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**LESSONS LEARNED FROM LEASING:
A BLUEPRINT FOR HOSPITAL-PHYSICIAN
ALIGNMENT**

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Lessons Learned from Leasing: A Blueprint for Hospital-Physician Alignment

By Alice G. Gosfield

1. Introduction

The drumbeat for improved value has been incessant since the enactment of the Affordable Care Act. One of the fundamental problems in generating value stems from the two long-standing reimbursement systems in the Medicare program working at odds with each other: DRGs for hospital payment drive towards under-service – the less you do, the more you keep; Fee For Service (FFS) for physician payment drives towards over-service – the more you do the more you make.

The great quest to bridge this absurd policy gap has been through the much sought after *alignment* between hospitals and physicians. The purpose of alignment is to overcome the impact of the perverse reimbursement incentives that remain in play. A vast array of techniques have been bandied about and implemented to foster this fundamental change. These include pay for performance, bundled payment, accountable care organizations, clinically integrated networks and variations on each of those.

The modern version of alignment requires closer attention not to the reimbursement models, but to clinical performance. This has shifted much of the dialogue to a need for *clinical integration* between the two significant others – hospitals and physicians -- that remain, like the Montagues and Capulets, stuck in their historical fiefdoms, while warring from time to time over services, reimbursement, shared savings and more, but most of all the loyalty of the physicians.

To garner that essential loyalty and bind the physicians more closely to them, many hospitals have moved to employ physicians directly. For a variety of reasons set forth more fully here, I believe a far better alternative lies in the practice leasing itself to the hospital. I have been involved in a broad range of these transactions across the country involving varying factors including the specialties of the physicians involved. In this article, I share in depth what I have learned about the document that structures the relationship between the parties and the implications of its provisions.

1. Background, Motivations and Overview.

1.1 *Employment*

The phenomenon of physician-hospital consolidation which began during failed Clinton health reform has been long noted. Even though the legislation was never passed, the employment of physicians by hospitals (along with the acquisition of their practices often at inflated rates) burgeoned. Reportedly by 1998, hospitals employed about 70,000

physicians.¹ By 2013, it was estimated by the American Hospital Association that roughly 18% of practicing physicians were employed by hospitals with an additional 8% employed by affiliated practice entities, sometimes fashioned as foundations, sometimes as non-profits with the hospital system as the sole member and sometimes as true professional corporations.² As of 2016, the Agency for Healthcare Research and Quality said that almost 45% of American physicians were “in vertically integrated health systems,”³ although the form of how they were “in” them -- by employment or other affiliation -- is not clear.

The motivation of the hospitals to employ physicians is several-fold: they seek market share that comes from the employed physicians’ patients. They hope to thwart competition from physicians who have increasingly gone into business in service lines previously reserved to the hospitals alone, from imaging centers, to endoscopy suites, to infusion centers and more. And they have often claimed that the more closely aligned relationship would improve value. That they have routinely lost large sums of money on these relationships has been widely reported with most commentators reporting at least a \$100,000 annual loss and some reporting even double that amount on each physician employed!⁴ Still further, these relationships have not improved quality at all, even two years after the initial acquisition.⁵

For their part, the physicians seek financial security. Among the most recent wave of acquisitions was a host of cardiologists who had invested in expensive imaging equipment, when Medicare changed its reimbursement for the services.⁶ Fearful of being isolated from developing networks and accountable care organizations if they remained independent, specialists and primary care physicians sought solace at the employment bosom of their local hospital. Many had become fed up with dealing with insurers and shouldering increasingly demanding administrative burdens. Consolidation of the

¹ Goldsmith, Kaufman and Burns, “The Tangled Hospital-Physician Relationship”, Health Affairs Blog, May 9, 2016, <http://healthaffairs.org/blog/2016/05/09/the-tangled-hospital-physician-relationship/>

² Id.

³ <https://www.ahrq.gov/sites/default/files/wysiwyg/snapshot-of-us-health-systems-2016v2.pdf>

⁴ Kocher and Sahni, “Hospitals’ Race to Employ Physicians – The Lgoci behind a Money-losing proposition”, *NEJM* May 12, 2011 pp1790-1793; O’Malley, Bond and Berenson, “Rising Hospital Employment of Physicians: Better Quality, Higher Costs?” Issue Brief No 135, Center for Studying Health System Change, Aug 2011; Kutcher, “Some hospitals employing physicians see greater losses,” *Modern Healthcare*, Dec 20, 2014, <http://www.modernhealthcare.com/article/20141230/NEWS/312309942>;

⁵ Scott et al., “Changes in Hospital-Physician Affiliations in US Hospitals and Their Effect on Quality of Care,” *Annals of Internal Medicine*, Sept 20, 2016 <https://scholar.harvard.edu/files/cutler/files/aime201701030-m160125.pdf>

⁶ Ingle, “A change of heart: Cardiologists leaving private practice for hospitals,” *FOXNEWS Health*, Feb. 13, 2012, <http://www.foxnews.com/health/2012/02/13/change-heart-cardiologists-leaving-private-practices-for-hospitals.html>

hospitals themselves was a spur, striking fear in the hearts of physicians⁷ who didn't think they could go it alone against the developing challenges of the new environment after the Affordable Care Act.

There is scant actual evidence as to why the employment mechanism hasn't worked generally, but hastily created documents where the hospitals promise much higher compensation than physicians were making in private practice, without much by way of performance metrics has characterized many of these transactions I have seen and reviewed. Unlike the earlier phenomenon, the physicians have pushed the hospital with an urgency that does not reflect careful planning. Sometimes the hospital is the driver to strategically block their competitor from an impending deal that will bring the 'other guy' the sought after physicians. Later, failure to clinically integrate the physicians they do employ is endemic.

There is no question that in many instances these relationships have ended up costing payors and patients more without getting any change in the performance of the physicians whatsoever. In fact, data now shows that a 49% increase in hospital employed physicians between 2012 and 2015 led to a \$3.1 billion increase in Medicare costs related to only four specific outpatient procedures: diagnostic cardiac catheterizations, echocardiograms, arthrocentesis, and colonoscopies⁸. This represents 27% higher costs paid to hospitals (\$2.7 million) and 21% higher costs to patients (\$11 million) by comparison with physicians in independent practice settings. Moreover, hospital employed physicians were seven (7) times more likely to perform those services in hospital outpatient settings than independent physicians. Whether the compensation incentives or the higher facility costs⁹ are to blame is unclear, but the higher facility costs were very much at issue.

Often the motivations of both sides have been misaligned from the start,¹⁰ and at their essence have little to do with quality or value at all. That is not to say that employment relationships impede quality; but I have believed there is a better approach that creates all the alignment the parties want, gives better results, both financially and from a quality perspective, has a more level playing field and is far simpler in some ways. That said, in the many transactions I have done around the country leasing the physician practice to the hospital, the first response by the hospital to such a proposal has uniformly been employment. When the subject of this article is broached, from both the hospital and hospital counsel there has mostly been befuddlement, although that is now changing.

⁸ O'Malley, Bond and Berenson, n. 3, supra

⁸ Avalere Health LLC, "Implications of Hospital Employment of Physicians on Medicare & Beneficiaries," Nov. 2017
http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI_Medicare%20Cost%20Analysis%20--%20FINAL%2011_9_17.pdf

⁹ See Section 3, below

¹⁰ Gosfield and Reinertsen, "Informed Consent To The Ties That Bind," The Physician Executive (January/February 2010) pp. 6-13

1.2 *The Basic Premise*

The fundamental transaction that this article addresses is an antidote to the master-servant nature of the employment relationship. The group practice “leases” itself, pursuant to a professional services agreement to the health system, hospital or its physician practice entity. I have done these where the hospital has segregated practice pods by specialty or by the former practice entity, without requiring full merger into a larger entity. In the lease arrangement, the group retains its cohesion, much of its culture, and most often its staff. In the dialogue between me and in-house counsel who asked if employment was off the table for my large cardiology group client, I replied, “It is completely off the table. My clients do not want a master-servant relationship with you. They want a you can never replace 22 cardiologists at once, relationship with you.”

The physicians reassign their right to payment to the hospital which takes the risk of billing for the services. More on that risk later. The termination of the relationship is a simple contract termination (although there are issues with electronic health records), but it does not involve a lot of human resources decisions, and, if managed properly, ought not entail repurchase of assets previously sold to the hospital, which I try to avoid, always.¹¹

Picking the right partner is obviously a critical first step and sometimes the answer is not so obvious. One might think that the hospital at which the physicians primarily admit would be the ideal partner, but that is not always the case. I had one transaction where the physicians admitted to four community hospitals and they leased themselves to an academic medical center which was more interested in their quaternary referrals than their day to-day business. I have had another transaction where a large group crossed state lines. They leased themselves to a different academic medical center system which was executing a very expansionist strategy. Their home base was relatively far from the academic mother ship and their cross state partners were even further removed from the center. The terms of the agreement explicitly stated that the group’s use of the center’s facilities, whether in affiliated hospitals or at the center itself, was not the basis of the relationship which was far more about the center making a statement with respect to its commitment to community-based cardiology, having leased two other major groups at one of its facilities.

2. The Deals That Never Happen

Many of the lease transactions have taken far longer to develop than would seem necessary. The very first one I did in the mid-west took 14 months, the first two of which were spent convincing the hospital that the physicians would not accept employment and that the hospital would get everything they needed from the lease. That one has already

¹¹ One of the big problems with the 90’s version of the employment phenomenon was, in addition to inflated compensation, over valued assets, which, when the deals cratered, had to be repurchased. Even with employment the purchase or practice assets is far rarer. See O’Malley et al, supra n. 3 at 2.

rolled over once for an additional four year term. The biggest obstacle is usually that the hospital is unfamiliar with the entire approach. I have had circumstances where, while I represented the physicians, the hospital ended up paying me to do a PowerPoint presentation to the CEO and CFO to explain the fundamentals of the proposal and how it would work from their side of the table.

In other situations, there has been a notion that there should be some better alignment, so the hospital initiates discussions, but other financial burdens get in the way. When the administration changes during the negotiations, it is often difficult to make the deal happen. In the fast changing environment of health care, what starts as a discussion with a community hospital changes as the board decides to affiliate with other facilities. I have had transactions where discussions were begun, deal points were tossed around, nothing was reduced to writing and the parties simply weren't sufficiently motivated to continue to execution. The extent to which the physicians are truly motivated to do this can have a major impact on whether the transaction happens. Having one physician who really takes responsibility for knowing why every word in the document is there helps enormously, as does the presence of a sophisticated practice manager who really understands the performance and finances of the group. I have not had a single one of these deals come to fruition without the very close collaboration of those two individuals with me.

3. Structure

The simplest structure for one of these relationships is a professional services agreement (PSA) with the professional group, including all the staff, clinical and non-clinical, to provide a quantum of services typically measured by wRVUs. Where a very large group practices in multiple hospitals, I have done arrangements where only the physicians who practice at the mother-ship hospital are included; and physicians who practice in farther flung locations were either leased to the more local hospital or simply went on billing as they had been without the PSA. For the transaction where the physicians did not use the leasing academic medical center hospital at all, all the physicians were included, even while they continued to hold positions in the medical staffs and as medical directors of the community hospitals where they were dedicated in their day-to-day work. In these arrangements, the management services are typically handled through a separate management services agreement (discussed more fully below at 7.5)

Another version, which I have seen, but do not favor, is that the leasing hospital buys the assets of the group, and then enters into a pure PSA and nothing more with the group practice. The problem in these transactions is the same as the asset acquisition employment arrangements: upon termination the group has to buy its now further depreciated assets back again. I have one client who before I represented them, had done this twice: an academic medical center leased them and bought their assets and then said they only wanted an employment arrangement. The parties terminated. The group repurchased its assets and leased itself again to a second facility where the majority of the group but not all, rendered services. That entity bought their assets again. When the

hospital was purchased by another system that had no interest in the cross borders in another state part of the group, they parted company again, with a second repurchase of their assets. For the third lease, there is another asset purchase. They are hopeful they have landed for good. Given their market, though, they have very few options if the last lease does not work: they can go independent, which will require major retooling of the entire operation; or they can merge with another group to form a mega-group. Given the consolidation of the hospitals in their market, there simply are no further options left.

In a third version, which I also don't like, the hospital employs the group's staff and while the group stays together to render services for the PSA, they don't have a management contract because the staff is working for the hospital. Depending on whether the leasing facility is leasing directly as a hospital or has a separate practice group in which the staff is employed, this arrangement can create Stark problems if the physicians rely on the now hospital's personnel to assist them in their work. For example, if the practice has mid-level practitioners, if they are now employed by the hospital, even though the hospital is billing for the physicians' services, they are not hospital services; and the physicians can't use the NPs or PAs to assist them in the office-based practice without paying for those services. I find this creates enormous complexity and the worst part of it is that if the transaction ends, the group has to reassemble its support staff in order to be able to make its next move.

The other structural issue which used to be more of a problem than it is now, is whether the location where the physicians practice is designated as provider-based.¹² While changes in the rules have limited the applicability of provider-based status to on-campus (within 250 yards of the hospital) locations, the issue can still arise in a lease arrangement. When the locations where the group practices become provider based, they come under the hospital's license for state regulatory and licensure purposes; they impose organizational integration and signage requirements; but they get the hospital additional monies over what physician office practices get for the very same services. But the patients are seeing the same professionals, in the same space, using the same equipment as they were before, but now they have a hospital co-pay and deductible, and Medicare pays more to the hospital for precisely the same services. The very first lease arrangement I did involved a cardiology group which had spun its diagnostics out into a separate corporation some years before. The hospital bought the assets of that corporation and made the location provider-based. The patients were not happy. Thereafter, I made it a condition of all the transactions I did, that the hospital or health system could not designate the location as provider-based without the consent of the group. The circumstances that permit provider-based billing are now so limited, that this ought not present the same problem going forward, at least not with the same frequency.

¹² 42 CFR §413.65. For an excellent discussion of the changes in the provider-based rules and their current applicability, see Vernaglia and Ruskin, "Provider-Based Status, Under Arrangements, Enrollment and Related Medicare Requirements," American Health Lawyers Association, Institute on Medicare and Medicaid Payment Issues, March 2017

4. Scope of The Services and Clinical Personnel

All of the transactions I have done, while not necessarily encompassing all the physicians in the practice when they work at multiple facilities, have all included both inpatient and office-based services. Some transactions have included the physicians staffing outpatient clinics which they did before the lease. These were simply rolled into the lease.

Depending on the nature of the practice, it would not be hard to imagine leasing only for inpatient services and maintaining the office-based practice separately. Still further, primary care physicians, who rarely set foot on the inpatient side of the hospital, these days, could also lease themselves to the hospital on the same basic terms. Involving primary care physicians more closely in true clinically integrated undertakings is becoming more and more important with the emphasis on avoiding readmissions and managing care more effectively in the community.

A related issue becomes how to treat mid-level practitioners. In some instances, they are included in overhead when they do not contribute to wRVUs the practice can generate. But one problem I have had to fight against with multiple hospital counsel, is the reference to qualifying in the contracted for compensation only those wRVUs 'personally performed' by the physicians. This is typically a misreading of the Stark statute and its emphasis on compensation for personally performed services under the definition of a group practice.¹³ In the first instance, this is only in relationship to designated health services since Stark is irrelevant to referrals for other activities. Evaluation and management services rendered by mid-level practitioners are not designated health services and Stark, therefore, has nothing to say about them or the allocation of revenues associated with them.¹⁴ Still further, the definition allows physicians to be given direct credit as wRVUs or compensation, for services provided 'incident to' their services. In many instances the problem of allocating midlevel wRVUs to the physician compensation when services are billed 'incident to' does not arise because the mid-levels are invisible on the claim form. This is also true for shared/split visits in the hospital inpatient, outpatient or emergency departments. I have had one situation where a group leaving a lease arrangement was hit with a demand from the hospital for north of \$2 million based on an earlier reconciliation (more on that later at 6.1) from prior years when neither the hospital, nor the group had a billing software package that could identify services rendered by mid-levels in these ways (nor could they identify claims with other modifiers). Because the prior agreement in which I had no involvement allowed for compensation only for personally performed services, there was an enormous disagreement. The hospital unilaterally began withholding \$200,000/month. The physicians sued.

¹³ 42 USC §1395nn (h)(4)(B)(i)

¹⁴ For an in-depth analysis for the disconnects between Stark and the Medicare reimbursement rules, see Gosfield, "Stark And Medicare's Physician Reimbursement Rules: Unraveling The Knots", HEALTH LAW HANDBOOK (2015 ed.) Thomson Reuters, pp. 179-211

Some mid-levels or other ancillary practitioners can be billed on their own numbers in a physician practice. Some get paid at 85% of the Medicare Physician Fee Schedule (nurse practitioners, physician assistants, clinical nurse specialists). When a practice uses those clinicians their wRVUs can be taken into account in the totality of what the hospital is buying under the lease. I have had one transaction where the NPs and PAs were used differently; so some were included in overhead and others were included in the wRVUs which comprise the base compensation. (See below at 7.1) Other ancillary practitioners like physical and occupational therapists can be billed incident to the treating physician or not. When they are billed on their own numbers, like audiologists and clinical social workers, they are paid at 100% of the Medicare Physician Fee Schedule; and their wRVUs ought to be taken into account in determining what the group will produce for its compensation.

5. Exclusivity

Exclusivity arises from both sides of the table, although it isn't always necessary. Sometimes the hospital wants the group to commit to be exclusive to it. That works for a smaller group that only admits there. It does not work for groups who admit to other facilities. Sometimes you can negotiate so that the group will only lease itself to the primary hospital while it still admits elsewhere or renders outpatient services elsewhere. In that instance, sometimes the argument is that the far flung hospitals will generate tertiary or quaternary admission to the primary facility. Sometimes the right approach is to have the physicians who are primarily dedicated there be the only ones who are exclusive to the hospital.

Sometimes the primary motivation for exclusivity comes from the physicians. In the same way that any hospital-based exclusive contract would be created for radiology, pathology or emergency services, the same can be done for orthopods, cardiologists and anyone else who seeks to be the sole provider for the facility. This means that if any new physicians come to the hospital, they can only do so through the one group.

But the real question is whether exclusivity is necessary at all. The purpose of these arrangements is to bind the physicians more closely to the hospital so they can generate better value, improve hospital processes and outcomes, and get some financial security for the physicians. None of the success of those efforts will turn on whether the arrangement is exclusive or not. I have had a situation where, because of consolidation of hospitals, one system ended up with two formerly arch-rival competing groups of leased cardiologists, and yet another large group which barely used the system's facilities at all. How they ultimately manage true clinical integration is yet to be seen.

6. Duties

6.1. *Providing Medical Services*

The primary activity under a professional services agreement is to provide professional services. Defining what those are by description is useful, especially if there are any carve outs. As an example, I have had groups where the physicians held medical directorships and did other activities at other hospitals which were not the hospital leasing them. Those services were explicitly excluded. Typically the agreement includes inpatient, hospital outpatient and office based services. In some instances it has included services provided at other facilities affiliated with the leasing hospital. The point is that the scope of the services has to be clearly stated. Sometimes there are subspecialists, who are handled differently. I have one arrangement where the cardiologists and their partner cardio-thoracic surgeons are included in the same transaction, even though the scope of what they do was different and had to be stated differently. Their on-call requirements were different in addition to the programs in which they participated at the hospital. Their payment structure was different as well and had to be taken into account separately. (See below at 7.1)

In addition, these arrangements are typically conducted between hospitals and groups that are already significantly involved with each other. Many of the physicians already have medical directorships which may change as the focus of the relationship shifts toward clinical integration and not just administrative duties. I have had more than one transaction which shifted medical directorships to the creation of a true Center of Excellence for the specialty, sometimes involving interdisciplinary activities. On call coverage is usually rolled into the transaction. In addition, especially when the arrangement is exclusive for the physicians, meaning there are no other physicians of that specialty practicing at the hospital, elements of co-management agreements with far closer working relationships between the physicians and administrators for specific purposes are also included

6.2. *Clinical Integration Duties*

To create one of these relationships without an explicit shift to clinical integration makes them nothing more than a bad pseudo-employment agreement. One of my principal criticisms of most of the hospital employment arrangements of the last five or more years has been that they have done nothing to create value. They have not clinically integrated the physicians of like specialties. They have done nothing but consolidate bodies now paid at higher rates than before.

The indicia of real clinical integration are “*Physicians working together, systematically, with or without other organizations and professionals, to improve their collective ability to deliver high quality, safe, and valued care to their patients and communities.*”¹⁵ Standardizing as much care delivery and process redesign in support of

¹⁵See, Gosfield and Reinertsen, “Achieving Clinical Integration with Highly Engaged Physicians,” 2010, <http://www.gosfield.com/images/PDF/ACI-fnl-11-29.pdf>

different care to reflect what evidence says patients need for their clinical conditions is the real work of clinical integration. Doing that with the hospital to address its impact on the patients is part of what can make one of these PSA arrangements powerful and effective. Selecting, using, and measuring performance against clinical practice guidelines and protocols are essential work that physicians can bring to bear in these relationships.¹⁶ As new payment models are introduced, both for physicians and hospitals this integration becomes more and more important. In virtually all of the arrangements I have created, at least some of the compensation to the group reflects this significant shift in thinking.

7. Compensation and Payment Issues

7.1 *Base Pay Compensation*

For all the discussion of new payment models, whether ACOs, or bundled payment or the Merit-based Incentive Payment System (MIPS) under Medicare (which is merely pay for performance or penalty for performance), all are based on a foundation of fee-for-service payment which draws on relative value units to quantify work performed. Almost none is even paid prospectively as a budget. Most entail some form of gain-sharing with the physicians. As a result, the basic compensation around which the PSA is constructed is a quantum of wRVUs that the physicians commit to performing. Some hospitals have tried to measure this by physician. That undermines the very purpose of avoiding the employment trap. Under these arrangements it is the group, as a whole, that commits to deliver the services and the group as a whole, which is measured for its performance.

In establishing the price that the hospital will pay for the wRVUs, the most important step for the physicians is to engage their own valuator. In every deal I have done where the physicians have taken my advice, they were ultimately paid more than the hospital's valuator initially proposed. Fair market value under the law is a range and not a number. Valuation is an art and not a science. Choosing the right valuator, especially for some of the more sophisticated measurements described below, is absolutely critical. Unfortunately while there are many experienced valuers at work in health care today, their ability to monetize quality performance is quite variable.

The number of work RVUs should include services incident to the physicians, shared/split visits, as well as visits rendered by NPPs billing on their own numbers – although, since they are not recognized by all payors and when recognized by Medicare are paid at 85% of the Medicare Physician Fee Schedule, the calculation of total wRVUs

¹⁶ Many physicians and hospitals have no idea how to begin making these kinds of changes. Several tools I have participated in developing have jump-started efforts in a variety of venues. See, Gosfield and Reinsertsen, "Clinical Integration Self Assessment Tool v 2.0", 2011, <http://www.uft-a.com/CISAT.pdf> which offers guidance for multi-specialty groups and hospital-centric efforts including an ACO-type entity as well as the hospital medical staff. Gosfield, V 2.1 (2012) http://www.uft-.com/PDF/CISAT_IPA_V.2.1.pdf for a network of physicians or an IPA.

or a segregated number of wRVUs for them can be used. For any clinicians who can be billed at 100% of the fee schedule, including physical therapists, occupational therapists and audiologists, even when not billed ‘incident to’, their numbers should be included as well, where payors recognize their separate billing.

The theory of the PSA is that the group is leasing itself as a group, maintaining its cohesion and being responsible for the performance of its members. Some hospitals have attempted to assign wRVUs per physician. The productivity of individual physicians should be the burden of the group and not of the individuals. Consequently, my favored approach is to establish a fixed volume of wRVUs for the year. The group as a whole is then paid 1/12 of the value of that quantum of wRVUs on a monthly basis. If there is significant variance – and I have used a range from 8%-15% as a “corridor” for stability, but I have also done deals with a 2% corridor¹⁷ – that can be addressed in several ways. First, if there is a lowering of the productivity in the aggregate over a quarter, then there can be a commensurate lowering of the base compensation amount, as negotiated between the parties at the time. I have never had the specific numbers entered into the original PSA because the amount of slippage can be variable and for widely varying reasons: participants leave the practice, someone becomes disabled, or someone simply slows down and ceases to be as productive or someone is going through a personal crisis that lowers productivity or the like. Often the group can cover for the person for at least a while. But if someone leaves completely, and recruitment is necessary, it is legitimate for the compensation to reflect that change. This has to be worked out in the moment, however, and can be touchy.

Where the change in performance reflects higher than expected productivity, again, above the corridor, for variable reasons – something happens within the market like a fire at another facility – additional compensation should be made to reflect the additional work being done. So as not to incentivize churning or under-service, it is also legitimate for the hospital to require that quality standards be met before the additional payment will be made. Those standards should be established in the original agreement, since they are harder to select and determine which data will be used to measure performance, than a simple calculation of work performed.

Another problem analogous to the hospital desire to treat the physicians as individuals in terms of their productivity is a hospital’s insistence on reconciliation of payments made to actual wRVUs provided. (See also billing issues below at 7.4) The purpose of the lease transaction is to bond the physicians and hospital in terms of clinical behavior as well as financially. Part of this bonding includes the hospital accepting the variability from week to week and month to month in performance. Where the physicians are in a community which has seasonal influxes and exoduses of patients, this can be significant. The point of a decent valuation is that none of it should matter over the year. The transaction should be evaluated in the aggregate. It becomes burdensome to engage in claim-by-claim reconciliation; and provides the physicians with less financial security than they seek. I have never created a deal that used reconciliation and have seen its pernicious effects as described in section 4, above. Fair market value as a range is not

¹⁷Depending on the size of the group, a lower percentage of many wRVUs may be fair.

implicated with the use of the corridor approach, which gives both equity and stability to both parties, while being compliant with the Stark and anti-kickback statute requirements.

One of the issues in establishing compensation is for how long it will remain in place. I have not done any of these arrangements with an initial compensation term of less than three years; and I have had some with initial compensation which has lasted for a longer term. I have had one transaction where after the Term Sheet was signed, the hospital's major payor lowered the rates to them by 25%! The conversion factors changed to reflect the downgrade, but the group knew that to get their compensation up, they would have to generate other efficiencies. Because financial stability is a major goal of the physicians, being assured that only a major dislocation in the context --- a vast change in Medicare payment rates, the disappearance of FFS medicine from the market – could change the compensation is important. The corridor acts as a bulwark against the problem of failed FMV because of under-performance. I have had several arrangements where changes caused the parties to agree to lower the overall compensation during the term, but generally speaking one of the purposes of these transactions is to create financial stability for both parties.

To add clinicians who generate wRVUs to the practice will change the base compensation. The parties need to mutually agree on when such a need arises. It can be to expand the practice or because someone has left. If it is to expand the practice, it is possible to state in the initial agreement what level of performance above the initially established wRVUs would trigger such need, but I have never done that in my transactions. If a recruit is coming without a patient base already loyal to that physician, then my approach has been to establish a fixed stipend for an anticipated period of ramp up, up to a pre-defined level of wRVUs. If the physician exceeds that level of productivity, then he is paid a pre-determined value for the additional wRVUs, although the value is lower than the other physicians, because he is already being paid for his basic work through the stipend. The recruiting is conducted by the group. The hospital can support that recruiting as it traditionally has done under the Stark regulations¹⁸, although the income guarantee is now fashioned as straight compensation to the group.

I have had one situation where a physician who was employed by the group but had been assigned to a farther flung hospital and was not part of the transaction initially, lost the contract at that hospital and just stepped seamlessly into the base agreement under the terms that had been established in the original document. After a year, the physician gets included in the base compensation now based on augmented volumes of wRVUs.

Often the group can cover the absence of one of its members for some period of time, while additional help is recruited. If the group decides to downsize and not replace that person, then there should be a mutual reevaluation as to whether the group believes it can produce what the absent physician did, in which case there need not be any reevaluation of the base compensation, and the corridor continues to act as the hospital's protection. If, however, they will not produce what had been originally determined, then the compensation should be lowered a pro rata amount, going forward.

¹⁸ 42 CFR §411.357(e)

I have had one situation where cardiologists and cardio-thoracic (CT) surgeons were in the same group. There was a different quantum of wRVUs and different valuations for the two specialties. When the group lost one of its CT surgeons, however, it proved incredibly difficult to recruit someone new under the wRVU focused compensation. The market would not support such an approach. All potential candidates wanted a fixed salary with bonuses. The group and the hospital had to renegotiate that aspect of the arrangement mid-term. There should be a mechanism to address this without triggering the draconian effects of a true fair market value dispute. (See 7.7 below)

Given the dynamism in health care, another issue that needs to be addressed is what happens if additional monies become available from payors. As an example, if meaningful use money were still around, how would it be allocated? Without being able to predict all the changes in the market, one approach is to establish a committee of representatives from both sides to address such issues and incorporate them into the compensation. A related problem will arise when physicians participating in MIPS or similar programs either earn an augmented fee schedule, or are penalized for poor performance. Depending on the payor mix of the group and the extent of the penalties or bonuses, this will affect the FMV compensation without calling into question the entire base compensation. These issues should be taken into account in the original document rather than down the road, when the administration players may have changed, or the entire relationship may have soured in some way.

7.2 *Bonuses*

Bonuses on top of base compensation is where clinical integration's effects will be found. Quality metrics vary widely. Some specialty societies, like the American College of Cardiology,¹⁹ have developed very good ones that physicians believe in and are willing to use. Avoided complications can now be monetized by a sophisticated valuator, but that valuator really has to understand the clinical components of complications. The hospital rarely has useful data available on these points, although very sophisticated places can tell you to the penny what a ventilator acquired pneumonia used to cost them. The best organizations have completely eliminated them.²⁰ I had one transaction which involved urologists who were interested in robotics. Our valuator went to the literature and read about complications associated with robotic urologic surgery (e.g., blood loss, return to the OR, extended operating times) and was able to construct a dollar amount associated with each to the hospital. Preventing those complications from happening is financially critical to a hospital; so they have an interest in rewarding their avoidance. Patient satisfaction scores are another measure of quality. It is also important to remember that the hospital is benefiting from the office performance as well, so quality scores there should be considered as the basis for a bonus, too.

¹⁹ <https://cvquality.acc.org/initiatives/acpc-quality-network/quality-metrics>

²⁰ Institute for Health Care Improvement, "Ventilator-Associated Pneumonia: Getting to Zero...and Staying There" <http://www.ihc.org/resources/Pages/ImprovementStories/VAPGettingtoZeroandStayingThere.aspx>

The key is to determine the metrics before executing the document, agree on the data source from which performance will be evaluated, and then attach monetary value to the performance. There should be a set time when they will be reviewed; but it need not be annually. And for those who would say Stark may present a problem here, they would be wrong. The Stark regulators have explicitly acknowledged, long ago, that quality can be a basis to pay physicians without running afoul of the law.

“Compensation related to patient satisfaction goals or other quality measures unrelated to the volume or value of business generated by the referring physician and unrelated to reduction or limiting services would be permitted under the personal services arrangements exception, provided that all the requirements of the exception are satisfied (for example, compensation to reward physicians for providing appropriate preventive care services where the arrangement is structured to satisfy the requirements of the exception.”²¹

I have had one transaction where the parties agreed to something we referred to as the “super-duper quality bonus.” If the group achieved the highest quality targets 3 quarters in a row, they would earn a single additional payment per year of \$200,000. Bonuses might also be keyed to additional bonuses paid to the hospital for work the physicians have performed which has produced the improved and financially recognized results.

It is now more possible to address bonuses for efficiencies: lowered costs; faster through put and the like. A major change is that lowered length of stay can now be used as a basis to provide rewards as well since the law was changed with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Originally the law had provided for a civil money penalty if a hospital paid, directly or indirectly, or a physician accepted such payment, to reduce or limit services to a Medicare or Medicaid patient under the care of the physician.²² This meant that even if the hospital wanted to remediate its over-utilization it could not pay physicians anything to help reduce even medically unnecessary services. MACRA added the phrase “medically necessary” before the word “services,”²³ for all Medicare and Medicaid services thereby liberalizing enormously the ability to reduce services from a baseline of overuse. Still further, to pay physicians bonuses for improved efficiency which may produce increased profits to the hospital should not trigger the problems faced by the oncologists in the infamous *Halifax* case.²⁴ There, the employed oncologists were paid 15% of the profits associated with the hospital’s medical oncology program, which included outpatient prescription drugs and outpatient medical oncology services that were not personally performed by the physicians. The payments were found to extend beyond what the employment exception

²¹ 72 Fed. Reg. 50146 (Sept 5, 2007) cross-referencing 69 Fed Reg 16091

²² 42 USC §1320a-7a(b)(1)

²³ MACRA, PL. 114-10, §512(a)

²⁴ *US v. Halifax Hosp. Medical Center*, 2012 WL 921147 (MD FL 2012)

allows (e.g., no incident to services) and to directly reflect the volume or value of designated health services they referred. The *Halifax* compensation formula represented the opposite of paying for efficiency, in that the more the physicians ordered, the more money they made. By contrast, if physicians were paid a bonus for reducing unnecessary costs in the delivery of the service line those issues would not arise.

As to gain-sharing models that may be available to the hospital, if their contours are known when the agreement is created, the allocation of those dollars and the basis for them should be stated as early as possible. If such programs are not yet present, then including a process by which future allocations will be determined can be important. The same is true for any new payment models which emerge during the term of the agreement.

7.3 *Medical Directorships/Centers of Excellence/Teaching*

These administrative services have traditionally been paid at an hourly rate. Some of them might be handled that way, and some might be paid with attributed wRVUs. Under any of them, it is more important to be paid for the effects of the management for the hospital, in other words, for outcomes, or quality or efficiency improvement, than on the basis of hour sheets which have little to do with the value of what these services are to the hospital. There is far more money to be found in the results of these activities than in the mere performance of them. There is nothing that mandates that any one pathway be selected; and both can be present in the same agreement.

7.4 *Billing*

How the billing is conducted is arguably the biggest potential risk point in one of these transactions. It is almost without exception, far better for the physicians to continue to control the billing. The billing is now done using the hospital's tax identification number, with the claims produced by the group. But the group won't do collection because the money typically is going into the hospital's account to which the group won't have access. This raises issues of how to resolve problems that appear on explanations of benefits (EOBs) and the like. It also raises potentially interesting confidentiality concerns. I had one transaction in which the hospital was so fearful of any disclosure of its negotiated rates with payors that it initially tried to impose both an obligation for everyone involved in the billing process – from the physicians who created the encounter records, to the coders, to people who entered data on the claims forms – to sign confidentiality and non-disclosure agreements. That was fairly extreme. But worse yet was their attempt to impose a \$1 million liquidated damages clause, including on the coders and billers, for even an inadvertent disclosure of the hospital rates. While we asked, we never got an answer as to what was motivating this, other than the hospital counsel's reply that the hospital wanted to make clear that there would be a severe penalty if their charges were disclosed. Clearly there had been some problem in the past they were trying to prevent again; but no one in their right mind would sign such an agreement. We managed to negotiate it away into an overall confidentiality clause with injunctive relief and damages as well, but the irony of it was that while the relationship has been in place for six years now, no one in the group has any idea what the hospital's negotiated rates are because

they don't engage in any of the collections. They simply provide the charges. What the hospital has negotiated as what it will accept for those claims remains a total mystery to all on the physician side of the deal.

If the hospital takes over the billing, they often do a terrible job, or a mediocre job at best. I had one situation in which the group let their billing staff go because the hospital would bill. They began with tardy claims submission and a collection rate of 14%! The group had had about a 55% rate of collections. They got their collections up to 29% and then implemented better training for the staff. The hospital's billing staff were given the right to change what the physicians submitted in accordance with their understanding of the billing rules. One coder made the decision to change to level 5, visits that one of the lead physicians had submitted as level 3s and at most 4s. The coder claimed she was coding based on the extent of the review of systems, when the dominant factor is the complexity of the decision-making. After much complaining with little response from the billing department, I had to confront the compliance officer who immediately understood the risk at hand. Because under Medicare the physicians and the entity to which they reassign have joint and several liability for over-payments, even though the primary risk of collection was the hospital's, the physicians could not stand idly by. The same organization had never completed loading all of the charges for drugs into the system so drugs that were typically paid at \$650 per dose were entered at \$.00!!

In more than one situation, where the hospital's billing has been sub-par, and therefore so are their collections, if the disparity is great enough, the hospital begins to argue that the compensation is not fair market value because they are losing money on the physicians. (See FMV Disputes at 7.7) There are two approaches to preventing these problems: (1) the entire billing arrangement could be handled as an arms-length billing agency contract would. It should state who does the coding, who has any authority to change what the physicians submit and whose opinion ultimately determines how the claim is submitted. At a minimum, any questions should require communication with the involved physician. The group should get indemnification and a representation and warranty that the hospital will submit claims in accordance with the standards of the industry. To the extent those standards can be stated (e.g., aging of accounts receivable, timeliness of claims submission, collection efforts) they should be stated. The group should retain the right to an outside auditor if questions arise. (2) The hospital represents that it will meet the standards of the industry (stated, again, if possible); and if they don't the parties select a third party billing company which might even be named in the agreement at the outset. While the hospital has the risk of proper billing and collection, because there is joint and several liability for the physicians on whose behalf the hospital is derivatively submitting claims under a reassignment, the quality of the billing process is important to the physicians despite the hospitals' compensation commitments irrespective of collections. (See also Section 11 on Disputes.)

Sometimes the hospital has sought to hire the group's billing personnel. I have usually resisted this because then it is very difficult to move on, if the relationship does not work out. If the hospitals absolutely insist on this, then there should be protection against any

non-solicitation of employees post-termination; and the group should be able to take back those billing personnel who want to rejoin them without penalty or barrier.

7.5. *Overhead and Management*

The overhead of the practice was formerly covered by the revenues the group generated. Now that those are generated through the hospital, there has to be a mechanism to pay for overhead. The group is now being managed, in a sense, on behalf of the hospital, so that to has to be taken into account. I have seen a variety of approaches to both of these issues.

In only one instance, the hospital in an early transaction involving an incredibly productive, in terms of volume of services, solo practitioner, agreed to pay his overhead expenses as a direct pass through. It turned out that his was a relatively inefficiently managed practice and they found it too expensive. They switched to putting a calculation for overhead into his wRVU compensation. They have struggled over time with these issues, but neither has walked away from the other yet.

The most typical approach to overhead is a mutually agreed upon annual budget, with some wiggle room allowed both within line categories and among them. Where capital expenditures become necessary sometimes distinctions are made between replacing obsolete or aging equipment, which often can be anticipated and budgeted for, as opposed to adding new equipment to expand services. Typically, a joint committee of practice and hospital representatives meets to determine what to do. If the group has a good argument as to why this is a benefit to the hospital in the long run, they often get what they need, but not uniformly. Sometimes the hospital will complain about competing demands from other sources that must be met. These issues also turn on the expense of the equipment involved.

With regard to management of the group, most typically there is either a separate management services agreement or there is a provision in the PSA covering management. I have most often seen this compensation in the form of a fixed stipend. Sometimes the lead physician has wRVUs attributed to him (e.g., 2,000 annually) which are sometimes referred to as 'shadow wRVUs', because of the lost time from producing wRVUs that he will spend on managing the relationship between the group and the hospital. There are always on-going issues that have to be addressed and sometimes some very unusual problems. I had one transaction where a physician in the group violated the hospital's compliance plan as well as the law by using a physician assistant to perform services she was not licensed to do as well as submitting claims as if he had rendered the services himself. The time the group spent in managing that mess was extensive. Obviously only part of it was relevant to the on-going issues between the hospital and the group; and the group had to absorb all the expenses associated with negotiating his termination from the group, including some difficult restrictive covenant issues.

There are some expenses which are typically not considered part of the overhead for which the hospital is responsible. These are fringe benefits including life insurance, health insurance, retirement plans, car expenses, malpractice insurance and the like. To

cover them, the wRVU payment must be sufficient to provide a cushion, but then the group handles its compensation the way it wants. Even so, I have seen and worked on transactions where these expenses were covered in the budget.

7.6 Space Leases

Even if the location does not become provider based, it has to be paid for. The hospital does not need to lease the space itself. Many people believe that there has to be a connection between the billing entity and the location for the claims to be submitted as office-based. As long as the hospital is paying for the space, even if to the group itself, that is fine from a reimbursement, Stark and anti-kickback perspective. Sometimes the group gets the lease assigned to the hospital. Sometimes the group subleases to the hospital. Other times it is merely an expense in the overhead budget.

I have worked on transactions where the space was in a medical office building (MOB) that belongs to the hospital that is not the one to whom the practice is leasing itself. Then it has to be included under the expense budget. Similarly if no subleasing or assignment is allowed that is the only way to go.

If the location can meet the provider-based rules, there are signage requirements that can be problematic depending on the circumstances. Again, if the MOB is owned by another hospital, this can completely thwart the ability to bill provider based, although given the location requirements to be on-campus, those situations are fairly unusual.

7.7 Fair Market Value Disputes

All of the discussion in this section turns on payment issues. Of course, because of Stark and the anti-kickback statute, fair market value can be an issue. This is one of the reasons I always recommend that the physicians engage their own valuator since fair market value is a range and not a number. But given the necessity for fair market value, one party may believe that circumstances have changed and the compensation no longer reflects fair market value. There may be disagreement between the parties as to whether that is the case. These disputes are not really contract disputes which would ordinarily go to arbitration (See 11). These disputes are purely about valuation and often don't merit the full approach of arbitration.

One approach which I have used, where the only issue is fair market value, involves only valutors. First, the parties have to agree on the precise wording of the issue being posed to the valutors. When the question is not asked in exactly the same way, different answers are possible based on different valuator perceptions of the issue. Then each party selects its own valuator and requests a report. If their answers are within 5% of each other, the parties split the difference and accept half of the difference as a resolution of the problem. If their answers are not within 5% of each other, the parties agree on a single valuator whose determination on the same issue is binding. If either party cannot accept the answer, then they can terminate the agreement with no post-termination restrictive covenant. (See 9.3)

I have had transactions where there have been quibbles over calculations which have been resolved without having to resort to the above described provision. I have had circumstances where the compensation for a new CT surgeon could not generate any recruits because the market had moved so that any new surgeon would want a guaranteed salary. They were able to negotiate how that would be handled without triggering the FMV dispute provision. The effect is fairly draconian since disagreement results in the ability to terminate. But by using the two valutors and then one approach, at least the problem of one party falsely using FMV as an excuse to terminate, is eliminated. It has worked as both a sword and a shield in the instances where it has been included. I have seen the parties work harder to come to a resolution rather than trigger the process.

8. Medical Records

In virtually every transaction I have done, the hospital or health system has asserted that it will own the medical records. Understanding that they need the medical records for a variety of reasons (e.g., liability claims, audits) that does not mean they need to actually own them. Although some hospital licensing regulations require that the hospital own its medical records for the hospital services, the PSA does not convert the physician services nor their medical records to hospital medical records. These transactions vary when the physician group is joining a larger health system affiliated practice entity through a lease rather than employment. The hospital tends to default to what they know best, which is employment where the employer does own the records. But there is actually no legal reason, per se, that the hospital has to own the records. This is best exemplified in an unusual deal I negotiated:

A group of cardiologists, as alluded to earlier, chose to lease themselves to a university based system, when the bulk of their practice had nothing to do with the system, but was conducted at four community hospitals only one of which -- the smallest hospital among them -- was part of the university's system. But their electronic health record (EHR) they had been obtained by using the Stark and anti-kickback donation safe harbor²⁵ from one of the other community hospitals. As a result, there was no way the university could "own" the records per se. They couldn't even have access to them directly. We bargained to provide the leasing hospital with a copy of whatever they needed whenever they needed it. Over three years, there were no problems.

9. Term and Termination

9.1 Term

As in any agreement, the term and termination provisions are critical. If there are any quality or performance bonuses at issue, it is virtually impossible and certainly unfair, to

²⁵ 71 Federal Register 45109, August 8, 2006, amending 42 CFR §411.351, 357(v), and 42 CFR §1001.952(x)

do an agreement with a shorter term than three years. The benefit of the bonuses both in terms of hospital results and physician value typically takes a while to be perceived. Along with termination, some of the issues associated with the length of the term can be driven by market issues. I had one group that was leasing to a facility that was going through some instability with changes in administration in the second year that turned out to be significant. Their agreement had an initial term of four years with an automatic rollover at four years and then another automatic rollover after the second four years for another three years. They turned out to be prescient in their position because after the fourth year and the first revaluation (which was only permitted at the time of rollover), the hospital had become affiliated with an academic medical center which had not been in the picture at all on the initial negotiations.

In contrast, the group which leased itself to the academic medical center they did not admit to was not sure how well the arrangement would work. They bargained for a three year term with a ninety day notice of non-renewal. As they expected, the initial theory of the arrangement did not meet the center's needs over time. The group felt they weren't getting the attention they deserved and they simply let the agreement expire. Without a post-termination restrictive covenant they then simply leased themselves to another organization.

9.2 *Termination*

Termination raises other issues. Standard breach provisions with opportunities to cure are typical. In the transactions I have done, exclusions are for FMV disputes which go through the other process described above. None of the transactions I have been involved with have included without cause termination, even with a long notice period. In the first major lease deal I did, the physicians felt that this would require everyone to work harder to make the relationship work; and they were right. While they had a long-standing relationship with the hospital prior to the lease, the change in the relationship really did make them work more collaboratively and work out their problems when they arose with a greater sense of purpose. It has proven distinctly different from their prior relationship without the PSA.

9.3 *Post-Termination Restrictions*

The typical post-termination restrictions in employment on solicitation of patients and preclusion from practicing within a defined geographic area actually aren't necessary in a lease arrangement. I have no problems with employee anti-solicitation clauses, as long as they are mutual. It is far more often the case that the hospital wants to hire the group's manager or other personnel than vice versa. With respect to the solicitation of patients, in the employment context, typically there are other physicians of that specialty to whom the patients might be assigned by the hospital. In the lease arrangement, the patients will follow the practice under any circumstances, and often there are either no other physicians available to cover those patients, or the physicians who are available are not those who are familiar as a group to the transferring patients.

With regard to the post-termination geographic practice restrictions, the standard argument for protection from competition by the former employee is that the hospital has invested significant assets in building the practice. That is typically not the case in a lease transaction. The hospital does not invest money, hasn't bought assets (or at least hasn't bought much, and hasn't created most of the business for the group. The group is of value to the hospital, at least in part, because they bring their patients with them. In the current environment, hospitals will typically push for a covenant that protects against joining a competing health system within a geographic area. They often will agree to let the group go back into practice on its own, or to join with a physician owned entity that is not affiliated with a system.

To be able to go back into practice, the group has to have its assets or if it has allowed them to be bought, they will have to buy them back. As I described above, I have one group leasing themselves for the third time in a few years. The first system after three years decided they would only employ physicians. I would not have sold the assets in the first place, but the group bought them back before they became my client. They then leased themselves to the hospital that at least half the group used primarily and sold their assets again. After four years, that hospital was bought by an out of town very large system which decided they weren't interested in the half of the practice who practiced across borders in an adjacent state. The group has had to repurchase and resell the assets – again! This is just silly.

Defining who the competition is post-termination is essential, when the post termination geographic covenant is used. The covenant should allow any number of physicians in the group and not just the group as a whole, to go back into private practice or to join a larger physician group. I have seen hospitals insist that the group must leave as a whole to go back into practice. I don't understand the logic of this and never got a good explanation of what the purpose was when it was proposed. In the end, I have not done a deal which included this.

Where there is a post-termination geographic covenant it should be made consistent with any covenant which the group itself imposes, both in geographic scope and in duration. I have had one situation where the group itself had no post-termination geographic covenant and had to impose one to make the lease deal work. This was in a state where covenants are only enforceable after initial employment if they are supported by additional consideration, so they had to figure out what to do to provide something additional of value to their physician employees and shareholders to make all the moving parts work.

10. Assignment

As some markets have become enormously volatile with acquisition wars abounding, many groups find themselves relating to a system that was not in the picture at the inception of the transaction. Against that background, some groups want assurance that the lease they have so assiduously negotiated must be assigned if there is an acquisition

by another system. They believe that gives them security even if they are unfamiliar with the party to whom they will now relate. Some groups have had bad experiences with a potential acquirer whom they regard as their mortal enemy and in no instance would agree to an assignment. Some have tried to bargain for the right to reject an assignment. That is rarely successful. The most flexible approach is assignment only with consent, as in most commercial transactions.

11. Dispute Resolution

Besides disputes over fair market value, there are a host of disputes that can arise in these arrangements. Some might include an inability to agree upon what to include in the wRVU conversion factor in later years, whether quality targets have been met, an inability to agree on the budget and problems with allocating dollars when new payment models emerge. Some transactions impose a formal joint committee to be the first point of resolution of issues. In most of the deals I have done, this has not been necessary because the typical actors are the CEO and general counsel of the hospital on one hand with the manager of the group and the lead physician, who may not be the titular head but becomes the lead in knowing everything about the contract, on the other. As I said at the outset, the importance of the role of these two individuals from the physician side of the deal cannot be overstated.

Other issues which can arise include compliance concerns, and not just whether a coder has the right to change what a physician has submitted as the service he or she has provided. With the 60 day voluntary repayment rules²⁶, whether a voluntary repayment is necessary, how it should be quantified, and how far back to look, can all be points of contention. Since the hospital as the reassignee and the physicians have joint and several liability for any overpayments²⁷, there is much at stake in managing repayments of overpayments. Depending on the nature of the dispute, in employment agreements, we have included the right of the employed physician to have his own auditor evaluate an analysis of the reason and quantification of the repayment proposal, based on executing a non-disclosure agreement. Thereafter, depending on a standard of materiality (e.g., the repayment at issue will be more than \$5,000) we typically suggest mediation. Although we have had compliance issues emerge with the hospital repaying money it improperly billed, with no effect on the physicians who were not at fault, I have not had a transaction where this specific type of dispute has emerged. I would still think that a materiality standard might motivate mediation if the parties cannot resolve the matter themselves. Thereafter, like all other commercial disputes under these arrangements, we recommend binding arbitration using the AHLA Alternative Dispute Resolution Service, which has been written into every PSA on which I have worked. The only exceptions are for

²⁶ See, Gosfield, ““The Oxymoronic Landscape of Voluntary Repayments,” HEALTH LAW HANDBOOK, (2017 Edition), pp. 71-99; Gosfield, "Voluntary Repayments: The Physician Perspective", Journal of Health Care Compliance, (Jan-Feb 2017) pp.5-9; Gosfield, “Understanding The New 60-Day Overpayment Rule”, Family Practice Management" (May/June 2016) pp. 12-14

²⁷ Medicare Claims Processing Manual Chapter 1, §30.6.7

breaches of confidentiality, a restrictive covenant or a provision prohibiting solicitation of employees. These are all typically subject to injunctive relief and other damages if they are ascertainable.

12 The Second Negotiation

In the beginning, the parties have to learn what is now different in their relationship. They are financially bound, yet the physicians remain independent. If the transaction is structured effectively, and even savvy counsel cannot always make it happen, they both will see positive results. Of the multiple deals I have concluded, I have had only one where the physicians walked away from their first arrangement because the other side, they believed, had lost track of why they had entered into the deal in the first place, and did not take their contributions seriously enough. This was the arrangement where the group leased itself to an academic center where they did not practice. They ended up going back to one of their primary community hospitals where the administration had changed, a new person wanted to make her mark by capturing them, and now she herself has been fired. The whole organization is now affiliated with a different, rival academic medical center.

As I write this, I am working on a transaction for a different group, with that same academic center, which has had a change of administration in the last four years, has gone on a spree of acquiring other hospitals and is picking up a large cardiology group who were essentially rejected when their prior partner was taken over by an out of town system. So, some deals are not sustainable for various reasons from either side of the table, Of greater interest, I think, is what happens in the second negotiation when the parties do want to stay together, but both have learned much from the history of the relationship.

There is usually a revaluation of the wRVU conversion factor, and a revisiting of the assumptions regarding productivity. Sometimes physicians have left. Occasionally physicians have been recruited and added. Sometimes the parties learn they want to specify various additional guarantees going forward. In one deal, for the fifth year, they combined the surgeons into the original deal with the cardiologists (they had previously done it with two separate PSAs), but the surgeons wanted a greater commitment for OR time, and the hospital wanted more coverage for cardiac rehab Neither got exactly what they wanted, but each got enough that they were willing to move ahead again. To make matters more interesting, in the same deal, the termination clause was changed because of the encroaching threat of the other big player in town. If the hospital lost 15% market share of cardiovascular services (with a clear metric stated) and productivity for the physicians dropped by 15% not due to loss of physicians, the physicians could give notice of a desire to terminate and that issue would go to arbitration. If the arbitration found the loss to both parties was not the fault of the group, they could terminate, but the post-termination covenant would remain in effect. In that transaction, the hospital is managed by an out of town company which has just lost its contract; so the administration is now a lame duck for two years, unless their contract gets bought out.

This will undoubtedly create additional wrinkles in their relationship, but the clinical results that have been achieved are so spectacular, it is very hard for either side to walk away completely. Working together they have saved the hospital money and it ranks as fourth in the state for cardiac care by *US News*. When the hospital saves money, the physicians benefit financially.

In another long term arrangement where fair market value can only be reviewed at the fourth and eighth years, the group came forward early and gave up money to help the hospital as it was struggling with other problems. A significant urology group, they have been in a particularly volatile context with changing administrations and affiliations. One of the struggles had been to get the administration to pay attention to obligations in the agreement. At the middle of the fourth year, approaching the new valuation which would occur, despite repeated entreaties from the physicians to establish new quality metrics for the current year which was fast slipping away, the administrators simply could not focus. Eventually the hospital brought in a valuator, looked at the group's quality performance over the prior time periods on all the quality metrics, and decided that since they had met all of them at the highest level, the whole quality metric undertaking was no longer necessary. The valuator approved an increase in the wRVU value and no quality metrics were imposed going forward, since they had demonstrated their ability to deliver what the hospital needed. This lowered administrative burden for everyone, saved time for the physicians in terms of meetings and discussions, and produced the same high quality care they had been providing anyway.

13. Conclusion

The lease transaction through a PSA offers physicians and hospitals a form of alignment which, when combined with efforts to improve value through clinical integration, results in better outcomes both clinically and financially. As the sagas above illustrate, however, there are many moving parts and the opportunity for failure exists in many ways. By the same token, these contracts can create a solid foundation on which the parties can work in their own spheres, maintaining some autonomy while making significant commitments to each other. The results are often better for patients, make the physicians happier with a sense of more control over their lives with some financial stability, and give the hospitals the loyalty and results so many other transactions don't really produce.