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creating PSAs that promote a meaningful hospital-physician bond

To be successful under value-based payment, a health system requires collaborative and binding relationships with affiliated physicians; the professional service agreements the organizations enters with the physicians should be designed to firmly establish such relationships.

AT A GLANCE

- Professional service agreements (PSAs) provide hospitals and health systems with a flexible and convenient mechanism to obtain services from physicians to help achieve essential goals related to care coordination, access, and alignment.
- Hospitals and health systems should structure PSAs as integrated, binding relationships that support value-based strategies and enable them to build high-performing provider networks.
- An effective PSA is characterized by a focus on provider network integration, care model improvement, clinical performance measurement and reporting, efficiency and financial performance, governance and financial control, and an optimized compensation methodology.

The abbreviation *PSA* stands for two very different things in health care. On the purely clinical side, it refers to the first form of surgical tape, called a *pressure-sensitive adhesive*, developed by a surgeon, Horace Day, in 1845. In the world of healthcare finance, however, PSA refers to a *professional services agreement*—a type of hospital-physician arrangement.

These two types of PSAs have an important characteristic in common: They both must be "sticky" to be effective. In this regard, the first type of PSA has come a long way in the past 173 years; it is much stickier today than it was when Day invented it.

Unfortunately, the same cannot be said about professional service agreements—they just haven't gotten much "stickier" over the years in the sense of binding the hospitals and physicians closely together in a way that ensures both parties have a shared vision for ongoing collaboration and aligned economic incentives and consequences. This quality has been elusive in these types of agreements, because there has been relatively little change in the types of PSAs hospitals and physicians have formed over the years. For the most part, they contain the same components and serve the same transactional function they have since their inception and expansion throughout the past two decades.

Traditionally, PSAs have focused on creating a structure for provider networks, but they have tended to fall short in establishing the meaningful and lasting bond between the parties that is crucial to provider network performance. It is time for hospitals and physicians to focus on creating long-lasting, mutually beneficial collaborations that help meet the needs of the communities these organizations serve. Taking an inspiration from the surgical type of PSA, we can aptly refer to these types of arrangements as *sticky PSAs*.

The Rationale for PSAs

PSAs provide hospitals and health systems with a convenient and highly flexible mechanism to obtain services from physicians and achieve care coordination, access, and alignment goals. Under a PSA, a physician or medical group remains independent (i.e., not employed by the hospital) and provides professional services in the hospital or at a hospital clinic. PSAs are used to contract for hospital-based services (e.g., hospitalists, intensivists, and anesthesiologists), emergency department coverage, and coverage at ambulatory clinics. They can range from part-time, narrowly defined, nonexclusive coverage with one physician to comprehensive, exclusive services with a large multispecialty group.[a]

One advantage of the PSA model is the arrangement can be tailored to meet specific objectives and enable hospitals and physicians to achieve clinical and financial integration without employment. However, in many ways, the flexibility of PSAs also adds to the challenges in managing them to optimize their effectiveness. PSAs often are fragmented, one-off deals with no clear alignment with the broader strategies or priorities of the organization. They tend to be loosely managed or ignored until it is time to renegotiate and renew or extend the arrangement, and management often lacks the necessary coordination for effective PSA development and negotiation.

Regardless of whether a healthcare organization has 100 beds or 100 hospitals, more consistent, goal-oriented, and integrated arrangements can be achieved by defining a clear vision for PSA relationships, developing PSA guiding principles and standards, and implementing a transition strategy to move existing arrangements to optimized PSAs.

Making PSAs Sticky

Most PSA documents have many sections in common, with legal language addressing issues such as obligations of each party, compensation, exclusivity, terms, and termination provisions. Occasionally, the PSA also will include provisions addressing some of the hospital's priorities, but too often, it does not occur to the drafters to include such provisions, and the priorities go overlooked and undocumented.

As health systems increasingly pursue value-based care strategies, they will succeed only to the extent that they can improve the quality and cost of services, and they require the full collaboration of physicians and their associated medical groups to help them do so. To deliver value, health systems must build comprehensive provider networks that not only demonstrate network adequacy and offer a full continuum of care but also enable the organizations to compete on better outcomes and lower costs. These imperatives make it incumbent on hospitals and health systems to transition their PSAs from transactional arrangements to more integrated and binding relationships that support their value-based strategies and enable them build high-performing provider networks. In short, they need sticky PSAs.

By creating accountability among medical groups, employed physicians, and hospitals, sticky PSAs can enable a health system to focus on optimizing the provider network's performance and increasing market presence, network stability, and competitiveness.

The benefits of adopting such a standard approach to PSAs are exemplified by the experience

a. For a discussion of PSA basics, see Reed, K., and Collings Ray, K., "Independent, Yet Integrated—The Increasing Popularity of PSA,' ECG Management Consultants, April 24, 2012.

of one large multistate health system whose provider network strategy has long emphasized alignment with independent physicians and medical groups. Initially, to expand the network, this health system had entered hundreds of PSAs that were negotiated in isolation from one another with local strategies in mind. This fragmented and cumbersome approach resulted in considerable variation and inconsistency that proved difficult to manage. Taking stock of the situation, the organization realized that it required a better framework for PSAs—one that could be deployed across the system and customized as needed by specialty. On creating such a framework, the organization was able to convert its fragmented and loosely managed arrangements into a uniform set of consistent, predictable, and integrated PSAs that have proved much simpler to manage.

Key Characteristics of Sticky PSAs

To help organizations achieve this higher degree of consistency, predictability, and integration, sticky PSAs include six key elements, comprising identifiable terms focused on provider network integration, care model improvement, clinical performance measurement and reporting, efficiency and financial performance, governance and financial control, and an optimized compensation methodology.

Provider network integration. An integrated provider network enables healthcare organizations to dismantle silos to better coordinate care, align resources, and rally providers around a shared goal of high-quality care. Sometimes, there is an implicit contract between aligned hospitals and physicians to integrate. Typically, however, PSAs lack clear expectations related to the level of commitment, effort, and investment required to become an integrated provider network. Sticky PSAs address this omission by including provider network integration provisions that call upon providers to actively participate in organizationwide quality, cost, and efficiency initiatives, thereby fostering a high degree of interdependence and collaboration among the physicians to control costs and improve quality.

Care model improvement. Because of the shift to value-based care, health systems and physician practices are undergoing a *care-model transformation* that involves adopting processes and developing capabilities that will help them compete on quality and affordability and succeed in taking on risk for large patient populations. This effort requires care coordination, clinical standards and protocols, clinical innovation, the delivery of high-quality care, and provider engagement—all areas that often are poorly defined or entirely left out of PSAs.

By contrast, a sticky PSA is more explicit in identifying a common set of quality metrics and clinical initiatives for delivering patient-centric care across the care continuum. Such a PSA also will incorporate appropriate incentives for provider to adhere to clinical standards, protocols, and patient care pathways and achieve targeted clinical outcomes.

CHARACTERISTICS OF STICKY PSAs AND HOW THEY CONSTITUTE IMPROVEMENTS ON TRADITIONAL, FRAGMENTED APPROACHES

Standard	Professional service agreement (PSA) content and development process are standardized, with templates that provide options to meet market needs. Traditionally, there has been no single standard approach, with terms and provisions varying significantly across multiple PSAs.
Controlled	Features are included that drive sustained collaboration and alignment of incentives. Such control mechanisms have tended to be lacking in traditional PSAs.
Consistent	Compensation plans follow a common and preferred philosophy, unlike approach seen traditionally, where there has been widespread inconsistency in terms regarding compensation and performance across similar specialties and related groups of specialties.
Integrated	PSAs are aligned with market priorities and the health system's priorities and strategic direction. Guiding principles are articulated to require an integrated network that ensures care delivered is efficient and of high quality. Traditional PSAs typically lack such alignment and structure.
Well Managed	Contract development is a clear, predictable process with established timelines from PSA initiation to approval. With traditional PSAs, management tends not to be well coordinated for effective PSA development and renegotiation.

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Clinical performance measurement and reporting. Clinical performance measurement and reporting capabilities are necessary for achieving a high-performing physician network. Despite the increasing adoption of electronic health records (EHRs), interoperability and data sharing remain a challenge for many provider networks. As a result, PSAs traditionally have been soft in setting expectations for practices. Sticky PSAs give health systems greater control over network performance by requiring physician practices to track, measure, and share clinical and quality data. Where practices have not yet invested in the requisite technologies, a sticky PSA will define a pathway for the adoption of the health system's EHR and data aggregation tools.

Efficiency and financial performance. An often-unrealized benefit of PSAs is the ability to achieve economies of scale in ambulatory practices. Alignment makes it possible to reduce operating costs by centralizing contracts, leases, and purchasing, particularly where physician preference items and outside services are concerned. Sticky PSAs encourage parties to identify opportunities to improve operational efficiency and financial performance across the enterprise. Furthermore, such an agreement can allow for the monitoring and management of revenue cycle performance and establish minimum requirements for subsidy arrangements.

Governance and financial control. To avoid governance issues that can occur when PSAs are poorly crafted, sticky PSAs include terms that ensure majority control over the physician enterprise or clinical program stays with the health system. For example, a sticky PSA can include a provision to control physician participation on advisory boards that provide input on strategic and financial matters.

Optimized compensation methodology. PSAs define the methodology for paying physicians for the services they provide to the hospital. Compensation methodologies may be time- or productivity-based depending on the specialty, and they typically include quality or performance incentives. When there is a lack of administrative coordination, compensation methodologies can vary widely, even among similar specialties, making them harder to manage. Sticky PSAs improve upon this situation by standardizing the compensation models for individual specialties and specialty categories and by reducing variation where it makes sense. Further, sticky PSAs align incentives with payment models, long-term operational and strategic goals, and fair market value.

Creating a Sticky PSA

In conducting an inventory of their existing PSAs, many health systems likely would uncover the following shortcomings:

> Variation in key terms and provisions across arrangements
> A lack of essential control mechanisms
> Inconsistent terms regarding compensation and performance across similar specialties and related specialty groups
> A lack of alignment with the hospital's strategic direction and priorities

To address these deficiencies, health systems should focus on developing the following:

> PSA content and a development process that are standardized, with templates that provide options to meet market needs
> Guiding principles requiring a more integrated network delivering more efficient and higher-quality care
> A compensation plan that follows a common and preferred philosophy
> Contract development processes with established time lines from PSA initiation to approval
> Care delivery models that right-size the mix of physicians and advanced practice providers
> Features that promote an enduring bond and aligned incentives

To structure and negotiate sticky PSAs—or to restructure and renegotiate existing PSAs to be sticky—organizations must first seek to thoroughly understand the existing arrangements and

HOW TO TRANSITION TO A 'STICKY' PROFESSIONAL SERVICE AGREEMENT (PSA)

Develop Guiding Principles	Design Standard PSA	Plan the Transition	Implement	Document Current Situation
> Inventory existing PSAs. > Document current PSA development and negotiation processes. > Identify areas of inconsistency.	> Determine contracting objectives and priorities. > Identify best practices regarding governance and financial controls. > Design a philosophy regarding consistency versus flexibility. > Define integration strategies and priorities.	> Determine standard and a la carte items. > Identify preferred compensation model(s). > Create quality and performance incentives. > Establish a governance structure. > Develop financial controls.	> Develop the rollout strategy (e.g., by market or specialty type). > Define the timing, objectives, enablers, barriers, and risks for each existing PSA. > Confirm roles and responsibilities. > Develop administrative tools.	> Update the financial impact analysis. > Prepare a preferred term sheet. > Prepare a contingency plan. > Negotiate terms.

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their effectiveness, and then engage in an internal discussion to answer key questions, including the following.

What standard contract elements and guiding principles should apply to all PSAs? Examples may include committing to a common set of quality metrics and EHR adoption standards, defining the desired level of governance and financial control, and establishing the framework for standardizing compensation models.

What are the preferred physician compensation structures to generate efficiencies and high-quality patient care? Consideration should be given to specific funding components, such as productivity and performance incentives, as well as the overall balance of risk and reward to the provider.

What physician participation requirements and incentives are required to promote greater integration, improve outcomes, and enhance systemwide performance? An organization's culture and experience will influence whether a carrot or a stick approach is followed and to what degree participation requirements and incentives evolve over time. For example, organizations just getting started on clinical performance measurement and reporting may set thresholds lower to be more inclusive and then become more selective as time passes and capabilities grow.

What processes should be followed, who should be involved in those processes, and what supporting documents are required to optimize the development of new PSAs and the renewal of existing PSAs? When addressing these questions, organizations should consider the current process, what is working well, and where it is falling short. They also should consider the key stakeholders that should be involved from the beginning, including those from the executive leadership team, finance, legal counsel, and physician leadership.

What are the systemwide best practices for contract management and coordination of the PSA negotiation process? Consideration should be given to where the contract management system is being optimized by pockets of users and what tools and templates can be used to standardize the process (e.g., timelines).

The answers to such questions will vary greatly by organization, depending on the history, current situation, and future goals. The important part is to engage in internal discussions to uncover the perspectives that will help inform the development of guiding principles and standardized features, terms, and templates for the PSAs. Then, a rollout strategy, management structure, and supporting tools and processes should be implemented for effectively transitioning to the new relationships and managing them on an ongoing basis. The exhibit above summarizes five steps to transition from fragmented and loosely

managed PSAs to consistent, goal-oriented, and integrated PSAs.

Organizations should strive to follow the modeled approach to achieve optimal results. Using this approach, a health system can expect to see a shift in how it spends its time developing or renegotiating PSAs and relating to its physicians. Instead of sinking time into managing the complexity of widely varied PSAs, this approach allows the organization to spend more time collaborating with providers on ways to meet the needs of the communities it serves. Furthermore, the transition to sticky PSAs will give a health system's provider network a competitive advantage based on the long-lasting, mutually beneficial partnerships it has established.

If you aren't getting this benefit out of your existing PSAs, then it's time to make them sticky. ■

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