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When Employment is Not an Option

Yes, most of you and your cardiologist peers now work for hospitals and health systems. Still, I continue to work with a number of cardiology groups that are not interested in or eligible for employment. Why?

The reasons are as disparate as the physician practices. Some cannot become employed due to state regulations or because they are part of a multispecialty group. Others simply treasure their independence. Regardless, the continued dings to reimbursement and crushing cost pressures are pushing more of you in private practice to take a peek at your available options. And, although employment is typically the simplest alignment model, there are alternative arrangements that offer similar benefits while preserving your independence.

The Professional Services Agreement Model

A Professional Services Agreement (PSA) is an attractive model for those of you who want strong ties with a hospital but are reluctant or restrained from becoming employed. In my experience, two common reasons that PSAs are pursued over employment (assuming both options are viable) are:

- physicians are already part of a multispecialty group and want to remain in partnership
- physicians continue to practice at multiple organizations and don't want to play favorites.

Most groups prefer a hybrid approach, which incorporates a Management Services Agreement (MSA) and pays the physicians for managing the cardiology clinic. While arguably more complex than employment, the PSA/MSA is appealing because it allows the physician group to maintain some control over operations and offers a payment structure that can lighten the payor risk private practice cardiologists often face. Since no two PSAs are alike, it's important to do your homework when designing an arrangement to ensure your interests will be addressed.

Comanagement

Comanagement represents a slightly less integrated model for physicians, but it still provides a strong bond between you and your affiliated hospital. These arrangements can span multiple physician groups, including those in solo practice. However, they get a bit tricky when a large number of independent practioners are involved.

Now, this model only works if you and/or members of your physician group are interested in service line

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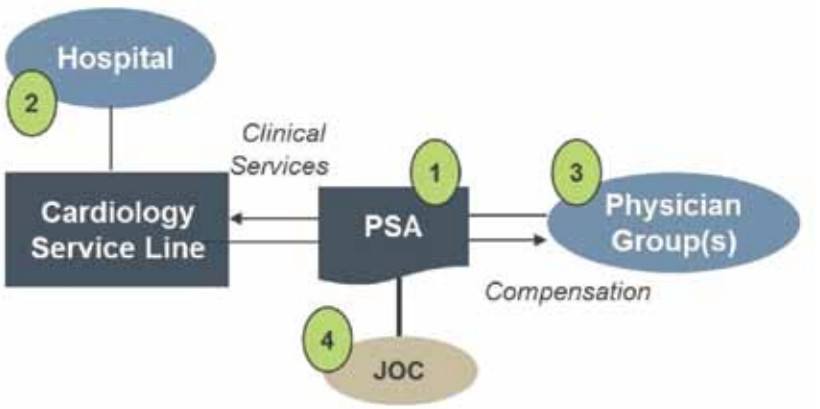
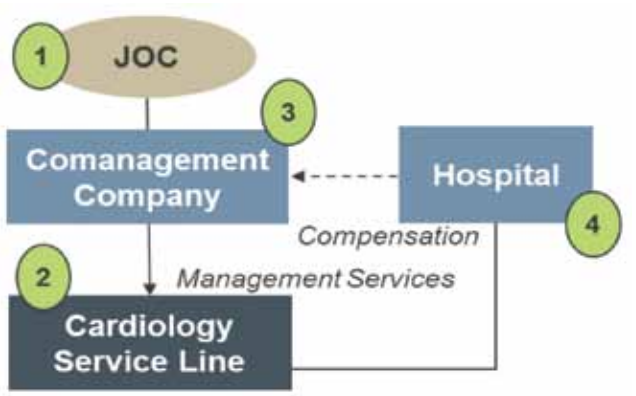
While employment often represents the simplest approach, many physician groups are pursuing alternate models.

Key Features of a PSA Model Structure



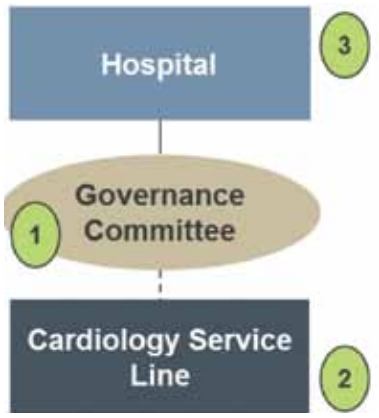
1. Cardiologists provide clinical services in exchange for a fee (tied to productivity and performance).
2. The hospital supports overhead administration activities (e.g., billing, IT support).
3. The cardiology group controls clinical coordination, internal compensation distribution, and physician hiring/termination. (Physicians could oversee other aspects of management through an MSA.)
4. A joint operating committee (JOC), including hospital and physician representatives, oversees the structure.

Key Features of Comanagement Arrangements



1. A JOC is established to monitor the program and contractual/performance issues.
2. Participants are contractually obligated to jointly manage the cardiology service line.
3. The physician group(s) remains independent and receives payment for the management of the service line. The physicians may create a new company under this approach.
4. The hospital makes fixed and/or variable payments for management services.

Key Features of Service Line Leadership Models



1. A committee is established to monitor the performance of the cardiology program and provide recommendations.
2. A leadership agreement contractually obligates the parties to manage specific aspects of the service line.
3. The hospital makes fixed and/or variable payments for management services depending on the structure of the arrangement.

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management. While these arrangements have been successfully implemented across a variety of markets, they do not always provide a high degree of financial sustainability since each physician still accepts risk for all clinical reimbursement. That being said, comanagement can be a favorable alternative if your affiliated hospital recognizes the benefits of cardiologist involvement in service line management and development—and is willing to invest significant resources to make it happen.

Service Line Leadership

A service line leadership model is the simplest option of the nonemployment approaches but is also rather thin on alignment. Even still, there are a number of physician groups drawn to this option because it is often less time-intensive than comanagement yet still gives physicians a voice in management.

This model has worked well in terms of service line development. It does not usually provide cardiologists with much stability, however, unless the payment for management services is at least comparable to their clinical reimbursement. You will find select organizations willing to invest a substantial amount of time, responsibility, and financial incentives to cardiologists for managing one of their high-revenue service lines. Depending on the level of alignment you want to gain with your affiliated hospital, this could be an ideal arrangement.

What Does This Mean for You?

The takeaway here is that employment is not the only option. While it often represents the simplest approach, there are a number of physician groups among you that are pursuing alternative models and achieving clinical and financial success. Regardless of your preferred model, though, it's important to work closely with your affiliated hospital (and, in many cases, your physician partners) to determine the type of structure that will best address the needs of your practice. ■

For more information, Ms. Reed can be reached at *kreed@ecgmc.com*.