ALICE G. GOSFIELD
& ASSOCIATES, P.C.
EST. 1986

Lessons Learned from Leasing

Alice G Gosfield, Esq
Pennsylvania Bar Institute
A Day on Health Law
October 2018

1

ALICE G. GOSFIELD
& ASSOCIATES, P.C.
EST. 1986

Alice G. Gosfield, J.D.
Alice G. Gosfield and Associates, PC
2309 Delancey Place
Philadelphia, PA 19103
(215) 735-2384
Agosfield@gosfield.com
www.gosfield.com
www.uft-a.com

ALICE G. GOSFIELD
& ASSOCIATES, P.C.
EST. 1986

Overview

- Motivation and Basic Premise
- Structures and Scope of Services
- Exclusivity and Duties
- Compensation
- Medical Records
- Term and Termination
- Dispute Resolution
- The Second Negotiation

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Motivation

- Alignment because of disparate payment models
- Create better value
- Bond the physicians more closely with the hospital
- Provide a better foundation for clinical integration
- Create better financial stability
- Avoid employment: which hasn't really worked
  - Master-servant individual relationship
  - Lease retains cohesion of the group which levels the field
  - Easier walk away: just a contract termination
  - 27% increase in costs from hospitals; 21% increase in costs to patients; employed physicians 7x more likely to order HOPD services than independent physicians

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

The Basic Premises

- A professional services agreement (PSA)
- Physicians reassign payment to the hospital
- Hospital takes the risk of billing
- Payment from hospital goes to the group which remains intact
- Choosing the right partner is key
  - Not always where you admit
  - Issues with practices that split where they attend
  - Typically the significant other hospital

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Structures: 3 Plus A Wrinkle

- Complete lease
  - All personnel; no asset sale; group manages itself for hospital benefit
- Hospital buys group assets
  - Leases all personnel rest as above
  - Assets have to be repurchased on termination
- Hospital guys group assets and employs non-clinicians
  - Creates problems on termination
- The provider-based issue: not so common anymore
  - Hospital deductibles and co-pays for same services and staff

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Scope of Services

- Inpatient, outpatient and office
  - All physicians in the group need not be included if they admit elsewhere, but they can be
- Midlevels
  - If they bill on their own, their wRVUs should count in the quantum the hospital is obtaining
  - If they do not bill on their own, they go into overhead
  - Do NOT agree to be paid only for wRVUs personally performed by the physicians; depending on the practice a wide range of non-physicians could be included (e.g., PTs, OTs, social workers, audiologists, etc.)

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Exclusivity

- Hospital wants group exclusive to it
  - If they are already, not a problem
  - If they split, issues arise
  - Only the physicians who work there should be exclusive
- Physicians want to be the exclusive providers of that service
  - New docs in that specialty join them
  - Just like any exclusive hospital-based practice
  - Problems if some other physician gets disenfranchised
- Is it really necessary?

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Duties

- Providing medical services
  - Define them
  - At which facilities
  - On call coverage
  - Some services at other facilities explicity excluded (e.g., medical directorships)
- Medical directorships which often morph into Centers of Excellence
- Teaching

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Clinical Integration: The Sine Qua Non

- Without it these are just pseudo-employment agreements without value
- "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."
  - Gosfield and Reinertsen, 2010
- How to get started: Gosfield and Reinertsen, "Clinical Integration Self-Assessment Tool v 2.0", *http://www.uft-a.com/CISAT.pdf*

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

What are essential elements?

- Selecting, using and measuring conformity with clinical practice guidelines or protocols
- Standardizing as much in care processes and administrative support as possible
- Measuring performance
- Changing performance basd on measurement
- Can include forms of co-management

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Compensation: Base

- Valuator establishes price for projected volume of wRVUs
  - By physicians, by NPPs billed incident to, shared/split visits, NPPs billed on their own numbers (some at 85%of MPFS)
- A corridor above which more wRVUs are paid below which compensation is lowered when performance persists over time
  - 8-15% early on; 2% in one deal; is a quarter enough or is 180 days enough?
- Different specialties can be in the pile but calculated differently
- Reconciliation should not be included with a corridor
  - It's punitive
  - It's burdensome
  - It undermines stability
- FMV for how long: three years is about right unless something dramatic happens

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Adding People

- Mutual agreement on what triggers the need
- Replacement is not issue; just drop into the pile
- New recruit without a patient base
  - Fixed stipend for a year with presumed wRVUs
  - If he's really productive, additional payment at a lower rate
  - After a year, wRVUs get adjusted as does total compensation
- All should be in the base agreement to avoid problems

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Losing People

- Often the group can cover for some period
- If the group decides to downsize, readjustment of wRVU expectations and payment
- The CT surgeon problem:
  - Wanted fixed salary, no risk
  - Entire market had shifted
  - Tough to recruit
  - Had to renegotiate mid stream
- Other issues: Additional monies earned from new payment or MIPS; what if penalties are imposed?

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Compensation: Bonuses

- Hospitals can pay physicians even without leasing for improved quality results: Stark cites
- Determine metrics, source of them, weighting, targets, amounts — put in the document
- Set a time for rereview: does not have to be annually
- Avoided complications can be monetized
- Patient satisfaction
- Improvement in the office based practice counts too
- Efficiency
  - Length of stay is now OK
  - Lowered costs
  - State metrics, weighting, source, baseline and effects
- Hospital gainsharing can be shared
- New forms of payment: establish a process to address allocations

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Medical Directorships/COE

- Hourly is traditional
- Attributed wRVUs can be used
- Better to be paid for outcomes of the work: there is much more money there
  - Time is not the appropriate measure of the value of clinical integration
- Can be some of each

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Billing

- Always better if the physician group functionally does the billing
  - Hospitals are notoriously worse
- If the hospital insists on doing this handle as an arms-length billing transaction
  - Who codes?
  - Who can change what the physicians submit?
  - What if there are disputes?
  - Get indemnification
  - Get th right to bring in an outside auditor
- The hospital should represent that it will meet standards of the industry in terms of aging of A/R, timeliness of claim submission, collection rate
  - If they can't a new billing agency should be brought in

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Overhead and Management

- Pass through -- has no incentive to control costs
- Increase in wRVU amount is another approach
- Typically it's an annual budget with some wiggle room within and across categories
- Joint committee for capital expenditures above $X if not budgeted for
- Payment for management of the group
  - Sometimes an MSA
  - Typically a stipend
- Sometimes the lead physician gets attributed wRVUs for what he does regarding interface
- Fringe benefits have to be covered by the wRVU rate or they can be in the budget – this is variable

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Space Leases

- Hospital doesn't need to lease directly
  - Lease can be assigned to hospital
  - Lease can be included in the budget for overhead
- If MOB won't allow another hospital in there, then it has to be an overhead, but there could be signage issues as well
- If no subleasing or assignment allowed, it has to go into overhead

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

FMV Disputes

- Either party believes the compensation doesn't reflect FMV any longer
  - Taking this to arbitration is too time consuming
- Parties agree on the *precise* wording of the issue to be valued
- Each submits to their own valuator
- If the answers are within 5% of each other, split the difference
- If not within 5% agree on one new valuator and that determination is binding
- If either party can't accept, termination with no post-termination restrictive covenant

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Medical Records

- Hospital will say they have to own—they don't
- When the groups EHR was donated by another hospital
  - Leasing hospital can be given whatever they need whenever they need it
- If the hospital controls the records, the initial document should address post-termination
  - Format of the records to be given
  - All to be given and not just patient by patient
  - Group needs access during term and post-termination

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Term

- No less than three years
  - Takes about a year to get the kinks worked out
  - For value-based bonuses there has to be enough time to develop data
  - Time for notice: some as long as 180 days
- Unstable hospital, group wanted serious commitment
  - Initial four year term, FMV reevaluated only then, four year rollover with another revaluation then for a three year rollover

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Termination

- A group unsure of how relationship would unfold took only a three year term with no rollover
  - When it expired without a restrictive covenant they released themselves to someone else within three months
- Bases are standard breach with opportunity to cure except
  - FMV disputes
  - Breach of confidentiality, employee solicitation, restrictive covenant which are subject to injunctive and other ascertainable relief
- No without cause termination
  - Makes the parties have to work things out

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Post Termination Restrictive Covenant

- It isn't necessary
  - The hospital is not investing money in advance
  - The physicians are bringing their own patients who will follow them
  - If it is exclusive there is no one to service the patients
  - Depending on the market, with consolidation, options post termination become extremely limited

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

If A Post-Termination Covenant Is Imposed

- Define competitors very clearly to be only other systems
- Going back to private practice is only possible if the group has its assets
  - That has to be handled in other parts of the agreement re: solicitation of employees, buying hard assets back; getting records back
- Any portion of the group should be able to go into practice with any physician-owned entity which isn't a hospital system
- If the group doesn't have a post-termination covenant in their employment agreements they need to add one that is consistent with the PSA's
  - New consideration necessary?

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Assignment

- With the dynamism of affiliations and consolidations this is a big deal
  - Some groups want assignment mandated to stay with what they have bargained so hard for
  - Some define other transactions as creating assignment type issues: e.g., change of control but not full merger
  - Some groups want to be able to reject assignment if the new entity is their former mortal enemy
- Assignment only with group consent is the most physician-friendly but not the most system-friendly

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Dispute Resolution

- Types of disputes in addition to standard breach
  - Appropriateness of wRVU valuation
    - FMV
    - What's included in the valuation (e.g., benefits, etc)
  - Whether the group qualified for a bonus
  - The amount of the bonus
  - Inability to agree on a budget
  - Disagreement over how to handle new payment models
  - Failure to establish agreed upon Center of Excellence…
- Arbitration with AHLA Alternative Dispute Resolution Service

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Voluntary Repayment Rule Issues

- Joint and several liability for overpayment
- Should there be a standard of materiality for challenging decision to repay?
  - Who makes the decision given the liabilities?
- Issues of potential dispute
  - Was there an overpayment
  - How far back to look
  - Whether to extrapolate or pay claim by claim
  - Is the amount right
  - Who bears the financial burden
  - Mediation?: Potential use of joint operating committee?

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

The Second Negotiation

- Everyone has learned a lot and may require new and different things
  - More committed time in the OR
  - More commitment by physicians to cardiac rehab
  - Different concepts of quality
  - Reorientation of administrative roles of physicians
- Often a revaluation of the wRVU and productivity
- Market changes may motivate other things
  - Initiation of a joint operating committee
  - Different types of bonuses
- No more quality metrics
- Group termination for market dynamics: 15% loss of market share or productivity over 6 months not the Group's fault
  - Arbitration to determine
  - Post termination covenants remained

ALICE G. GOSFIELD & ASSOCIATES, P.C. EST. 1986

Resources

- On last page of the handout