based incentives, and other forms of guaranteed and at-risk compensation.

³ The negotiations relative to the management fee can be sensitive given the fact that the physicians are now negotiating with their employer. Hence, it may be best to enlist the services of an independent third-party expert to complete same.

FIGURE 3 - PRACTICE MANAGEMENT ARRANGEMENT



The advantage of the PMA is that the practice can be easily transferred to full ownership by the hospital or because the infrastructure is retained, the providers could also revert to a private setting, post-transaction. Reverting is typically not preferred nor the intent when entering the transaction, but the provision allows for a check and balance in the alignment process. Although this caveat may be perceived as too great a negative actor for the hospital, a lack of flexibility may also be the single greatest obstacle in getting the physicians to agree to complete the transaction in the first place. That is, the physicians/practice owners may have a lack of trust or confidence in the hospital to manage their practice operations efficiency. Once these fears are mitigated and trust gained through the PMA, the PSA structure could easily be converted to a standard employment model, wherein the practice entity would be dissolved and all staff absorbed (employed) directly by the hospital. As an alternative, this structure could evolve to allow for a jointly owned management entity between the physicians and the hospital. Combining ownership in the management structure is more complicated and requires much more scrutiny and analysis to make sure that the structure is both fair and reasonable but also legally compliant and consistent with all applicable federal and state regulations. Nonetheless, this level of flexibility exists within the PMA.

So why even consider a PMA within the spectrum of employment lite options? The answer to this question should be rather obvious. That is, the physicians may already have a management services organization (MSO) in existence or they may believe that their

management structure is actually more efficient and better run than it could be by the hospital with whom they are aligning. Furthermore, the confidence that the transaction will stand the test of time, even moving into a “Second Generation” model, may be lacking at the outset of the working relationship. Thus, the physicians, while accepting the premise of becoming employed themselves, may not want to give up the operations and management oversight. With this noted, most Second Generation transactions have moved away from the PMA if in fact this is the model within the initial alignment relationship. However, certainly the PMA could continue beyond an initial term and be extremely functional.

TRADITIONAL MODEL PSA

The Traditional Model PSA is another common PSA structure. Under this model, the hospital contracts with the practice for the professional services rendered by the physicians. In this model, the physicians remain employees of the practice, keeping the practice entity intact. In contrast, however, their support staff become employees of the hospital. Typically, this arrangement includes all employees, from clerical staff to practice administrators to non-physician clinical employees. Under this model, many of the operational and administrative duties previously completed by the practice now become the responsibility of the hospital. From an operational perspective, the ultimate result is a structure that looks and feels like employment in that the practice transitions its “ownership” of all management and operations to the hospital and is no longer directly accountable for these functions. The practice is relieved of all day-to-day operational oversight, including the risk of operating from a financial/economic standpoint. This change is the largest differentiating point between this and the other PSA models previously discussed. Some physicians see this shift as a positive, as they are relieved to have abdicated responsibility for the operations of their practice to a hospital partner. However, other physicians interpret this transition as a loss of control, which makes the model less desirable to them. Ultimately, in this model, the “practice” stays intact, but only from the view of the physicians (and perhaps the non-physician providers, who may also remain in the existing practice entity. However, as noted previously, more likely is that the non-physician providers will transition to employment by the hospital along with all other staff). Similar to the Global Payment PSA, under the Traditional PSA, the hospital controls the payer contracts, including the negotiation of them, and bills for all professional charges going forward, and thus owns the accounts receivable. While the practice stays intact from the standpoint of the physician ownership of that professional entity, all other areas of the practice transition to the property/control of the hospital. The only remaining component of what was the previous practice is its professional members, i.e., the physicians. The key to this model is that the hospital has responsibility for ongoing management of the practice, and the physicians do not.

Figure 4 identifies the differing scope of responsibilities of the health system and the medical group under the Traditional PSA, illustrating that the practice may be allowed to retain the

ancillary services if so desired (which may be a preferable option for some specialties). Ancillary services are an important component of these PSA affiliations. Like employment where the hospital implicitly acquires them (along with the entire practice entity), the PSA models consider the possibility of a similar scenario. However, a significant distinction between these PSA models and full (W-2) employment is that the practice does not have to sell its ancillaries. However, the PSA model itself often drives this discussion, as ancillaries are more likely to be acquired by the hospital in a Traditional PSA than the other PSA models.

FIGURE 4 – RESPONSIBILITIES WITHIN THE TRADITIONAL PSA

Traditional PSA Model		
	Practice	Hospital
Employment of Physicians	X	
Employment of Staff		X
Real Estate Ownership	*	*
Ownership of Ancillary Equipment	*	*
Payer Contracting		X
Tax ID Used		X
Bears Cost of Practice Support Overhead		X
Ongoing Management of Practice		X
Billing/Collections Functions		X
Recruitment of Physicians	X	
Capital Expenditures		Through Management Committee

*Depends on negotiated structure

CARVE-OUT PSAs

A PSA model that has grown in popularity over the past several years is the Carve-Out PSA. As a variant of the models above, the Carve-Out PSA involves a subset of the practice aligning with a hospital partner. One prime example is when a single specialty within a private multi-specialty practice aligns with a hospital. This model began in earnest for cardiology after the significant cuts in their reimbursement for echo and nuclear studies in 2009. At that time, many

cardiologists began looking for stability, but they were reticent to leave their private practice model and become employed. As a result, many practices approached hospitals about carving out their cardiologists and forming a PSA with only those physicians from within the practice, thus beginning the popularity of the Carve-Out PSA. With its evolution, we now see this model occurring for even subspecialized physicians within a single specialty (for example, only the hand surgeons within an orthopedic practice). While the Carve-Out can take the form of any of the previously-discussed PSAs, it is most often structured as a Global Payment PSA, with the overhead reimbursement limited to the direct overhead (and some limited allocated overhead) for the attributable physicians within the PSA.

ADDITIONAL SERVICES “WRAPAROUNDS”

Regardless of the employment lite structure, there are other opportunities available to practice physicians and their hospital partner. These structures are typically “wrapped around” the core PSA model, and include the following:

- Clinical co-management
- Shared cost savings initiatives
- Administrative duties
- Non-physician provider supervisory duties
- Teaching functions
- Research
- Medical directorships
- Call responsibilities

Wraparounds are complementary to the core PSA structure and offer excellent opportunities for additional forms of alignment, though typically in limited or moderate forms

An additional “wraparound” that is a part of some PSA relationships is an incentive for quality. In fact, this component is growing in popularity as the overall healthcare reimbursement paradigm shifts to be more significantly focused on quality. In its most limited form, this structure involves an incentive payment to physicians simply for reporting on their actual cost, quality, and/or outcome data. In its most robust form, the model included hospitals providing at-risk compensation to physicians for demonstrating simultaneous achievement of both high-quality and cost-efficient care. Quality incentives are an important part of PSA relationships and, in fact, both their prevalence and level of economic impact within individual PSAs is increasing, thus it is not uncommon to see quality as a component of total PSA compensation, either in addition to or in lieu of production-based compensation. As opposed to having quality outlined in a separate, but a corollary, wraparound agreement, it is more often becoming a central component of the PSA model itself, impacting the funds that flow to the physicians more than ever before.

Wraparound scenarios offer excellent opportunities for some additional forms of alignment, although in limited or moderate forms, and are complementary to the core employment

lite/PSA structure. They do come at an additional price to the hospital in that the physicians can be compensated for these services legitimately, assuming there is an appropriate definition of duties and responsibilities and documentation of their work. However, recognizing that additional time must be spent performing these duties, physicians must be willing to forgo clinical duties in order to perform these duties. This also comes at a cost, but this time for the physicians.

PSA STRUCTURE COMPARISON

A comparison of four key PSA models discussed above is shown in Exhibit III. This chart depicts the standard terms of PSA models and how they differ between the Global Payment PSA, the Practice Management Arrangement, the Traditional PSA, and the Carve-Out PSA.

REIMBURSEMENT TRENDS

The changes to the fee-for-service healthcare system tend to be most striking as they apply to the new, value-based reimbursement paradigm. CMS has begun the push towards alternative payment methods, stating that the goal by the end of 2016 is to have 30 percent of traditional,

Hospitals and physicians are being incented to work together now more than ever to capitalize on the value-based incentives being offered both by Medicare and private insurance payers.

or fee-for-service, Medicare payments tied to quality or value and 50 percent of payments tied to those models by the end of 2018. Commercial payers will not be long behind them, with some already moving in this direction.

The value-based reimbursement models vary widely; however, the models that have been growing in prevalence recently include shared savings, shared losses, and bundled payments. Shared savings programs can be structured different ways; however, the basic concept is that if a payer

spends less on a procedure than the expected level, the provider is entitled to a share of that savings. Shared losses are essentially the same concept as shared savings, except that the provider would owe the excess amount spent by the hospital on a standard procedure. Bundled payments offer a single payment for an episode of care, encompassing all services from the admittance of the patient to post-discharge periods and including allowances for abnormalities such as complications.

These new payment changes will affect how hospitals and practices interact, pushing physicians to seek alignment with hospitals to ensure they can take advantage of some of these models, including those that require ACO participation. Meanwhile, hospitals are looking to employ or integrate with physician groups that have historically demonstrated positive

outcomes and thus, could take advantage of the quality initiatives being put forth. In any scenario, the two constituencies are being incented to work together now more than ever to capitalize on the value-based incentives being offered both by Medicare and private insurance payers.

One important update to reimbursement is in regards to the hospital outpatient prospective payment system (OPPS) that was set forth by Medicare to allow clinics within a health system to be considered departments of that hospital and receive additional reimbursement from government payers, including Medicare and Medicaid. On November 2, 2015, the Bipartisan Budget Act reversed this policy and systems now have to bill under the lower paying Physician Fee Schedule or Ambulatory Surgical Center Payment System.

There are a couple of important items to note when understanding the new reimbursement legislation. The act grandfathered in all existing hospital outpatient departments (HOPDs), allowing them to continue billing as hospital departments. The HOPD must have been billing as such before November 2, 2015, to continue to receive these benefits after January 1, 2017. The new laws have no impact on on-campus outpatient departments. Moreover, the act expanded the definition of on-campus to include all facilities within a 250-yard radius of the hospital's main buildings, plus other areas determined on an individual case basis by CMS. This limitation only applies to those entities not meeting the definition of on-campus; therefore, services furnished at remote locations of a hospital will be considered on-campus. Additionally, facilities that meet the requirements of a "dedicated emergency department" under existing regulations are also excluded from the reimbursement change and may continue to receive provider-based reimbursement even if located off-campus. Finally, the act does not apply to off-campus organizations that are necessary for satisfying provider-based regulations including satellite facilities and rural health clinics.

As noted, all of these changes to reimbursement are serving to drive physicians and hospitals to working more closely together. Many structures exist to accommodate such relationships, the PSA model is just one such viable option.

LEGAL CHALLENGES APPLY

Many of the same legal considerations still apply when considering PSA models versus a full employment arrangement. Hospitals and practices need to remain cautious and aware of these when entering into an agreement to ensure they are remaining within the confines of the law.

The issues of fair market value and commercially reasonable rates of compensation are present within any of the PSA models. However, this is no different than employment (or any other financial relationship between a hospital/health system and a physician). Wraparound

agreements are likewise subject to FMV/commercially reasonable rates of compensation. We recommend that once the compensation structure is designed, it should be reviewed; ultimately, an independent valuation expert should render a formal opinion as to the veracity of the compensation structure and amount.

Hospitals must also ensure that the PSA agreement does not break Stark Law through referrals of patients. While fair market value assessments play a large role in ensuring this, there are other nuances of the law that must be observed. In addition to Stark Law, hospitals are also beholden to federal Anti-Kickback Statutes. PSAs must be arranged in such a way as to eliminate kickbacks from referrals of Medicare and Medicaid patients to the hospital. Although these two points cover most federal regulatory issues, the hospital still needs to be educated on their state laws, which can sometimes impose even stricter restrictions on the agreement.

After serious consideration of these matters and with the completion of appropriate due diligence, the compliance and legal challenges, while still present, should be mitigated significantly. With this in mind, there are no legal restrictions on the PSA models; however, they must be structured to comply with the regulations in various relevant areas of the working relationship, especially the economic arrangements between the hospital and the physician group.

Finally, many of these structures are relatively new and have not been tested to the fullest degree. Care must be taken to consult with an experienced healthcare attorney before entering into any arrangement discussed in this paper. Moreover, hospitals should consider reviewing the PSA agreement and fulfillment at periodic intervals to ensure all federal and state healthcare laws are still being met.

OVERALL BENEFITS OF EMPLOYMENT LITE MODELS

As with all things, there are advantages and disadvantages to the PSA model. In most cases, the “cons”, which include such things as less stability than employment or the inclusion of a non-compete or exclusivity, are seldom untenable and, thus, can be addressed through productive discussions and negotiations between the parties.

The *benefits* of the PSA include the following:

- Physicians maintain their independence from the hospital by remaining either an employee of the practice or controlling their management infrastructure, which would enable them to go back into private practice smoothly.
- While these models are more complex than direct employment, their structures offer high flexibility, and some physicians often prefer (at least initially) going into such an alignment arrangement.

- Under some PSA models, specifically the Global Payment and Traditional PSAs, and their subsequent carve-outs, physicians can keep their existing benefits plans in place.
- The support staff may be employed by the hospital but remain with the practice while typically enjoying the perks of being employed by a larger organization (i.e., better benefits, job security, etc.).
- The structures are similar to employment, yet there are distinct differences that often are prevailing in preferences for the physicians.
- The PSA structures can be viable segues to full employment; many physicians need time to make certain that the hospital partner is the “right” long-term affiliate.
- The PSA structures can be viable segues to participation in the hospital’s CIN or ACO.
- While perhaps slightly less stable than employment, the PSA models offer a high level of stability for the hospital and physician relationship going forward.
- These models avail opportunities to increase revenue (within legal and ethical bounds) as well as to control costs.
- The PSA models present opportunities for physicians and hospitals to expand services together without being fully aligned (i.e., employment).
- Wraparound agreements (i.e., a clinical co-management arrangement and/or medical directorship) are easily structured within the PSA models and usually are a viable complement to them.
- The ability to unwind and disengage from the relationship is greater under the PSA models than traditional employment, particularly if there is no post-termination non-compete.
- While the ability to unwind exists, there are usually agreements that require high levels of commitment and inhibiting factors regarding the overall ability for the practice to partner with someone else (e.g., exclusivity and non-compete terms are typical traits of the PSA models).
- The ability to expand the elements of clinical integration clearly exists within the PSA models. Like employment, clinical integration is clearly possible, and the strategies prior to CINs/ACOs can easily be implemented in the PSA models.
- By nature, the Traditional and Global Payment PSA models provide the physicians a level of independence and autonomy that employment simply cannot provide.
- The Carve-Out option allows all parties to hone in on the areas of greatest need, either for the practice or the hospital, or both.
- The Carve-Out option also avails the opportunity to partner under a fully integrated structure but on a more limited basis.
- Although often not as favorable as full employment from the hospital or health system standpoint, the PSA models provide them full integration with the practice.

- The parties often share the same EMR system (or have access via interfaces/portals), which facilitates care coordination, data sharing, communication, and overall care management.
- From the hospital system, often the PSA models are more attractive because they reduce the typical economic and financial risk of owning and managing a medical practice (this is especially applicable to the Global Payment and Practice Management Arrangement PSA models).
- A management committee should be structured to develop joint strategies and other day-to-day operative initiatives, such as budgets and areas of opportunity for growth and expansion. Thus, the management committee within the PSA contract provides many of the governance and decision-making processes that should exist, regardless of the alignment model.
- Hybrids of the models discussed herein can be created to accommodate the specific needs of both the hospital and the practice.
- The PSA models will not preclude the establishment of fully-aligned models and other important structures, such as patient-centered medical homes and ultimately, ACOs/CINs.
- Both the hospital and the private group are better prepared and equipped to respond to the Accountable Care Era in a manner that does not compromise their current operations/structure.

Figure 5, PSA Model Comparison, can serve as a useful tool for the physician practice and the hospital to determine if the PSA is an appropriate strategy for the parties involved and if is the best fit for current and future planning, strategic goals (i.e., succession planning), and the unique market environment in which they exist. The Global Payment PSA works well for physicians who are interested in maintaining a clinical practice and continuing to manage a business. This arrangement includes retaining control over staff, managing overhead, and supervising other daily operations relating to their office.

Some physicians only want to be responsible for the clinical—not the business— aspects of medicine. Those physicians fare better with the Traditional PSA because it eliminates the responsibility to manage the business side of the practice. In this model, staff are employed by the health system partner and the overhead is managed by the hospital. Physicians in this scenario can focus solely on productivity.

FIGURE 5—SELECTING THE RIGHT PSA STRATEGY

Global Payment PSA works well for:

- ✓ Physicians interested in maintaining a clinical practice and managing a business
- ✓ Physicians capable and competent to retain control over staff, manage overhead, and supervise daily office operations
- ✓ Practice with a strong existent infrastructure and administrative team

Traditional PSA works well for:

- ✓ Physicians who no longer want to manage the business aspect of practice
- ✓ Physicians who want to focus on clinical aspects of medicine only
- ✓ Physicians willing to transfer employment of staff to health system partner who also manages overhead

The Carve-Out PSA option allows only those physicians and/or only those sites/services that are necessary and/or desired to be a part of the PSA. The parties realize the numerous benefits of greater integration without experiencing the full breadth of a comprehensive transition process.

Finally, by retaining its management infrastructure, the Practice Management Arrangement allows the practice to achieve its goals of flexibility in the event it elects to revert to a private practice setting if the employment arrangement does not prove satisfactory. Also, the employment of the physicians and other providers is an effective alignment strategy, providing opportunities for improved relations and even economic and performance outcomes.

IS EMPLOYMENT LITE FOR YOU?

After you explore the options in PSAs models and consider their advantages and disadvantages, use Figure 6 to summarize key items to evaluate the appropriate alignment model for your situation. These questions apply to a hospital/health system and a qualified medical group.

FIGURE 6—EMPLOYMENT LITE CHECKLIST

QUESTION	ANSWER
<p>1. What does the practice prefer regarding overall structure relative to its alignment? For example, does the practice believe that the hospital’s management structure is lacking and, further, are there questions in the minds of the practice about the sustainability of the hospital management structure? Currently, does the hospital provide adequate support services for their aligned practices?</p>	

<p>2. Is there a strong preference among the parties (i.e., both the practice and the hospital/health system) for the staff to be employees?</p>	
<p>3. What is the gestalt of the parties relative to ancillary services? What are the applicable state (and federal) legal requirements and parameters surrounding the issue? Is it essential for the hospital/health system to own the ancillary services going forward?</p>	
<p>4. How are leadership and governance addressed? What are the voting rights and reserved powers the health system may require? What will be the effect of ethical and religious directives, if applicable?</p>	
<p>5. What value-based criteria are to be considered, and how will they affect the PSA model going forward? Will a portion of the compensation plan include consideration of such non-productivity-based (i.e., value based) criteria?</p>	
<p>6. Is compensation comparable under both PSA and employment? Are fair market value/commercially reasonable rates under consideration, regardless of the structure? Has an independent valuation expert provided an opinion?</p>	
<p>7. What assurances are given the physician group that the hospital/health system will allow a level of independence and governance, particularly if the structure is the Practice Management Arrangement or Traditional PSA model?</p>	
<p>8. What is the term of the agreement? More importantly, what are the rights for early termination (with or without cause)?</p>	
<p>9. How much security, both financial and otherwise, will the hospital/health system provide to the practice? What guarantees of income may exist?</p>	
<p>10. What leadership duties and responsibilities will be assigned to the physicians? These may include medical directorships as well as non-clinical leadership positions.</p>	
<p>11. What service line responsibilities, if any, will be assigned to the physicians?</p>	
<p>12. Does the PSA include any “wraparounds?” For example, are there any clinical co-management or service line management responsibilities? What about medical directorships? Are these enveloped within the PSA or subject to a separate agreement?</p>	
<p>13. Have the strategic, relational, economic, and functional advantages or disadvantages been articulated between the hospital/health system and the practice? Does the employment lite structure allow for full alignment as well as a high level of partnership?</p>	

14. What is the status of the staff and their security, as well as compensation, assuming the Traditional PSA is the model of choice? Will there be a guarantee of employment for a period of time, post-transaction?	
15. What are the restrictive covenant/non-compete terms and conditions? Are they different than what an employment model entails?	
16. What are the terms of the employment lite agreement in the context of a changing reimbursement paradigm? For example, if a shift from productivity- to value-based reimbursement occurs, would the increase trigger an automatic change in the compensation structure from productivity to value?	
17. Under the Global Payment PSA, how is the overhead reimbursed? Is the amount a budgeted total? A fixed amount that is only adjusted upon mutual agreement through a governance committee? Or is it a combination of fixed budgeted total to be reimbursed and certain variable expenses tied to wRVUs?	
18. Is the employment lite model a precursor to employment? Is this matter specified in the definitive agreements?	

These question and your answers will address many, if not all, of the key terms and conditions of an employment lite agreement. The information you gather will enable you to summarize and analyze your position before consummating the employment lite contract.

CASE STUDIES

The aspects of the professional services agreement described above are general in nature. The following sections address specifics to past Coker clients, laying the groundwork, outlining the actions, and reporting on the progress of the various arrangements after their implementation.

CASE STUDY #1: GLOBAL PAYMENT PSA

A 61-physician multi-specialty practice in the Midwest was considering ways to align with a local health system. Recognizing that they did not have any experience with anything other than limited forms of alignment with this system in the past, they desired an alignment structure that would accommodate a single service line, at least initially, to establish trust between the organizations and create an alignment foundation that could be built upon in the future. The practice recognized a relative strength within their orthopedics department and, initially, wanted to develop an alignment structure with this department only. However, the practice realized that from a strategic perspective, they needed first to increase the size of their orthopedic provider base in order to create the leverage they desired in their local market. As a

result, the practice acquired a single-specialty orthopedic practice in their primary service area. The practice acquired the smaller group not only because of their desire to expand but also because the smaller group was a solid cultural fit and was in agreement with the practice’s desire to align more fully with the local health system. With the addition of the single specialty orthopedics group, the practice increased their orthopedist provider base to 20 physicians across a range of subspecialties (hand, foot and ankle, sports medicine, etc.). Then the practice approached one of the local hospitals regarding potential alignment, exclusive to this service line; that is, they requested a Carve-Out PSA, with a Global Payment PSA structure. The practice obviously came from a position of strength, as they had the majority of orthopedic providers within the community unified, and they were negotiating on behalf of the entire group. This position allowed them to have influence over the alignment structure as well as the terms and conditions of the transaction. Also, because the local market included more than one health system, the practice had the leverage to approach another health system if their preferred partner was unwilling to meet their desired terms. Ultimately, the multispecialty group carved out their orthopedic service line under a PSA while the remainder of the group remained private. The orthopedists are currently aligned with the health system under a Global Payment PSA at a specified rate per wRVU. The table below defines the payment schedule.

Total Unit wRVUs	Global Fee/wRVU		
	Year 1	Year 2	Year 3
Tier One: 0-144,000 wRVUs	\$96.00	\$97.92	\$99.88
Tier Two: 144,001-155,000 wRVUs	\$98.00	\$99.96	\$101.96
Tier Three: 155,001 wRVUs and Above	\$100.00	\$102.00	\$104.04

In this transaction, all wRVUs produced up to 144,000 (an aggregated total for the group) are compensated at \$96. After this Tier One production threshold is exceeded, the excess wRVUs (up to 155,000) are compensated at \$98. Finally, any wRVUs above 155,000 are compensated at \$100. We note that the payment structure is incremental, rather than retroactive, meaning that the wRVUs in each Tier are compensated at that individual Tier rate. For example, if 151,000 wRVUs are produced, 144,000 are compensated at \$96, and 7,000⁴ are compensated at \$98; all 151,000 are not compensated at the higher rate (e.g., \$98). Also within the practice’s compensation model is an escalator for Years 2 and 3 of the agreement, where each Tier receives a 2% increase in compensation.

We note that this Global Payment PSA structure falls into Option One (see pages 7-9 for a description of the two compensation alternatives and Figure 1), where the compensation rate per wRVU includes consideration of both the practice’s overhead expenses as well as physician compensation and benefits. We also note that because this PSA included a carve-out for a single department within the larger practice, the overhead expenses that were effectively calibrated in

⁴ 151,000 minus 144,000

the determination of the Global Payment PSA rate were specific to orthopedics-only expenses, rather than the entire overhead rate of the practice. This action is necessary for compliance purposes and also makes logical business sense.

As a result of this transaction, the practice has solidified its relationship with one of the local health systems for the foreseeable future. Further, the potential for closer alignment exists across additional specialties in the near term. This practice's experience demonstrates the benefits of foresight. By aligning first with another orthopedic group and then with the hospital, the practice stabilized their orthopedic service line and strengthened their provider base. This groundwork will support their position in future negotiations with the hospital or its competitors, much as it did in its initial negotiations.

CASE STUDY #2: PRACTICE MANAGEMENT ARRANGEMENT

A 49-provider multi-specialty practice in a large metropolitan area in the Southeast was considering aligning with a health system as a way to prepare for the shift to accountable care. The practice was well respected within their primary and secondary service areas, had high patient satisfaction and low employee turnover, and was fiscally sound. The practice had no true need to align with a partner (i.e., there were no financial challenges and no real operational risks) but felt that alignment was an important consideration as they prepared for coming changes in healthcare.

As a result of the size of their community, the practice had a several options relative to potential partners, including two major health systems, each with a number of inpatient facilities throughout the region, and a smaller, independent, stand-alone hospital. While this situation is a "good problem" to have because it results in options to consider and creates leverage for the practice, deciding which hospital to partner with was the single most difficult decision for the practice throughout their due diligence process.

One difficulty in the decision-making process was the variety of alignment models that were proposed by the various potential partners. For example, the partners considered not only employment, but also various joint venture opportunities, a Traditional PSA, and a Practice Management Arrangement. One of the first challenges for the practice was understanding the models that were proposed and the strengths and weaknesses of each. The practice recognized that they wanted to retain some level of autonomy, so acquisition of the practice and employment of all staff and physicians was not seen as viable. They also knew they wanted a closer relationship than a joint venture would afford, so they limited their consideration to the Traditional PSA and the Practice Management Arrangement.

One of the two larger health systems in the community proposed the Practice Management Arrangement. Under this system's model, the physicians would become employed through a wholly-owned subsidiary of the health system. This employment would allow the practice to

remain separate from the system's existing physician network. (The practice was unwilling to join the system's larger, existing physician network as they felt it would eliminate the group mentality they had worked hard to create among their providers.) The health system proposed a compensation model where the physicians received the greater of their guaranteed compensation (equal to prior year actual compensation) or their productivity-based compensation (based on a practice-wide conversion factor, which would be multiplied by the actual number of wRVUs produced). Under this model, the health system would not acquire the tangible assets of the practice, but would execute a management services agreement with the practice under which they would pay a fair market value fee for all services provided by the practice, encompassing compensation and benefits for practice staff, billing and collection services, equipment, clinical and support space, and administrative management services. The health system believed that this model would create a platform for clinical integration between the parties but also helped to ensure the existing practice structure remained in existence and continued to improve its operations.

The practice ultimately decided to pursue the Practice Management Arrangement and, as a result, decided to align with the health system that had initially offered it, because they were not ready to completely divest of their staff and operating infrastructure as would be required under the Traditional PSA that had been proposed by the other system. This transaction has now been in effective for its entire initial term and is the process of being renegotiated for a second term. The health system and practice continue to be pleased with the level of clinical integration that has been possible under this model and are busy working towards the development of their mutual ACO entity.

CASE STUDY #3: TRADITIONAL PSA

An eight-physician single specialty cardiology practice in the Northwest was continuing to feel the pressure of declining reimbursement, particularly for their diagnostic ancillaries after the changes in CMS reimbursement for these services. In addition, the practice was having difficulty managing their expenses. At a time when reimbursement was declining, their overhead seemed to be steadily increasing, not only as a percent of revenue, which would be expected, but also in "real dollar" terms. For this practice, the overall business operations were becoming more burdensome by the day and were requiring additional time from the physicians that they needed to be spending increasing their patient throughput to help ensure the practice's ongoing financial solvency. As a result, the practice approached the local hospital (in this area, there was only one main hospital within a 30-mile radius of the practice) regarding potential alignment. Unfortunately, like many cardiology groups, this practice needed to align with the hospital because of the fear that their rising economic challenges would soon become insurmountable.

The local hospital was quite willing to align with the practice, as they recognized this transaction would likely create greater stability within their cardiology service line, something that the hospital had been lacking. At that time, the hospital employed three cardiologists and wanted to

expand their provider base to ensure adequate coverage. For example, the hospital only employed one interventional physician, which was creating difficulties in consistent coverage for interventional services. The hospital and practice agreed to pursue a Traditional PSA, where the physicians would remain employees of the practice, but the staff, overhead expenses, and management functions of the practice were transitioned to the hospital. Further, all existing ancillary assets were sold to the hospital.

The hospital developed a single-tier productivity-based model where all physicians received compensation at the highest rate then offered by the hospital to its employed physicians to ensure the relationship between the existing employed physicians and those newly contracted was consistent (and amicable). For the practice physicians, this shift resulted in an increase in compensation of 10 to 15 percent over the prior year. Ultimately, it helped bring the physicians back to their 2008 historical compensation levels, which was reflective of their consistent levels of compensation before the cuts in CMS reimbursement for cardiology services. The physicians were elated not only to receive this increase in compensation but also to be relieved of the practice management responsibilities, which had increased significantly over the past several years.

Although the physicians and hospital were pleased with the Traditional PSA, they have recently transitioned their relationship into full employment, including an acquisition of the practice and employment of the physicians. The physicians have now built trust with the hospital and consider this transition desirable. This example demonstrates the ability of a PSA model to (a) meet immediate needs, (b) allow physicians to remain in private practice yet still aligned with a hospital, and (c) serve as a natural segue to employment.

These three case studies demonstrate the flexibility of PSA arrangements and some of the solutions that they offer when adopted.

SUMMARY

While the PSA models have grown dramatically in popularity since they were introduced approximately five years ago, the truth of the matter is that most “full” alignment transactions are still focused on “W-2” employment. And many of the PSA models, as they move into their Second Generation deals, entail terms and conditions that are more consistent with employment. However, the PSA models have indeed stood the test of time, and even a great deal of legal securitization. For the most part, physicians not only like but prefer the employment lite models. In addition, some are happy and fully-satisfied with moving to employment and if not immediately, are willing to do so after a period of time under a PSA structure. All of these things are appropriate and worthy of consideration as hospitals/health systems and physician groups contemplate their strategies for working together in a contractual affiliation.

PSA models therefore require both parties to be willing to not only allow for some common ground, but also a willingness to work together in harmony. PSA models are truly still employment lite structures, meaning that if assembled properly, they look, feel, smell and taste much like full employment. We have pointed out some notable differences but again, at the conclusion of the process, employment lite models mirror full employment. Why they are they so popular? Truthfully, they allow physician groups more independence and autonomy but yet clearly have the checks and balances of full employment that health systems seek and prefer. They allow for transitioning back to private practice but also easily to full employment and frankly, most of the time the latter is the course that is taken.

As the healthcare industry moves further from “volume to value,” the question of whether employment lite PSA models will continue to exist is a very fair one. We believe they do have a place in the alignment model portfolio and should be seriously considered—no matter the perspective (i.e., medical group or hospital/health system). Employment lite models have sufficient similarities to full employment to allow them to be very popular and indeed useful in a value-based reimbursement setting.

Coker Group has assisted numerous organizations in implementing various employment lite arrangements. Contact Max Reiboldt at mreiboldt@cokergroup.com or Aimee Greeter at agreeter@cokergroup.com to learn more about these options and to explore ways this strategy may apply to your group, and visit us online at www.cokergroup.com.

EXHIBITS

Exhibit I – Descriptions of Prevalent Alignment Models

Limited Integration	Moderate Integration	Full Integration
<p>Managed Care Networks (Independent Practice Associations, Physician Hospital Organizations): Loose alliances for contracting purposes</p>	<p>Service Line Management: Management of all specialty services within the hospital</p>	<p>ACO/CIN/QC: Participation in an organization focused on improving quality/cost of care for governmental or non-governmental payers; may be driven by practices or hospital/groups</p>
<p>Recruitment/Incubation: Economic assistance for new physicians</p>	<p>MSO/ISO: Ties hospitals to physician's business</p>	<p>Employment "Lite": Professional services agreements (PSAs) and other similar models through which hospital engages physicians, typically as 1099 contractors</p>
<p>Group (Legal-Only) Merger: Unites parties under common legal entity without an operational merger</p>	<p>Clinical Co-Management: Physicians become actively engaged in clinical operations and oversight of applicable service line at the hospital</p>	<p>Employment*: Strongest alignment; minimizes economic risk for physicians</p>
<p>Call Coverage Stipends: Pay for unassigned ED call</p>	<p>Equity Group Assimilation: Ties entities via legal agreement; joint practice ownership</p>	<p>Group (Legal and Operational) Merger: Unites parties under common legal entity with full integration of operations</p>
<p>Medical Directorships: Specific oversight duties</p>	<p>Joint Ventures: Unites parties under common enterprise; difficult to structure; legal hurdles</p>	

	Typically Physician-to-Physician		Typically Physician-to-Hospital		Either Physician-Physician or Physician-Hospital
---	----------------------------------	---	---------------------------------	---	--

**Includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model, both of which allow the practice entity to remain intact even after employment of the physicians by the hospital.*

Exhibit II – Alignment Models and Compensation Frameworks

Strategy	Level	Basic Concept	Compensation Framework
Managed Care Networks (i.e., IPAs, PHOs)	Limited	<ul style="list-style-type: none"> Loosely formed alliances Primarily for contracting purposes Limited in ability unless clinically integrated Being used as platform for ACO/CIN development 	<ul style="list-style-type: none"> No true impact on pay unless in improved contracts Could result in distribution of incentives Shared savings programs within ACO/CIN framework
Call Coverage Stipends	Limited	<ul style="list-style-type: none"> Comp for personal, financial, and risk of ED coverage 	<ul style="list-style-type: none"> Payment can be daily stipend, FFS, or hybrid
Medical Directorships	Limited	<ul style="list-style-type: none"> Payment for defined administrative services Must be a true need for services 	<ul style="list-style-type: none"> Typically paid via FMV hourly rate
Recruitment/Incubation Model	Limited	<ul style="list-style-type: none"> Hospital financially supporting new recruit 	<ul style="list-style-type: none"> Allows existing MDs to prevent compensation decrease with addition of new MD
Equity Model Assimilation	Moderate	<ul style="list-style-type: none"> Ties all entities via legal entity Can jointly contract with payers Can be with hospital and/or private group 	<ul style="list-style-type: none"> Can result in increased profitability through better contracts Possible additional value through operational efficiencies
Provider Equity (i.e., JVs)	Moderate	<ul style="list-style-type: none"> JVs on specialty hospitals, ASCs, OP, etc. 	<ul style="list-style-type: none"> Can provide additional revenue stream to private physicians
Targeted Cost Objectives	Moderate	<ul style="list-style-type: none"> Focus to ensure delivery of cost-effective care Quality maintained at consistent levels 	<ul style="list-style-type: none"> Savings shared with providers Based on an hourly fee, percentage, fixed fee, etc.
Management Services Organization	Moderate	<ul style="list-style-type: none"> Services provided to manage aligned entity Revenue cycle, HR, IT, etc. Can be hospital-owned, JV, or practice-owned 	<ul style="list-style-type: none"> Can provide additional revenue strength Charged FMV rates for services rendered
Clinical Co-Management	Moderate	<ul style="list-style-type: none"> Provision of admin services Works towards certain strategic initiatives May include pay-for-call, directorships, etc. a/k/a service line management 	<ul style="list-style-type: none"> Involves payment based on hourly rate Administrative and incentive payments allowed for achieving metrics
Professional Services Agreement	High	<ul style="list-style-type: none"> Allows practice to remain private, hedge payer risk Hospital owns receivables 	<ul style="list-style-type: none"> Hospital pays practice on wRVU basis wRVU payment rates must be at FMV

Exhibit II – Alignment Models and Compensation Framework (Cont.)

<u>Strategy</u>	<u>Level</u>	<u>Basic Concept</u>	<u>Compensation Framework</u>
Employment	High	<ul style="list-style-type: none"> - Hospital owns payer contracts - Contract with practice for professional services - a/k/a Employment Lite" - Traditional employment arrangement with hospital 	<ul style="list-style-type: none"> - Overhead costs covered by practice from PSA payment - Typically includes productivity payment - Potential for incentive payments (i.e., quality, cost control)
Group Practice Subsidiary	High	<ul style="list-style-type: none"> - Single/Multispecialty practice functions as subsidiary - Wholly-owned by hospital - Physicians employed by subsidiary 	<ul style="list-style-type: none"> - Entails a group income distribution plan - Standard entity dynamics remain at play
Quality Collaborative	High	<ul style="list-style-type: none"> - Consortium of providers in group under hospital - Various degrees of integration within hospital - Focused on furthering quality outcomes - Usually focused on defined population 	<ul style="list-style-type: none"> - Internal or external funding sources determine scope and structure
Clinically Integrated Networks	High	<ul style="list-style-type: none"> - Interdependent healthcare facilities form network - Providers collaboratively develop clinical initiatives 	<ul style="list-style-type: none"> - Incentive (at risk) compensation - Based on achievement of pre-determined measures
Accountable Care Organizations	High	<ul style="list-style-type: none"> - Participating hospitals, providers, and others - Collaboration on quality and efficient care - Focused on Medicare and other patients 	<ul style="list-style-type: none"> - Incentive (and punitive) financial impacts - Based on cost savings and quality

Exhibit III – PSA Model Comparison

	Global Payment PSA	Practice Management Arrangement	Traditional PSA	Carve-Out PSA (Applicable for Carved-Out Components Only)
Physicians Employed by Hospital		X		
Physicians Employed by Practice	X		X	*
Staff Employed by Hospital			X	*
Staff Employed by Practice	X	X		*
Real Estate Owned by Hospital	*	*	*	*
Real Estate Owned by Practice	*	*	*	*
Non-Ancillary Medical Equipment Owned by Hospital			X	*
Non-Ancillary Medical Equipment Owned by Practice	X	X		*
Ancillary Medical Equipment Owned by Hospital	*	*	X	*
Ancillary Medical Equipment Owned by Practice	*	*		*
Hospital/Hospital Affiliate Physician Benefit Plans Utilized		X		
Practice Physician Benefit Plans Utilized	X		X	*
Hospital/Hospital Affiliate Billing Tax ID Used	X	X	X	X
Practice Billing Tax ID Used				
Hospital/Hospital Affiliate Retains A/R (post-alignment)	X	X	X	X
Practice Retains A/R (post-alignment)				
Managed Care Contracting Negotiations Completed by Hospital	X	X	X	X
Managed Care Contracting Negotiations Completed by Practice				
<i>*Depends on negotiated agreement</i>				