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Clinical Co-Management Arrangements: What Are You Paying For?

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Among the first questions hospitals typically ask themselves when considering the development of a co-management arrangement with physicians is, "What can we pay?" An appropriate response is, "What are you paying for?"

In most arrangements between hospitals and physicians, the services for which physicians receive compensation are relatively straightforward—medical director agreements, on-call agreements, and employment agreements, for example—and usually come with a customary set of duties. Clinical co-management agreements, however, exhibit wide variability in the services delivered and can involve a multitude of structures, participants, services, and compensation levels. In other words, if you've seen one co-management arrangement, then you've seen one co-management arrangement.

Co-management arrangements tend to have a common purpose: to engage physicians in the management of a program or service line so that their interests will be aligned with those of the hospital regarding quality improvements and overall service line performance. There has been a resurgence of interest in these arrangements, particularly in cardiology and orthopedics, consistent with hospitals' need to engage physicians to achieve successful clinical integration and prosper in a value-based world. Such arrangements also can help align the interests of all physicians in a given specialty and promote collaboration among employed and independent physicians.

Typically, co-management arrangements have compensation structures that include fixed and incentive components. But beyond these common features, the million-dollar question is, "What services will be provided under the agreement?"

Services provided may fall into the following areas, with a range of activities possible in each category:

- Staffing and personnel (e.g., interviewing, staff development and training, provision of staff)
- Operations support (e.g., provision of an administrator, day-to-day clinical management, patient scheduling, policy and procedure development, process improvement)
- Quality improvement (e.g., oversight or leadership of initiatives focused on areas such as best practices, clinical pathways, patient satisfaction, and quality indicators)
- New program development (e.g., development of new programs or services and assumption of responsibility for accreditation requirements, physician recruitment, ultimately, or program promotion)
- Financial planning and reporting (e.g. statistical reporting, development of operating and capital budgets, ongoing budget monitoring)

The parties need to agree on the services to include in any given arrangement. The physicians must determine which services they are interested in executing, which they have the resources to pursue, and which they can deliver well.

The execution of a co-management agreement does not change ownership or overall accountability for the service line; ultimate authority and responsibility continue to rest with the hospital. Therefore, from the hospital's perspective, the objective should be to contract for only those duties that supplement and are complementary to the management services provided by the hospital's own staff.

As hospitals and physicians contemplate co-management agreements, they should have open dialogue about matching the services the physicians wish to provide with those the hospital needs and wishes them to provide. Only after the services are identified is it possible to determine the value and associated compensation levels of those services. As with all physician arrangements, compensation must be consistent with fair-market value and cannot be linked to the volume and value of referrals, and the compensation arrangement must be commercially reasonable. The nature and variability of co-management arrangements raise regulatory issues that should be proactively addressed during the development of any such arrangement.

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