Hospital and Independent Physician Alignment: Structural Options, Business and Compliance Considerations

By Bruce A. Johnson and Janice Anderson

I. Introduction

Numerous policy initiatives are now being implemented to transform the nation’s health care system. The overall goal is to improve outcomes, enhance quality and value, and reduce health care costs. Medicare program rules governing hospital inpatient quality reporting, value-based purchasing and payment incentives linked to preventable conditions and readmission rates have been released, and similar policies are well under way for physicians. These and other changes are transforming the health care payment and delivery environment, and breaking down the silos that have traditionally existed between hospitals and physicians.

As health care provider communities reorganize to participate in the new environment, many pursue a “one-size-fits-all” approach based on full structural integration of hospitals and physicians via some species of physician employment. Yet complete structural integration is neither possible nor appropriate in every setting. Hospital relationships with independent medical practices will likely continue to exist into the foreseeable future – even while ongoing policy and other changes continue to push physicians and hospitals even closer together. This article reviews some of the options for working relationships between hospitals and independent physicians that are short of full integration models.

II. Relationship Requirements in Future Payment and Delivery Systems

Successful hospital and physician relationship models of the future will likely need to:

- Bring together participants who are willing to adopt new approaches and accept some amount of change
- Balance the need to work together, with the desire to maintain some level of independence and autonomy in financial, operational and other areas.
- Develop and refine health information technology infrastructure that can facilitate integration, both clinically and financially, along with other forms of “soft” infrastructure such as effective physician leadership, governance and other systems to shape organizational performance and cultures
- Align financial incentives with payment and delivery system goals
- Accomplish the above in a fiscally prudent, legally compliant manner in light of applicable laws and rules directed at fraud and abuse (e.g., the Stark, Anti-Kickback and Civil Monetary Penalty statutes), those governing tax-exempt organizations, health care antitrust and other federal and state legal concerns

Relationship structures short of full physician-hospital integration involve contractual and/or structural joint venture relationships. They range from far-reaching “Accountable Care Organization” (ACO) models that seek to engage with payers, change how care is delivered and accept performance risk, to more limited initiatives that focus on hospital and/or physician quality, operating practices and infrastructure. Each structure has strengths and weaknesses and no single model is perfect. Moreover, each individual relationship will have its own operating features and other details due to the
unique variables of the community in which it is created.

III. Assessing the Options.

“Accountable Care Organizations” and Similar Clinically Integrated Structures. ACOs have an almost mystical existence today as many communities are said to have an “ACO” either already in place or under development – even though the push for payment and delivery system changes by public and private payers remains in its infancy. Despite this, most provider communities will likely need some form of structure that can bring a variety of providers together and assume an ACO’s core functions (i.e., changing how care is delivered through enhanced clinical integration and care coordination, and accepting and disbursing payments from shared savings, bundled and other payment systems among the ACO’s participants).

Many provider communities have previously created or are now creating “Physician-Hospital Organizations” (PHOs) and similar joint venture organizations. These structures can be used to participate in the emerging payment and delivery environment—although previously existing PHOs may have operational, legal and/or other challenges since they likely were created previously for contracting purposes and not as a platform to change how health care is delivered. Common challenges for existing PHOs include that many PHOs involve virtually all members of a hospital’s medical staff, as opposed to a subset who have a commitment to adopt new approaches and change. Many existing organizations also have leadership, governance, cultural and other legacies that worked for a PHO that only was used for contracting but now may be hostile to new payment and delivery system demands.

Where existing PHO organizations serve as the platform for physician and hospital engagement today (whether newly created or modified from an existing one), it is necessary to incorporate modern governance structures, new processes to promote quality, and other strategies including those involving financial and/or clinical integration to promote antitrust law compliance. PHOs historically were developed using a taxable non-profit corporation or similar form on the assumption that participating providers would not directly receive compensation from the PHO through ownership or otherwise. The use of a more flexible limited liability company (LLC) or similar entity form will likely be useful for today’s PHOs due to “shared savings,” other future payment systems and the need for significant infrastructure.

An ACO/PHO organized as an LLC can implement ownership, governance and other structures required to serve as a unified structure to drive change across the continuum of care. The form can also provide a framework for participation by individual specialties in more discrete pay-for-quality, service line co-management and other relationships described below. Many communities are evaluating whether to restructure existing, or create new ACO/PHO type structures to meet contemporary health care payment and delivery system needs.

Pay-for-Quality Programs. ACO-type structures may represent the end goal, but a variety of more limited programs are also available to promote quality and cost saving objectives, address operational and infrastructure issues, or both. These more limited structures can be used to bridge the gap where payment options are not conducive to a true ACO or clinically/financially integrated PHO, and, if structured correctly, can evolve to an ACO/PHO model as payment systems transition.

“Pay-for-quality” programs align hospitals and physicians in furtherance of hospital performance under hospital pay-for-performance and similar programs. Under pay-for-quality models a “quality enhancement professional service” or similar agreement is entered into between a physician-owned legal entity (typically organized as an LLC) and a hospital. The LLC’s physician owners engage in specific projects and activities (e.g., policy and procedure development, peer review etc.), to improve hospital quality and they devote a defined amount of time per month in activities that are designed to help improve hospital quality. The model was designed for the hospital to meet its own commercial payer pay-for-performance program goals; creating a win-win for the hospital and physicians. Such programs can also be modified such that the hospital simply pays for the service – so called “quality co-management” arrangements. The physician-owned organization may be paid a portion of pay-for-performance awards earned by the hospital, or other fair market value amount for services with that compensation typically distributed among the LLC’s physician owners on a per capita basis.
Pay-for-quality programs are established with select subsets of a hospital’s medical staff in order to focus on specific quality improvement, patient safety and other goals. The operating, financial and other systems used in pay-for-quality programs can help to develop key infrastructure elements (e.g., governance, data-reporting and other systems) that can be used when payment systems (such as shared savings, bundled payments, etc.) catch up to the particular market place. They can also provide physician time and motivation to push for improvement and change in the hospital and potentially other settings. Structurally, the use of a physician-owned LLC legal entity other than the physician’s medical practice (to potentially include an ACO/PHO with separate ownership classes) permits physician earnings to be distributed based on services and/or ownership, with partnership tax treatment. The structure also provides compliance benefits, although close attention to Stark law, Antikickback Statute and Civil Monetary Penalty law compliance is still essential.

Service Line Management and Co-management Agreements. Service line “co-management” or management agreements, permit hospitals to align with physicians to address management, efficiency, quality of care, patient safety and other variables within a particular hospital service line. The arrangements are crafted with only a subset of physicians on a hospital’s medical staff – those who actively use, and therefore influence the performance of the service line being managed. Thus, the model while useful to improve quality and efficiency in a specific service line, is not readily amenable to evolve to an ACO/PHO structure.

Service line management and co-management agreements will typically use a physician-owned legal entity as a contracting and management vehicle. The entity is generally organized as a LLC, and may be solely physician-owned, or potentially jointly owned by physicians and a hospital, although contracts with existing physician groups also can be used. A common element of all such arrangements is the establishment of physician-driven leadership and governance processes (commonly structured to also include hospital representatives as consistent with the concept of “co-management”), to focus on service line variables which are linked to operational, quality, safety and other goals.

A co-management agreement’s compensation structure will typically involve payments from the hospital to the physician-owned entity through a combination of “base” payments for physician medical and administrative activities, plus “variable” incentive compensation paid upon the achievement of pre-defined quality and other performance goals. Total compensation paid by the hospital to the physician-owned entity must be consistent with fair market value (FMV) and otherwise structured to promote compliance with applicable antifraud laws. Incentive measures must be structured carefully so that those directed at cost management do not unintentionally implicate the Civil Monetary Penalties statute by involving hospital to physician payments that have the incentive to reduce or limit care. Moreover, because service line co-management arrangements relate to hospital services, Medicare rules governing management contracts in “provider-based” hospital departments, and potentially other laws applicable to management contracts in tax-exempt settings must be considered in structuring the arrangements.

“Gainshare” Arrangements. The structure, operating format, financial and other features of “gainshare” arrangements are generally well known due to the existence of numerous OIG advisory opinions evaluating such programs in recent years. Gainshare programs involve written contracts coupled with FMV payments from a hospital to a physician or physician-owned entity in exchange for performance of various activities directed at reducing hospital costs. Compensation is only earned when pre-defined hospital cost-saving goals are achieved, and minimum quality standards are maintained. The arrangements are created solely with physicians on a given hospital’s medical staff specific to a department or service line whose decisions and use of hospital resources affect the hospital’s cost structure. As with other models described above, the use of a separate, physician-owned LLC entity to engage in the gainshare arrangement permits earnings to be distributed to the entity’s physicians based on ownership, with positive tax treatment and other compliance benefits.

While feasible, the regulatory compliance requirements applicable to gainshare programs, including limits on program duration, the need to rebase cost savings and others, among others are numerous. As a result, hospitals commonly explore how gainshare-type programs can be crafted and implemented in conjunction with co-management, pay-for-quality or similar programs to promote fuller alignment.
**Professional Service Arrangements (PSA).** Under a typical PSA model a hospital pays an independent medical practice FMV compensation for physician and midlevel provider professional services, and for the use of some or all of the practice’s infrastructure (e.g., space, staff and equipment). The PSA addresses professional service billing and other details associated with the practice operations, while making the practice “hospital-affiliated” via the PSA relationship. The end result is a physician practice that is similar to employment, yet allows physicians greater autonomy, governance and decision-making by preserving the “group” structure and mentality.

Effective PSA structures can be created with participants who are willing to engage in new payment and delivery systems, but seek alignment through a structure short of employment. They can help promote physician practice financial stability, medical staff development, recruitment, retention and other goals. PSA models can also provide a means to coordinate technology, governance and other infrastructure that can provide the foundation for more closely aligned future relationships. All compensation and other forms of “remuneration” under the PSA must be structured carefully to promote compliance with applicable fraud and abuse laws. The compensation structure can, however, include incentive compensation designed to promote quality and other variables within the medical practice operated under the PSA, and PSAs can potentially be coupled with one or more other relationship structures described here.

Because PSA arrangements are generally established with existing physician-owned medical groups, physician recruitment, retention and related goals must be pursued carefully. This will require close attention to numerous issues including how compensation is determined and for what services that compensation is paid, the existence of community need, the potential application of rules governing physician recruitment and others.

PSA relationships must also be carefully structured and operated to avoid prohibited “joint action” and other conduct that may impede competition in violation of applicable antitrust laws. Such issues can generally be avoided by furnishing professional services under a single party’s payer contracts (typically those of a hospital or hospital-affiliated group), through financial and/or clinical integration, and by imposing contractual and operational safeguards to prevent the sharing of fee or other sensitive information and to prevent other actions that could effect competition.

**Infrastructure Joint Ventures.** Infrastructure joint ventures range from limited purpose organizations formed to support the deployment of electronic health records (EHR) and other forms of health information technology, to more comprehensive management services organizations (MSOs) that provide operational support to physicians, hospitals and other health care organizations. Depending on the scope of the joint venture’s activities, such models may be the least aligned of the options reviewed here, but they are useful in that they can still begin to align technology and other infrastructure.

Provider communities that use these models will sometimes create a separate legal entity to provide a platform for the joint venture’s organizational and operating systems, and to provide structure to governance, decision-making and other relationship details. Infrastructure support arrangements must be assessed closely to ensure compliance with the federal Stark law and Anti-Kickback statutes, including with respect to the provision of health information technology and other forms of support. Such models may be limited in driving delivery system change due to their narrow focus; although they may still provide a framework for more effective communication and working relationships that can serve as a stepping stone for future strategies.

**IV. Conclusion**

The precise structures, strategies and tactics used by local health care provider communities to participate in the emerging quality and value-based payment and delivery systems will require local consideration. Many provider communities will be able to build upon currently existing arrangements, while others will elect to distance themselves from the limitations and “baggage” of already existing structures and relationships.

Hospitals and their independent physicians should assess whether and how the proposed relationship promotes key success factors for the development and operation of next-generation payment and delivery systems. These factors include whether the partners in the relationship are willing to adopt new approaches and change; how the relationship balances the need to work together with the preservation of autonomy; the ability to implement necessary hard and soft infrastructure; how financial
incentives are aligned; and the relationship model’s regulatory compliance and business risk. Provider communities will be well served to consider a range of business and professional relationship structures, rather than adopting a “one-size-fits-all” approach.

About The Authors

Bruce A. Johnson is a health care shareholder in Polsinelli Shughart’s Denver office. His extensive experience includes providing representation and services to medical groups, hospitals, academic practice plans and other health care enterprises in a variety of matters. He can be reached at 303.583.8203 or brucejohnson@polsinelli.com.

Janice A. Anderson is a health care shareholder in Polsinelli Shughart’s Chicago office. She has more than 25 years of experience focusing on health regulatory and compliance issues and more than 30 years’ experience working in the health care industry. She can be reached at 312.873.3623 or janderson@polsinelli.com.

Polsinelli Shughart provides this material for informational purposes only. The material provided herein is general and is not intended to be legal advice. Nothing herein should be relied upon or used without consulting a lawyer to consider your specific circumstances, possible changes to applicable laws, rules and regulations and other legal issues. Receipt of this material does not establish an attorney-client relationship.

Polsinelli Shughart is very proud of the results we obtain for our clients, but you should know that past results do not guarantee future results; that every case is different and must be judged on its own merits; and that the choice of a lawyer is an important decision and should not be based solely upon advertisements.

© 2011 Polsinelli Shughart PC. In California, Polsinelli Shughart LLP. Polsinelli Shughart is a registered mark of Polsinelli Shughart PC