Physician Empowerment in the Hospital:
An Overview of Clinical Co-Management Agreements

White Paper

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Abstract: As healthcare organizations, operating in a shifting landscape, begin to recognize the importance of alignment and integration in this new “accountable care era,” many leaders hold an erroneous belief that pursuing one particular model, i.e., employment, is the only answer. However, multiple alignment models are available that can advance the agenda for provider organizations to remain viable and control their destiny while also meeting the needs of their hospital partner. Clinical Co-Management Agreements (CCMAs) are often discussed, though their relevance is regularly masked by a broader strategy, i.e., employment, professional service agreements, and/or clinical integration. These agreements are a moderate form of alignment and represent an arrangement wherein providers become actively engaged in setting and managing the clinical direction of a particular service line. CCMAs are frequently consummated between hospitals’ service lines and their medical staff members, whether they are employed or contracted. A CCMA can serve as a method of accomplishing “win-win” volume-to-value outcomes for both the physician and the hospital, without losing all independence and autonomy or becoming overly capital intensive, thus, driving value for all stakeholders.

Key Words: Physician-Hospital Alignment, Clinical Co-Management Agreement, CCMA, Alignment Models, Management Agreements

INTRODUCTION AND OVERVIEW

Physician-hospital alignment is often viewed as the precursor to clinical integration, which has been linked to the long-term success of provider organizations in the new value-driven healthcare industry. As healthcare organizations continue to recognize the importance of both alignment and integration in this new “accountable care era,” there is often an erroneous belief that pursuing only one particular model (such as employment) is the answer to the issue. However, multiple alignment models exist that can advance the agenda for provider organizations to remain viable and control their destiny under a shifting landscape. One model that is often discussed but whose relevance is regularly masked by the broader strategy (i.e., employment, professional service agreements, and/or clinical integration) is the Clinical Co-Management Agreement (CCMA). CCMAs are a moderate form of alignment and represent an arrangement wherein providers become actively engaged in setting and managing the clinical direction of a particular service line. CCMAs are frequently consummated between hospitals’ service lines and their medical staff members, whether they are employed or contracted, but can be accomplished between other institutions, such as skilled nursing facilities, dialysis centers, etc., and their private physician partners.

The CCMA is arguably more relevant now than ever before. At the start of 2015, the United States Department of Health and Human Services (HHS) set a goal to have 30% of Medicare reimbursements tied to value-based care by 2016, with this percentage increasing to 85% by 2018. Historically, commercial payers have followed the precedents set by The Centers for Medicare and Medicaid Services (CMS), the HHS department that administers Medicare and
Medicaid, which means that many will be looking to accelerate the migration of healthcare reimbursement from fee-for-service (FFS) to risk-based reimbursement, or fee-for-value (FFV). In general, the volume to value transition will force providers to re-tool their operations to focus more on population-based health initiatives, care management, cost reduction, effective data aggregation and utilization, and overall prevention and wellness. As discussed later in this paper, the CCMA is inherently designed to progress the tenets set forth by the value-based payment movement. Thus, the CCMA is a great tool for all provider organizations to consider as they prepare to respond to the long-term needs of the healthcare industry.

**CCMA Structures**

The CCMA can be categorized into four general structural types. These are described as follows:

**Traditional CCMA**

This model consists of a management agreement between an existing physician professional corporation and a hospital (usually on behalf of a particular service line). Management services are provided by the existing professional corporation and the hospital’s service line. Potentially, this CCMA model is the easiest model to implement because it does not require the creation of a new legal organization. Figure I illustrates the Traditional CCMA structure.

![Figure I. Traditional CCMA](image)

This model is often used when there is one physician group providing the totality (or the vast majority) of services to a hospital within a particular service line. Then, contracting directly with
that group, as opposed to another entity (as is contemplated in some of the other structures detailed below), is the most logical and typically the most expedient. For organizations seeking to align more closely with a private practice, this model is a straightforward path to establishing the CCMA.

**NEWLY-CREATED ENTITY CCMA**

In this model, a new legal entity is created, which then enters into a management agreement with a hospital (again, for a particular service line(s)). Management services are provided by the newly-created management entity to the service line in exchange for a management fee. This CCMA model allows for more flexibility in that there is less rigidity surrounding the physician composition of the newly-created management entity. In this CCMA structure, not all the physicians of a practice (or even of the service line) would be required to be a party to the transaction and thus could choose to participate in the CCMA at a later date (or not at all). Additionally, this model could allow for the participation of physicians from multiple practices. Finally, it would allow for a simple distribution of funds to those physicians providing the CCMA services.

Establishment of a new professional corporation (PC) or limited liability corporation (LLC) does not need to be an overly burdensome process. It primarily involves working with qualified legal counsel to complete the applicable documentation. Figure II illustrates the Newly-Created Entity CCMA structure.
JOINT VENTURE CCMA

In this model, a physician (or more likely, a set of physicians) and a hospital joint venture in the development of a management entity. The jointly ventured management entity then enters into a management agreement with a hospital for a particular service line.

It is important to note that participating in a joint venture requires the satisfaction of stringent legal regulations and often involves the longest preparation and implementation time. Thus, this model is the least commonly utilized and, often, only for a very specific purpose that cannot be met by the previous structures. This model signifies a more permanent alignment between the hospital and physicians, as the management entity is owned jointly by the two parties. Figure III illustrates the Joint Venture CCMA structure.

**Figure III. Joint Venture CCMA**

JOINT OVERSIGHT CCMA

A Joint Oversight CCMA structure consists of two or more physicians (which may be from the same or different medical groups) who, with their hospital partner, collectively comprise a Joint Oversight Committee. There are still management agreements in place between the hospital and the physician/group, but central to this relationship is a body with representatives from all parties that work together to meet the clinical, operational, and administrative needs associated with a given service line. While the administrative leaders have an equal partnership in the CCMA, the clinical leaders are empowered with oversight and input on the vital issues. This model also represents the potential for multiple practices to participate. Figure IV illustrates the Joint Oversight CCMA structure.
The CCMA structure is only as useful as the metrics that support it. A comprehensive, collaborative, and diligent process should be undertaken to ensure the establishment of relevant metrics. These metrics should be rooted in a joint effort between both the healthcare system and the physicians involved to emphasize quality improvement, provider accountability, and value-based goals. When defining measures, it is important to note that these metrics can be based on quality, cost, citizenship, and leadership. While the metrics must be verifiable and objective, they must also become more aggressive over time. During the initial roll-out of the CCMA, the metrics should include more attainable targets, with the targets gradually increasing over time so as not to continually reward the same level of achievement. Additionally, the metrics should allow for scalability (both in terms of volume growth within the service line and an increasing number of provider participants).

Historical performance data is necessary to consider when developing quality incentives. As evidenced in several pilot (and now permanent) programs, lawmakers have mandated that incentive payments consider the health system’s historical data in establishing the appropriate baselines. Thus, to determine that quality metrics have been achieved, it is necessary to include the historical data baseline. Additionally, historical data can accurately reflect where there is a need for improvement.
It is important to note that benchmarks and quality goals continuously change; thus, the CCMA metrics should be regularly assessed to ensure alignment with current market trends and the goals of the organization.

**Fee Structure**

In a CCMA, there are typically two forms of payment to participating providers. The first tier consists of the base fee, which is a fixed annual fee consistent with fair market value (FMV). The base fee values the physician’s time and effort to the service line development, management, and oversight. Compensation is typically focused on hourly-based services rather than accomplishments.

In addition to this base compensation, physicians have the opportunity to earn additional compensation for meeting or exceeding certain mutually agreed-upon metrics associated with quality, cost, or operational goals. These incentive payments should take into consideration the historical baseline and target levels of the hospital that the parties are agreeing to work toward achieving.

Examples of applicable metrics include:

- Patient access
- Panel size
- Outcomes
- Use of extenders
- Care coordination
- Medical home concepts

**Regulatory Considerations**

The following healthcare laws, statutes, and regulations should be taken into account when undergoing the development of a CCMA:

- Stark Law is designed to prevent physicians from referring patients to organizations in which they have a financial relationship or incentive to do so. Exceptions to this rule include instances where the hospital’s compensation to the physician and/or management company does not vary with patient volumes or referrals. FMV assessments play a significant role in ensuring this matter, yet other nuances of this law must also be observed.

- Similar to Stark Law, the Anti-Kickback Statute aims to prohibit payment for referrals for reimbursement services. This statute creates somewhat of a barrier for hospitals wishing to offer physicians ownership interest in the management company; however,
there are still opportunities available. Thus, the CCMA should be structured to eliminate kickbacks from referrals of Medicare or Medicaid patients to the hospital.

- The Civil Monetary Penalties Statute prohibits a hospital from purposefully making a payment, either directly or indirectly, to a physician as an incentive to cut services to a Medicare or Medicaid beneficiary. Penalties of up to $2,000 for each such instance exist, as well as the potential for exclusion from Federal and State Healthcare Programs. To avoid this risk, participants should exercise care and utilize legal counsel before entering into a CCMA.

While these regulatory considerations are germane to all provider-to-provider transactions, all parties should be cognizant of federal and local laws, which can sometimes differ or lead to the enforcement of more strict restrictions on the agreement.

**CCMA Benefits and Drawbacks**

Like most partnership arrangements, there are pros and cons to consider during the collaborative transaction structuring process. Figure V outlines some of the potential advantages and disadvantages of the CCMA that most organizations considering this strategy should assess:

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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<tbody>
<tr>
<td>▪ Can be structured as an add-on or wraparound to an existing or new,</td>
<td>▪ Entails a cultural shift that relies on transparency, open communication,</td>
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<tr>
<td>overarching alignment/integration strategy, such as employment or PSA.</td>
<td>data utilization, and collaboration.</td>
</tr>
<tr>
<td>▪ Advances key goals/objectives of the organization that relates to the</td>
<td>▪ Involves additional investment of resources (financial, time, and energy)</td>
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<td>quality, cost, and management of services.</td>
<td>to develop the CCMA and sustain it over time.</td>
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<tr>
<td>▪ Easily customizable to address the preferences of all parties involved.</td>
<td>▪ Can lead to “physician fatigue” or relational issues, if improperly</td>
</tr>
<tr>
<td>▪ The value of CCMA can range from relatively insignificant dollars to</td>
<td>structured.</td>
</tr>
<tr>
<td>material figures.</td>
<td>▪ While technically possible, seldom a long-term standalone strategy, i.e.,</td>
</tr>
<tr>
<td>▪ Better prepares all organizations to meet the increasing demands of the</td>
<td>it will require a broader alignment/clinical integration plan for the</td>
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<tr>
<td>Accountable Care Era.</td>
<td>outlying years.</td>
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<td>▪ Can offer a “win-win” solution for both physicians and hospitals wherein</td>
<td></td>
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<tr>
<td>physicians are given an opportunity to participate in FFV reimbursement</td>
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models without investing significant amounts of capital, and hospitals can utilize physician influence and clinical insight to control costs and improve quality.

- Allows physicians to be in the “driver’s seat” and, thus, better engaged in the movement to reduce costs without compromising care quality.
- Supports a collaborative and highly engaged culture.
- Allows for scalability and supports the development/success of models, such as accountable care organizations, patient-centered medical homes, and clinically integrated networks.

A CCMA can provide a mutually beneficial solution to many of the challenges private practices and hospitals face in light of the changes in the healthcare industry. More specifically, CCMAs are a way for hospital service lines to utilize a private practice for clinical and operational oversight, while providing a stable and rewarding relationship for the practice’s providers. CCMAs are gaining traction but remain underutilized. However, as organizations are faced with increased pressure to improve quality and reduce costs, it is likely that CCMAs will become a more prominent strategy than before.

CCMAs can be a useful approach to advance “value-centric” initiatives and create an interdependence between partnering groups, which are crucial ingredients for clinically integrating and assuming risk under population health models. However, CCMAs require careful planning as their structural details can impact the interplay between clinicians and administrators. In the balance, the CCMA is a more palatable proposition for physicians to partner with their larger institutional counterparts than many other approaches that may seem too aggressive. However, traditionally, the CCMA is not a tactic that can carry the success of partnering organizations on its own, particularly for the longer term.

**CCMA as a Complimentary Alignment/Integration Strategy**

As noted above, there are various forms of alignment for practices and hospitals to consider that allow for further collaboration between the two entities. While some practices may choose only to pursue a CCMA in the hopes of fully retaining their independence, others may consider “add-ons” once the original agreement is deemed successful. Thus, it is important to look at how a CCMA could be utilized as a complement to other models. In the following section, we
briefly outline the ways a CCMA can be pursued in addition to the following alignment strategies. Coker has previously published Whitepapers that detail these models, which are available on the company website (www.cokergroup.com). Please refer to these for an in-depth look at the following models (e.g., “PSAs as an Alternative to Employment,” “Optimal Alignment and Integration,” “Developing an Effective Clinically Integrated Network,” etc.).

- “Employment Lite”
- Employment
- Accountable Care Organization/Clinically Integrated Network Participation

### EMPLOYMENT LITE

“Employment lite” is a term signifying a relationship that has a high level of physician-hospital alignment but falls short of full employment. It is formalized by a legally binding Professional Services Agreement (PSA) that is specific to this arrangement (hence, the reason “employment lite” transactions are also referred to as “PSAs”). A PSA is an agreement between a hospital and physician practice that outlines the specific financial and operational terms of a relationship in which clinical services are delivered by the participating physicians in exchange for remuneration. A PSA can take different forms; however, the following models are highly recognized and the most commonly used variations on the PSA model:

- Global Payment PSA
- Practice Management Arrangement
- Traditional PSA
- Carve-Out PSA
- Hybrid Arrangements

We note that no alignment structure, particularly the PSA, is a “one-size-fits-all” method and that the transaction structure should be customized to meet the individual needs of the organizations contemplating this type of relationship. Concerning the CCMA, the CCMA would likely be included as a wraparound to the core PSA model. Historically, these models have been excellent complements to each other. The PSA structures the arrangement, and the CCMA defines how clinical and quality decisions will be made and applied.

### EMPLOYMENT

Employment is the most common approach to hospital and practice integration and has been applied heavily over the past few years. As practices become increasingly wary of the changes in the healthcare industry, hospital employment represents a stable and relatively risk-averse approach.

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1 See [www.cokergroup.com](http://www.cokergroup.com) for further details surrounding each of these models.
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An option for physicians to consider. While employment is the most pervasive of alignment forms, all employment models are not the same. The four most common employment models include:

- Traditional Employment
- Group Without Walls
- Group Practice Subsidiary
- EPN “Dyad” models

Even with employment, the CCMA has applicability, although it may be formalized within the employment agreements themselves for those to whom that it applies. For those providers who are not employed, the CCMA would be a separate agreement, likely with identical terms to those of the employed physicians.

ACOs/CINs

As noted, alignment can be an attractive option for practices and physicians to develop a responsive strategy to the current push for accountable care the healthcare industry is experiencing. Alignment, such as is possible through a CCMA, would be “Stage I” of the overall strategy, building a foundation for more comprehensive clinical integration (which would be “Stage II” of this process). This evolution should be considered by all independent practices as an option for weathering the unprecedented challenges brought forth by the present and prospective healthcare landscape and could include the development of a CIN or ACO. Again, this action is not a requirement of practices to remain competitive in the evolving landscape, but it does provide a unique opportunity to integrate further with other practices and, potentially, hospitals without entering employment.

A CIN or ACO is a network of interdependent providers, and possibly healthcare facilities, that collaborate to develop and sustain clinical initiatives and performance goals on an ongoing basis through a centralized, coordinated strategy and data transfer and sharing. Moreover, for an ACO/CIN to be successful, the participants must be dedicated to developing a governance structure to monitor the adherence to set care guidelines and metrics to hold physicians accountable to the goals of the organization. As an ACO/CIN, the organization can pursue centralized contracting that ostensibly benefits all participants. In both scenarios, it is critical to demonstrate a genuine level of integration (in both structure and implementation) so as to meet legal/compliance requirements.

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2 Herein we refer to ACO as the Medicare Shared Savings Program model, and CIN is used to describe similar structures, but those specific to commercial (i.e. non-governmental) payers.

3 While these are the general tenets of organization for both ACOs and CINs, ACOs are CMS sanctioned organizations and are bound by their individual rules and requirements for formation.
If an organization is interested in pursuing this level of integration but is not ready to commit to such an investment, a CCMA could be a Stage I alignment strategy. Once the two entities (either physician-physician or physician-hospital) have determined their clinical compatibility via the CCMA model, the two can build on that foundation to form a clinically integrated structure. Alternatively, if the two are found to be a poor match clinically or operationally, they can decide mutually to end their relationship. In that way, pursuing a lesser form of alignment (such as a CCMA) before entering into a fuller form of alignment can mitigate somewhat the risks associated with these entities.

For all of the alignment options presented above, a CCMA can pose as either an “add-on” to an additional structure or a building block for future integration. Because a CCMA requires lower levels of clinical integration, presents minor start-up costs, and can be easily unwound if the parties so desire, CCMAs are an extremely attractive alternative to private practices and hospitals alike. Thus, organizations should seriously consider pursuing a CCMA if either of the interested parties is somewhat wary about entering into alignment strategies or if a CCMA could be a value-added initiative to other alignment structures.

CASE STUDIES

CASE STUDY #1

A small orthopedic private practice (Practice A) in the Midwest offering comprehensive orthopedic services with no ancillaries is seeking to improve its financial state. Practice A has two main hospital affiliations: the first hospital (Hospital A) is the region’s major health system with numerous orthopedic service line alignment and integration initiatives underway. Its employed orthopedic group is the only other large consolidation of orthopedists in the area aside from Practice A. The second hospital (Hospital B) is a smaller health system and Hospital A’s major competitor.

Practice A, desiring to remain independent but improve its financial health over the long-term, decided to discuss alignment options with its hospital affiliates. While there were various pros and cons between the two Hospitals, Practice A was seeking direct impact on the organization. Thus, they approached both Hospitals with the concept of a CCMA, which Hospital B was somewhat averse to accepting. Hospital A continued to evaluate the various alignment/integration strategies and agreed to Practice A’s request to align via a CCMA. Practice A’s decision to accept Hospital A’s offer was predicated by realizing the following:

1. The opportunity for an additional stream of revenue from Hospital A’s cost/quality control initiatives that are inherent to the CCMA.
2. The ability to segue more easily into a full form of alignment/integration.
3. The capacity to continue providing services at Hospital B.
Key physicians and administrative leaders from both Hospital A and Practice A met via a series of Working Group meetings to discuss CCMA models and corresponding performance measures. The parties also discussed prospective cost reduction initiatives, which included a surgical implant standardization effort. Hospital A included Practice A’s physicians into an overall Management Services Agreement that memorialized the CCMA’s principal terms and conditions. Practice A’s physicians and Hospital A’s orthopedic surgeons were then able to collaborate to improve the value proposition for Hospital A’s orthopedic service line.

Coker served as the lead transaction advisor to Practice A, which included facilitating the Working Group meetings, structuring the CCCMA and the appropriate performance metrics/rewards, conducting due diligence and financial analyses related to the deal. Further, our services encompassed collaborating with legal counsel to develop definitive agreements and overall management of the transaction’s progress to ensure the best interests of the Practice were consistently represented.

CASE STUDY #2

A rural, not-for-profit hospital (Hospital) was seeking to further the strategic goals of their gastroenterology service line (GISL), which was struggling with inter-practice dynamics and an overall coordination of care. In the Hospital’s service line, there were five separate GI practices, each playing a key role in the success of the GISL. As such, the Hospital began evaluating methods to standardize care across the practices and reduce costs for the service line, while utilizing the clinical expertise of the physicians. The Hospital approached a third-party evaluator, Coker, who began facilitating discussions between the Hospital and the various practices. The Hospital was seeking to create a collaborative approach to its GI service line via the various practices in its service area. The central impetus for the Hospital seeking alternative alignment structures was the desire to standardize care and reduce costs across the entirety of the service line while utilizing the clinical expertise of the providers.

Coker assembled a subset of key physicians from each practice and administrative leaders from the Hospital to serve as the Working Group (WG) to discuss and plan for the potential arrangement. WG Meetings were conducted over a period to facilitate collaborative discussion between the parties regarding the preferred CCMA models and corresponding performance metrics. Eventually, this WG served as the foundation for the Newly-Created Management Entity CCMA, and a formal agreement was established. As a result, the Hospital made demonstrable progress in their patient satisfaction and quality scores, as well as decreasing their cost per case.

As the lead transaction advisor for the Hospital, Coker facilitated the WG Meetings and led negotiations to memorialize the agreed-upon CCMA structure and associated terms, which included the performance metrics and compensation terms. Additionally, Coker conducted the
necessary due diligence and financial analyses related to the transaction and collaborated with legal counsel to develop definitive agreements.

**RECOMMENDED APPROACH**

There are four stages of the CCMA development process, each one building on the previous stage and allowing organizations to achieve success gradually with the development of a CCMA. The parties should ensure that there are didactic processes and discussions supporting each step to guarantee all parties feel comfortable with the CCMA strategy. Figure VI illustrates the four-stage approach.

![Figure VI. Four-Stage CCMA Development Process](image)

**Stage I — Initial Evaluation/Consultation**

The Project should begin with an intensive discussion regarding the ultimate goals and desired outcomes of the process. This conversation should include all constituents that will be affected by the results of this process, and, if desired, a third-party consultant should be selected.

**Stage II—Facilitative Discussions**

At this point, the parties should develop a subcommittee with a cross-sectional team consisting of five to eight members who work together to create collaborative discussions that lead to increased education, ample buy-in from a representative group of members, consensus building and ultimately, establishment of a definitive direction and structure of the CCMA.

This process is critical in that it provides the additional time needed to consider the issues and ultimately to finalize the CCMA strategy and transactional terms for the client and the physicians.
of the service line. The involved parties will be able to demonstrate their ability to act collaboratively in structuring the CCMA with consideration of financial terms, governance, and oversight.

**STAGE III - NEGOTIATIONS/FINANCIAL ANALYSIS**

Once the basic operational components are established, the parties should define the financial parameters and operational considerations relative to the legal documents to be drafted. These economic terms and conditions and other key points relative to the proposed affiliation should be documented in a term sheet and presented to both parties.

While the discussion held in Stage II should leave relatively few issues left to negotiate, final terms will be agreed upon in this Stage, and all parties should agree to the CCMA components. These provisions will then be memorialized in a definitive agreement and executed by all parties.

**STAGE IV - IMPLEMENTATION**

At this point, the CCMA is finalized; however, the core leaders of this effort should remain intact and ensure that all points of the agreement are put into effect. Moreover, this body should continue to revise these terms, and monitor adherence to the agreed-upon performance metrics as these numbers will likely serve as the basis for some compensation components.

**SUMMARY AND CONCLUSION**

Given the current healthcare environment, particularly in light of the changes brought on by the implementation of the Affordable Care Act and the rapidly developing shift to value-based care delivery and reimbursement, organizations are seeking new methods to align with their providers and community practices. Alignment often is sparked by the desire for hospitals to use the clinical knowledge and oversight brought forth by the physicians and the reciprocal desire of private practices for support and the means to survive the impending changes. Thus, a collaborative relationship such as made possible through a CCMA can establish a “win-win” for these organizations.

A CCMA provides hospitals the opportunity to partner with practices and develop clinical oversight focused on improving quality and efficiency for their given service line. Meanwhile, practices can capitalize on additional compensation incentives and potentially shared cost savings. This factor enables both entities to prepare better for and respond to changes in the healthcare industry relative to value-based reimbursement, including possibly participating in more integrated structures going forward. Moreover, a CCMA can
be pursued either as a standalone arrangement or as a complement to other alignment strategies.

There are significant opportunities on the horizon in the healthcare industry, especially as care shifts from volume to value. While this transition may seem intimidating to both private practices and hospitals, there are various other options to mitigate the risks and capitalize on these changes. The ultimate goal of any strategic initiative should be to develop a viable strategy that incorporates the outlooks of both the physicians and hospital and creates a “win-win” scenario. A CCMA can present a method of accomplishing these outcomes without losing all independence and autonomy or becoming overly capital intensive, thus driving value for all stakeholders.