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Imagine the following conversation between a hospital executive and the leaders of a medical group.

“We want to partner with you,” the executive says. “This isn’t just a contract. It’s alignment. We want to build something together.”

As the conversation progresses, the physicians hear familiar phrases: partnership, collaboration, shared mission. The deal includes a medical directorship, a professional services agreement, and perhaps a co-management arrangement.

Everyone leaves the meeting feeling good.

Now fast forward three years.

Hospital leadership has changed. Financial pressures have increased. Someone in the C-suite is asking uncomfortable questions about referral patterns and service line profitability.

Suddenly, the tone of the relationship feels . . . different.

The hospital still uses the word alignment, but it no longer seems to mean the same thing.

And that’s the problem.

Hospital–physician “alignment” deals are often presented as partnerships. In reality, many of them are simply contracts with a marketing department attached.

Hospitals Love the Word “Alignment”

Hospitals use the term constantly. It appears in strategic plans, consultant reports, and PowerPoint decks explaining the future of healthcare.

Hospitals want alignment with physicians. Physicians want alignment with hospitals. Heck, everyone wants alignment with everyone else.

At least until the incentives change.

Over the past two decades, hospitals have pursued physician alignment through a wide range of arrangements: professional services agreements, medical directorships, co-management deals, joint ventures, and employment models.

Some of these arrangements work well, but many don’t.

The difference usually has less to do with goodwill and more to do with incentives, leverage, and contract structure.

The Compliance Piece (Yes, It Still Matters)

Whenever money flows between hospitals and physicians, the Stark Law and the Anti-Kickback Statute are quietly sitting in the background.

Most alignment arrangements attempt to address these laws through familiar concepts:

- fair market value compensation
- commercially reasonable arrangements
- payments not tied to the volume or value of referrals

In theory, that framework works.

But, in practice, arrangements rarely stay frozen in time. Responsibilities drift. Compensation changes. Documentation fades.

The medical directorship that once required defined services becomes an honorarium. The consulting agreement becomes something nobody can clearly describe, but the payments continue.

When regulators, or whistleblowers, start asking questions, the issue often boils down to a simple one: Were the physicians actually providing the services they were being paid to provide?

If the answer is unclear, the arrangement can start to look like something regulators have a very specific name for: payment for referrals, in other words, a kickback.

The Strategic Issue Physicians Often Miss

For very obvious reasons, legal risks get most of the attention. But the bigger issue for many medical groups is strategic.

Alignment deals frequently come with strings attached, some of which are quite obvious. Many others are buried in provisions that seem harmless at the time of contracting.

For example, hospitals often require physicians to provide services exclusively at the hospital's facilities, limit participation in competing ventures, or obtain approval before expanding services

None of this is unusual in terms of what hospitals seek.

But physicians sometimes underestimate how much these provisions affect the long-term independence of the medical group. A deal that looks attractive today may limit options tomorrow. Markets change. Leadership changes. Strategic priorities change.

Contracts, on the other hand, tend to last longer than optimism.

The Referral Expectation Problem

There's another issue that rarely appears in the written agreement but frequently exists in the relationship: the expectation of referrals.

Hospitals do not enter alignment deals out of altruism. They expect economic value from the relationship.

That value usually comes in the form of patient volume.

No one says it directly, at least not in the contract.

But if a hospital is paying physicians through multiple arrangements, it's not unreasonable for hospital leadership to assume those physicians will direct patients to its facilities.

When that expectation collides with physician judgment, or with competing facilities, the relationship can deteriorate quickly.

Physicians may suddenly hear phrases like:

- "We thought this was a partnership."
- "We expected alignment."
- "We're surprised by your referral patterns."

None of those phrases appear in the Stark Law, but they appear in real-world disputes with remarkable frequency.

A Word About Co-Management Agreements

One alignment model that deserves particular scrutiny is the co-management agreement.

Under these arrangements, physicians are paid to help manage hospital service lines, for example, orthopedics, cardiology, surgery, and so on.

Typically, part of the compensation under a co-management agreement is tied to performance metrics designed to measure quality or efficiency.

That structure can make sense. But poorly designed metrics create risk.

If the metrics are vague, easily satisfied, or indirectly tied to patient volume, regulators may view the arrangement as something other than a quality initiative.

Co-management agreements are not inherently problematic; however, they require careful design and periodic review.

Some Practical Takeaways

1. Alignment is not the same as shared incentives. Hospitals and physicians may cooperate for years, but their economic interests are not identical.
2. If compensation is tied to services, those services must actually occur. If nobody can explain the services being provided, regulators will supply their own explanation.
3. Watch the strategic restrictions. Exclusivity provisions imposed on you and approval rights can quietly limit a group's future options.
4. Referral expectations are real—even when unspoken. Understand the hospital's economic expectations before entering the deal.
5. Review arrangements periodically. Deals that made sense five years ago may not make sense today.

Hospital–physician partnerships can be productive and beneficial. Many are.

But physician groups would be wise to remember a simple reality:

In healthcare, alignment isn't a relationship, it's a temporary

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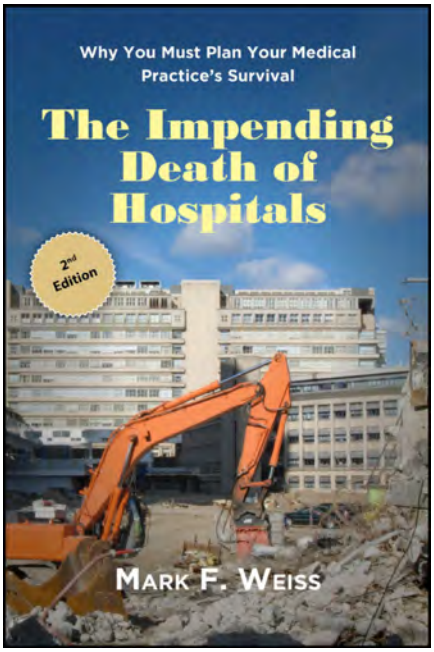

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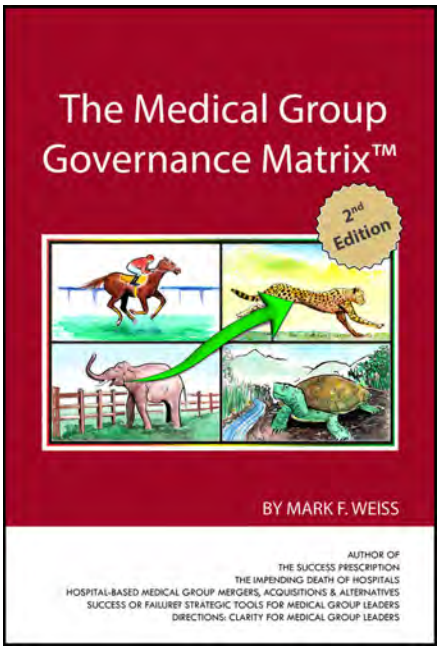

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