Evolving Models of Cardiovascular Practices

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Recently, there has been much discussion about the changes occurring in cardiology practices. There have been reports that as many as 60% of cardiology practices in the United States have merged with hospitals or are in merger discussions; however, these numbers remain unsubstantiated. Recently, the California chapter of the American College of Cardiology (CA ACC) asked Kathy Flood, Senior Director of Practice Strategies and Transformation of the ACC, and Chris White, Chief Executive Officer of MedAxiom (Neptune Beach, FL), to visit Southern California and observe what was happening to cardiology practices there. They had an opportunity to speak with a dozen cardiologists about the current status of their practices. One scenario that they observed involved a group of 10 cardiologists in Southern California that was split up because the hospital hired 5 of the members in a foundation model. Two of these members were employee physicians who used their position as a members of both the hospital and the group to garner a better deal for themselves.

What is becoming apparent is that discussions about the viability of cardiology practices include discussions about the possibility of hospital-physician alignment. The CA ACC did a survey of its membership in 2009 and one fact that emerged from this was that a majority of its members valued their autonomy. Most respondents stated that they would only merge with hospital systems if forced to do so. Cardiologists across the state, like in the rest of the nation, are grappling with how to remain viable. Creative ideas are being put into practice; for example, there is a large practice in Santa Monica that is offering various concierge services at rates ranging from $500 to $5000 (if patients choose to participate). Some have joined foundation models and have become employees. Some are looking at the various models of hospital-physician alignment. Charles Oppenheim and colleagues recently published an article in the *California Health Law News* on hospital- physician alignment models in the state of California.[1] They write, "At its core, the idea of alignment refers to the ability of hospitals and physicians to pursue common goals while limiting conflict of interest, lack of trust, or other impediments to success."

The increasing financial pressures for both physicians and hospitals have driven the discussion of hospital-physician alignment. The mutually beneficial relationship between hospitals and physicians has changed in the face of declining reimbursement, increasing consumerism, and changing trends in reimbursement and regulation. One

example of this is the movement in hospital reimbursement, which is linked to the pay-for-performance initiatives; hospitals recognize that they cannot meet quality targets without engaging the medical staff. Regulators are also exposing hospitals to financial risk for poor quality or medically unnecessary services—these movements connect hospital finances with the quality of services provided by their medical staff. These are just 2 examples of the financial and practice challenges that hospitals and physicians have to overcome. As mentioned by Oppenheim and colleagues,[1] complete alignment may be neither possible nor desirable.

In the state of California, there is a doctrine that prohibits the corporate practice of medicine. It was enacted to protect the practice of medicine from exploitation and inappropriate influence by non-physicians. California prohibits the employment of physicians by hospitals. These legal limitations, along with federal and state fraud and abuse regulations, dictate models of integration. Hospital and physician financial relationships are scrutinized under federal and state prohibitions on kickbacks and self-referrals. These, along with antitrust laws and laws pertinent to tax-exempt organizations, will also dictate which alignment model is appropriate. However, there are a number of different integration models that can work in California, some with loose integration (eg, directorships) and some with tight integration (eg, foundation model). The following is a brief overview of these models.

The first model is a medical directorship, which aligns physicians with the hospital for program planning, clinical leadership, or operational oversight. It compensates physicians for time spent on the hospital's behalf. However, this model restricts the number of physicians that can benefit, and payment levels are restricted to fair market value.

In the management service model, a group of physicians can come together and form a professional corporation or a limited liability company that can then contract with the hospital for administrative and practice management services. Physicians have operational control but it may not meet the financial requirements of the physician. It may be a good way for physicians to come together to have collective bargaining power or form their own accountable care organizations with or without their partner hospital.

Joint venture is a physician hospital integration model more familiar to most physicians. This model requires that both parties participate in the funding and profit and loss sharing. Although these are financially attractive to both parties, they are limited by fraud and abuse laws. Stark legislation is also quite stringent and if not done correctly, joint ventures can affect a hospital's nonprofit status. Non–joint venture physicians may resent the resources and attention spent on joint ventures. It also puts physicians at risk for downturns or shifts in billing and collections.

A tighter integration model is the hospital-based clinic model. The hospital can add a clinic to its license as long as the clinic and the hospital have one single governing body. Obtaining status as a hospital outpatient clinic requires that the clinic be integrated clinically and financially with the hospital. The hospital does not employ physicians; rather, it typically contracts with an independent physician or a medical group to provide services at the clinic. The hospital can also purchase a practice and convert physicians' offices into an outpatient department of the hospital. Physicians may contract with the hospital to receive payment for services or bill a professional fee separately. Typically, the hospital employs all staff and provides all staff services; however, the hospital may contract for these services. The hospital must operate and maintain the clinic space in compliance with regulatory standards, which are more stringent legal and regulatory requirements than for physician clinics. The cost and complexity of the set-up is one of the disadvantages of this model. Although the hospitals have more practice control over a clinic than they would a medical office, outpatient departments must meet specific requirements to be licensed as supplemental services of a hospital. For example, written procedures about their outpatient services must be created and approved by the hospital's governing body and the services must be evaluated periodically. Medicare's Condition of Participation rules, along with the lengthy process of adding an outpatient clinic to a hospital license, make this model challenging at best. In addition, as stated by Oppenheim and colleagues,[1] hospitals have to be "careful to avoid bestowing a windfall benefit to physicians practicing at a 1206(d) clinic by allowing them free use of the clinic facilities to see private patients."

Medical foundations are another model widely used in California. A California medical foundation is a nonprofit health care organization (tax exempt) that provides ambulatory care to the patients. It also does not employ physicians but contracts with them to provide professional services to foundation patients. They are required to conduct medical research and health education for their patients. The medical foundation employs its staff and provides all its

own support services. It provides care through at least 40 independent contractor physicians and surgeons, at least two-thirds of whom practice at the clinic full-time. The physicians and surgeons must together represent at least 10 board-certified specialties. Hospitals cannot own a foundation because of its nonprofit status. However, they can create a corporation that can serve as a foundation that runs the clinic and be a corporate member of the foundation so that it can participate in the election of the board of directors and reorganizations.

The CA ACC is aware of the need to educate the membership about the changing cardiology practice models. During our 21st Annual Meeting on October 8th, we had a satellite event entitled *Changing Cardiology Practice Models—Surviving in California*. There are numerous meetings planned in the next year throughout the state to educate the California cardiologists. We hope to see you at these meetings. ■

Reference

1. Oppenheim CB, Rifenbark RK, Shankar A. Hospital-physician alignment models in California. *California Health Care News*. 2008;26:4-17.