

# Service Line and Specialty-Specific Clinical Integration Programs: A Novel Model for Hospital-Physician Alignment

*White Paper*



Business Advisors for the Healthcare Industry

**ELLIS “MAC” KNIGHT, MD**

Senior Vice President/CMO

April 2017

## **CONTACT**

For further information about Coker Group and how we could be of assistance, call 800-345-5829 x2021 or visit [www.cokergroup.com](http://www.cokergroup.com).

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**Abstract:** All providers, regardless of specialty are now subject to the Medicare Access and CHIP Reauthorization Act (MACRA), which puts them at significant risk for payment adjustments based on their performance across four categories of quality, cost, and other measures. Furthermore, bundled payments are being rolled out by many payers, especially by the Centers for Medicare and Medicaid Services (CMS). Several hospital service lines, particularly cardiology and orthopedic, seem to be affected most directly by CMS's move toward value-based reimbursements (VBRs).

Any service line restructuring, particularly cardiology or orthopedic service lines, should consider these new payment models and how these areas of operations might best operate in a move to a VBR environment. This paper describes how the development of a service line-specific clinical integration program (SSCIP) can serve as a viable answer to this query. Further, it will address how to go about setting up such a model of care delivery.

**Key Words:** Clinical Integration, Specialty-Specific Service Line, MACRA, Bundled Payments, CMS, Value-Based Reimbursement, Hospital-Physician Alignment, Cardiology, Orthopedic, Care Delivery, Volume to Value

## INTRODUCTION

With the advent of the Medicare Access and CHIP Reauthorization Act (MACRA) and the roll-out of bundled payments programs around several clinical conditions, the Centers for Medicare and Medicaid Services (CMS) has signaled that they are intent on meeting their goal of having 95% of payments value-based by the end of 2018.

Several hospital service lines, particularly cardiology and orthopedic, seem to be affected most directly by CMS's move toward value-based reimbursements (VBRs). All providers, regardless of specialty are now subject to MACRA, which puts them at significant risk for payment adjustments based on their performance across four categories of quality, cost, and other measures. Bundled payments have been instituted (and mandated for total joint replacement) for acute myocardial infarctions (AMI or heart attacks), coronary artery bypass procedures, total joints, and hip fractures.

Thus, any service line restructuring, particularly cardiology or orthopedic service lines, should consider these new payment models and how these areas of operations might best operate in a move to a VBR environment. This paper describes how the development of a service line-specific clinical integration program (SSCIP) can serve as a viable answer to this query. Further, it will address how to go about setting up such a model of care delivery.

## CLINICAL INTEGRATION

Clinical integration (CI) is a way of organizing providers (hospitals, ancillary service providers, physicians, and others) around systematically and simultaneously improving quality and cost outcomes in the healthcare delivery system. CI has also become a well-recognized legal term in that those who engage in CI activities have been allowed to jointly contract with payers without running afoul of anti-trust concerns, even if all the participants are not legally part of the same corporate entity.

Clinically integrated networks (CINs) are often confused with accountable care organizations (ACOs) and indeed, the two function quite similar and differ mostly by with whom they contract. For example, CMS is the primary contracting agent with ACOs, and commercial carriers fill this role for CINs. Regardless of the terminology, however, these two entities operate similarly and organize themselves around the delivery of higher quality and lower costs at the front lines of clinical care delivery.

## SHARED SAVINGS, GAINSHARING, AND CLINICAL CO-MANAGEMENT AGREEMENTS

Another similarity between ACOs and CINs is that they commonly contract under shared savings arrangements with payers, both commercial and governmental. Furthermore, specialty-specific CINs are known to contract with hospitals under clinical co-management agreements (CCMA). This type of contract involves the utilization (and payment) of providers to work alongside non-physician administrators to co-manage a service line. The providers are usually asked to focus their efforts on managing the clinical affairs of a service line while the administrators focus on non-clinical management issues. In the value-based reimbursement era, however, it is often difficult to separate management concerns neatly into clinical or administrative sectors. Instead, clinical decisions, such as prescribing patterns or the utilization of certain items in the supply chain, increasingly effect financial performance. Further, non-clinical decisions, such as the selection of healthcare information technology (IT) vendors, can significantly influence clinical performance. Therefore, it is becoming imperative that co-management models of high-profile service lines, such as Orthopedics and Cardiology, be implemented.

CCMAs often involve payments to clinical co-managers through two mechanisms. First, clinical providers are paid a fair market value wage for their administrative time. Second, clinicians receive a share of savings resulting from the management decisions they make regarding purchasing or utilization of supplies, equipment, labor, and even real estate in the delivery of care within a specific service line. While it is essential for so-called gainsharing arrangements to comply with all legal and regulatory requirements, CCMA gainsharing arrangements have been structured successfully for many organizations across the country.

Another important factor is that gainsharing and shared savings programs differ as to which parties make up the two sides to these agreements. With shared savings programs, the counterparty to the provider/co-managers is a payer (CMS or a commercial carrier), and with gainsharing arrangements the counterparty is a hospital or healthcare system. Both types of agreements work similarly, with actual spending compared to projected expense budgets, and the two parties to the agreement sharing any realized savings. Therefore, specialty-specific or service line-specific CINs and CCMAAs are analogous models that can both be used to drive higher value (quality per unit of cost) into the healthcare delivery system.

## STRUCTURING SERVICE LINE-SPECIFIC CLINICAL INTEGRATION PROGRAMS

While the functional aspects of an SSCIP are more important than its structural components, there are several important points to keep in mind when setting up this model.

First, it is paramount to engage committed physician leaders. Historically, many organizations have preferred to use physicians and other providers who are highly productive and loyal to the hospital or healthcare system's service line for this purpose. Under an SSCIP, however, the ideal provider leader may not be the most productive. Instead, the best leaders may be those who are most interested in improving quality and cost metrics and who are most capable of engaging their colleagues in such activities. Nowadays, many physicians are interested in such non-clinical activities and have formal education and training in healthcare management. Other indicators of leadership and ideal candidates to encourage to participate in SSCIP activities are individuals who demonstrate their competence, regardless of their formal education, through service to the hospital's organized medical staff.

Second, and as mentioned, the basis of the structure of the SSCIP should be compliance. Payments from hospitals and healthcare systems to physicians are always subject to scrutiny for violation of Stark or Anti-kickback statutes. Further, bringing together providers from disparate organizations can run afoul of anti-trust regulations, especially when it comes to jointly contracting. Briefly, setting up a successful SSCIP can be in complete compliance; however, it is essential to engage experienced legal counsel. Attempting to structure an SSCIP without the appropriate counsel is ill-advised. Organizational components from the aspect of compliance include:

1. Avoiding "per click" shared savings arrangements, such as situations where a provider's compensation is on a per-procedure or per-case basis, particularly those involving certain supplies, such as surgical implants.
2. Ensuring that shared savings are calculated by comparing actual expenditures versus projected expense budgets and not on a retroactive basis, i.e., expense targets should be established prospectively and providers/co-managers should be tasked with hitting

these targets by managing operations in a way that drives high quality and cost efficiency.

3. Preventing the tying of any portion of the payments to physician co-managers for referrals to the service line or its hospital/healthcare system sponsor, which may violate Stark and anti-kickback rules.

Finally, service line owners (hospitals and healthcare systems) should carefully consider the degree of management responsibility they wish to cede to physician providers under an SSCIP. It is evident that physicians are uniquely positioned to manage certain aspects of a service line's operations, e.g., OR supply chain, patient access and flow, care process design, controlling costs in a way that doesn't jeopardize quality or patient safety, etc. There are other aspects of operations over which service line sponsors should maintain managerial control. These areas include nursing services, ancillary services (lab, imaging, rehab), housekeeping, facilities management, etc. It is vital to define roles and responsibilities carefully within the co-management structure for these models to succeed.

## FUNCTIONAL/OPERATIONAL ASPECTS OF AN SSCIP

### COLLABORATING

As mentioned, an SSCIP is comparable to a CCMA, and one of the hallmarks of a co-management agreement is that, for these agreements to thrive, collaboration must occur between the hospital and non-hospital co-managers. In contrast to situations where managers are all employed by the hospital or healthcare system, SSCIPs must work through a partnership, where the co-managers come to the table for the express purpose of managing the service line in a way that optimizes value to the patients it serves. Mutual trust and respect for the unique talents and competencies that each side of the co-management structure brings to this task are crucial, and creating a shared vision and culture within the SSCIP is paramount. Some say that cultural integration is harder to achieve than clinical integration, and, indeed, the two must go hand in hand. Ignoring or disregarding one or the other will surely jeopardize the success of the overall program.

Over the last decade or so, many healthcare systems have employed large numbers of primary care and specialty care physicians. These employment agreements are becoming more difficult to manage in a way that benefits both parties. Co-management partnerships, such as those inherent in SSCIPs, that place less stress on the balance sheet than do employment agreements, may be more viable for many hospitals or healthcare systems. Additionally, SSCIP arrangements can accommodate multiple groups of providers and do not need to be limited to one practice or another in a system where there may be multiple competing specialty practices.

## CONTRACTING

Ultimately, one of the goals of an SSCIP should be to contract with payers who are now offering VBRs. The two most large scale VBR models now underway in the healthcare marketplace are MACRA and CMS's bundled payment models. An SSCIP should target both reimbursement plans, and the focus of performance improvement initiatives within an SSCIP should be around MACRA or bundled payment quality and cost performance measures. With MACRA, quality metrics specific to Orthopedics, Cardiology, or other specialties related to the specific service line should be utilized to drive performance within the service line. Also, they can be used to ensure that service line providers can use their performance measures on service line initiatives to garner payment increases from CMS. With bundles, cost reduction initiatives can be used to ensure that savings will materialize and that participating providers can receive a share of these dollars as a reward for their efforts to identify and eliminate waste and inefficiency within the system.

Notably, many commercial payers are now introducing shared savings, pay for performance, and other VBRs into the market. These reimbursement models and CMS's MACRA and bundled payment programs are similar. SSCIPs, therefore, allow hospitals to parlay their ability to operate successfully under the government VBRs into successful operations under commercial VBRs.

## MARKETING

One frequent lament from non-hospital employed providers is that the hospital, to which they are loyal, does not help to market their practice. The counterargument from hospitals is that specific marketing efforts related to a single practice on behalf of a hospital system may be illegal and unwise, as these activities may alienate those providers who not included in the marketing activities.

An SSCIP, which commonly involves robust promotion of the service line, can circumvent the above restrictions and provide a legal way for clinical co-managers to benefit from participation in an SSCIP. These efforts can then benefit all involved (hospitals and physician providers) within legal and regulatory guidelines for compliance.

Further, building a successful SSCIP that delivers higher value (quality/cost) can position the service line and its affiliated providers to capture the greatest market share of value-based contracts. This includes those contracts offered by traditional payers and those now being offered by large self-insured employers, who are looking to contract with those providers, who can deliver high-value care, directly.

## CASE STUDY

A large healthcare system in the mid-western U.S. was interested in working closely with its affiliated orthopedic providers but hesitant to take on the significant risks and expenses of employing many providers in this specialty. The hospital was also facing mandated bundled payments for total joint replacement surgeries, and all the orthopedists on staff were planning to participate in the merit incentive payment system (MIPS) under MACRA within two years.

After considering several options, the system decided to form an SSCIP around orthopedics. The SSCIP structure was developed by contracting with four orthopedic physician leaders, whose charge was to co-manage the system's service line alongside the current non-physician service line administrators. Job description and co-management agreements were developed that specifically outlined the roles and responsibilities of these individuals. Weekly meetings began for the hospital and physician co-managers to work on specific service line initiatives.

The initiatives assumed during the first year included a program designed to limit the number and costs of implants used for total joint replacements, the utilization of blood products for inpatients, and actions designed to decrease 30-day readmissions of orthopedic patients, eliminate post-op wound infections for these patients, and other hospital-acquired conditions, such as thromboembolic events, falls, and pressure ulcers.

The program was very successful after one year. Both surgeons and the hospital's orthopedic service line saw an increase in patient volumes, savings around implants and blood utilization were achieved and shared by the hospital with the participating providers and quality parameters improved across all measures.

The hospital is now considering developing a similar system for their cardiology service line.

## CONCLUSION

Hospitals or healthcare systems that want to create novel relationships with their physician providers, that drive higher value for the patients served, are well advised to consider SSCIPs. These models are likely to be desirable as more VBR models, such as CMS's MACRA and bundled payment programs, become more familiar in the marketplace. While challenges exist to establishing the necessary structural and functional elements to create a viable SSCIP, this model may prove to be less difficult and less expensive to implement than other more traditional arrangements, such as hospital employment.