Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Physician Integration Alternatives: Management Services Organizations

J. Mark Clapp & Patti Jamieson

To cite this article: J. Mark Clapp & Patti Jamieson (1996) Physician Integration Alternatives: Management Services Organizations, Oncology Issues, 11:6, 21-23, DOI: 10.1080/10463356.1996.11904646

To link to this article: https://doi.org/10.1080/10463356.1996.11904646

Published online: 18 Oct 2017.

by J. Mark Clapp and Patti Jamieson, M.S.S.W., M.B.A.

Physician Integration Alternatives: Management Services Organizations

As managed care extends its reach across the United States, physicians are increasingly concerned about potential reductions in income and loss of clinical autonomy. Managed care's emphasis on cost reduction—together with its logical consequences—is forcing physicians to seek new organizational structures that will allow them to compete in this changing health care environment. Physicians realize that participation in some type of integrated delivery system is necessary to decrease the operating costs of their individual practices as well as to provide them the means to compete for the managed care contracts that are increasingly channeling patients into prepaid medical care.

The number of integration options available to physicians are legion. Complicating the choice of an appropriate model is the fact that one's peers, often within the same practice, all seem to have their own differing opinions as to which choice is best. Making the correct decision becomes even more difficult in light of the fact that some of these options include big dollar buy outs.

Management services organizations (MSOs) are a primary mechanism for assisting physicians. They provide access to the economies of scale available to large organizations. Depending on the particular model, MSOs typically provide the physician with capital, management, staffing, marketing, planning, research, and systems support. In return, the physician pays the MSO a percentage of collections. If the MSO has purchased the physician's practice, the physician receives a base salary with potential for a bonus. Types of MSO affiliations range from the simple merger of physician practices to complete buy outs by hospitals, other physician groups, or publicly traded equity organizations.

For physicians, knowing which option is right for them depends to a large extent on their own expectations, their goals for the future, the level of autonomy they are willing to relinquish to the affiliated organization, and the degree of risk they are willing to assume to consummate the deal.

Before entering into any affiliation agreement, physicians should first ask themselves the following questions:

- *What do I expect from this affiliation?* In simple terms, how will my life be affected by this decision, and how will I measure my satisfaction with it?
- *What aspects of my practice do I want to separate from the other entities represented in this decision?* Many physicians have some aspect of their practice over which they jealously maintain control. These special areas must be identified up front so that as the deal unfolds the impact on these areas will be clear.
- *Is this decision to integrate physician- or purchaser-based?* Is the physician driving the decision because of specific goals he or she wishes to achieve, or will the overall direction be determined by the purchaser? If by the purchaser, is the physician ready, willing, and able to take direction from another management authority?
- *Is integration a short- or long-term strategy?* Once consummated, the decision becomes difficult to revoke. All too often, the decision to proceed with an affiliation agreement is reached without any thought of fall-back options.

Despite all these questions and concerns, the decision to move beyond your current organizational structure can be a positive and strategically correct move. The difference between a successful and unsuccessful affiliation rests upon the amount of effort that one puts into it and the extent of self-appraisal that precedes the final decision.

MSO MODELS

Fortunately, there are a wide range of affiliation options available to meet physicians' varying needs. These options include but are not limited to:

- Hospital-owned MSOs
- Group practice without walls
- Open physician hospital organizations
- Closed physician hospital organizations
- Comprehensive management services organizations
- Equity management services organizations
- Foundation models
- Staff models

While each model has a distinct purpose, all try to focus on controlling costs and capturing enrolled lives in managed care contracting environments. Despite the number of options available, there is no one perfect solution that represents an ideal fit for each situation. The correct organization structure is unique to each physician/group and can only be arrived at after an indepth comparison of expectations against available options.

Hospital-owned MSO. This model was originally created to assist physicians with their billing operations. It was popular with hospitals as a way of bonding and, in more progressive environments, as a way of establishing databases of compar-

J. Mark Clapp is founder of Clapp & Associates in Morrisville, Pa. Patti Jamieson, M.S.S.W., M.B.A., is director of program development at ELM Services, Inc., in Rockville, Md.

ative practice information. Beyond billing, additional services typically include practice administration, purchasing, long-range planning, and physician recruitment. In this model, physicians purchase practice services from the hospital subsidiary at fair-market value. Physicians retain complete clinical and financial autonomy from the health system and each other. The hospital seeks to gain physician trust by demonstrating its ability to increase practice revenues with improved collections and reduce practice operating costs through efficient management.

In many cases, the hospital-owned MSO never reaches its true potential, because it is run by hospital administrators who are relatively unfamiliar with the operations of a physician practice. In addition, the risk of alienating the physician through reduced cash flow brought on by poor collections has caused many hospitals to rethink their commitment to this method of bonding. However, the concept remains a viable one if the supporting organization retains an experienced MSO administrator who can provide results. Prior to entering into this type of affiliation, physicians need to assure themselves that the MSO has a successful track record and can actually produce what it promises.

The hospital-owned MSO allows for quick network expansion and maintenance of physician independence, since the physician is selecting services on an a la carte basis and is not surrendering autonomy or decision-making authority. However, this model does not address the fundamental issue of physician lock-out of payer networks. Most hospital-based MSOs focus on management and administration of practices and not on the marketing of the managed practices for contracting purposes. As an MSO gains experience, its parent may expand its role to include contracting, Usually, however, this aspect is handled by some other entity within the health care system, such as a physician hospital organization (PHO). The hospital-owned MSO is recommended for the physician or physician group that wants assistance in practice management but expects to eventually move on to a more complex integrated delivery system.

Group practice without walls. This model was established as an initial response to Stark legislation, which is aimed at stopping referrals from physicians to ancillary providers with whom they have a financial investment. Prior to Stark, it was common for a group of physicians in a geographic area to invest in labs, imaging centers, and other service providers, and then refer all their patients to these entities. By ensuring a steady stream of patients, the entity was usually very profitable, and a percentage of these profits returned to the physician investors. With Stark, these arrangements became illegal, although physicians still saw the need for consolidated ancillary service providers, particularly in geographic areas where many of these ancillary services were unavailable. The creation of group practices without walls allowed a group of physicians or practices to affiliate while maintaining separate locations. By using one provider number they met the restrictions of the Stark legislation. But by maintaining their own separate locations, they retained most decision-making authority within the local office. This loose alliance can be effective in the sharing of overhead costs and the negotiation of payer contracts, and requires no hospital involvement. Physicians in a group practice without walls yield limited authority to the larger group. However, physician autonomy is maintained at a price, since this model is more effective at managing costs than in obtaining managed care contracts. Physicians who want to benefit from the economies of scale that come from consolidating overhead operations, such as billing and administration, while maintaining a high degree of independence may want to explore this option.

Open physician hospital organization (PHO). The open PHO is a joint physician-hospital structure that accepts all members of the hospital's medical staff. Its primary function is to negotiate managed care contracts. If the PHO is successful in obtaining contracts and acts as the entity that accepts insurer payments, it may then have to expand its structure to process the premiums paid by the insurer. The open PHO is typically a shell organization and is lightly staffed. Physicians retain 100 percent ownership of their practices and usually contribute annually to the PHO to fund operating expenses. The advantage of this model is that for a relatively modest investment, the physician can be part of a larger contracting organization. The disadvantage is that the PHO does nothing to fundamentally change the physician's practice; therefore, physicians are not necessarily any more competitive than before joining the PHO. Even if the PHO obtains managed care contracts, the loose structure of the PHO does not provide a mechanism for managing the cost of care. Many PHOs establish bonus systems to reward physicians who meet predetermined care standards within acceptable financial limits. Many physicians join open PHOs in response to pressure from the sponsoring hospital seeking to obtain the largest physician pool possible.

Closed physician hospital organization. The closed PHO functions like an open PHO except that membership is offered only to a select group of high-quality, cost-effective physicians. To ensure that it is attracting and maintaining only those physicians that provide care within the parameters required by its managed care contracts, the closed PHO usually establishes more comprehensive mechanisms for credentialing physicians than its open PHO counterpart. Sometimes these data come from the managed care organizations. Other times data are provided within the PHO. With its focus on exclusivity, the closed PHO is an effective way to build an elite primary care physician base. However, it can act as an irritant to the specialists on the medical staff because it is not all-inclusive. Those physicians not allowed to participate often leave the sponsoring hospital. The closed PHO is primarily a contracting vehicle, and typically does nothing to improve the management or efficiency of the physician's office. Consequently, over time physicians tend to gravitate to models that do. At best the closed PHO represents a transition to a more advanced model.

Comprehensive management service organization. The comprehensive MSO is formed when an entity purchases a group's assets, manages its medical practice, and negotiates its managed care contracts. Included in the purchase are the practice's hard assets, including medical equipment, furniture, real estate, supplies, and

information systems. Services provided to the practice include personnel management, administration, group purchasing, office leasing, and contracting. The physician group maintains a separate legal identity and retains ownership of its revenue stream. This model is currently quite popular because it allows the physicians to turn over all the headaches of management to the MSO while retaining control over physician compensation and governance. The MSO provides the management of the office, usually through employees that previously were on the physician's payroll. This model is used extensively by hospitals in response to competition from equity MSOs. Because not-for-profit organizations cannot bid up the purchase of a group's goodwill beyond a fair market value, they find it difficult to compete head-to-head with equity MSOs. By purchasing only the hard assets of a group, they are able to provide some infusion of cash into the practice while still allowing the physicians a higher degree of independence than is found in equity MSOs.

If the comprehensive MSO is successful in providing effective management services to its physicians, loyalty to the health system is increased. Nevertheless, this model is still viewed as transitional. Physicians tend to move on to more advanced models that integrate their practices, allowing them to better negotiate and manage risk contracts.

Equity management services organization. An equity MSO is a for-profit, private, or publicly traded organization that purchases a group's tangible and intangible assets, manages its medical practice, and negotiates its managed care contracts. The revenue stream, which used to belong to the physician, is now directed to the MSO, which either takes a percentage off the top for its services or pays the physicians a predetermined compensation and keeps the rest. The physician group may retain a separate corporate identity or become W-2 employees of the MSO or parent company. When the state in which the physician practices prohibits a business corporation from employing physicians (known as corporate practice of medicine), a separate professional corporation is established. This organization is owned by and employs the physicians but is contractually bound to the MSO for management services. This contractual bond is strong and essentially gives the MSO control over the professional corporation. The equity MSO provides the physician with an alternative to unilaterally affiliating with a single hospital or health care system.

An equity MSO provides the advantages that come from economies of scale and broad-based experience. By the time an equity MSO is ready to acquire a practice, it has usually developed a track record for successful management of physician organizations. The disadvantage of this model is that the equity MSO can be a risky option, since the MSO is subject to fluctuations in the stock market as well as the mergers and acquisitions occurring within the industry.

Foundation model. The foundation model is a truly integrated model. This large-scale, fully integrated entity involves a not-for-profit subsidiary of a health system that purchases the tangible and intangible assets of a physician's practice. Physicians remain employees of a separate professional corporation but sign a professional services management agreement with the foundation. This model is often used as an alternative to direct employment of physicians, which some states prohibit under corporate practice of medicine laws. The main difference is that the physician becomes affiliated with a health system that can negotiate for both hospital and physician services.

In many respects this is the not-for-profit institution's alternative to the buy-out of a physician's practice by an equity MSO. Both tangible and intangible assets of the practice are purchased by the foundation. Through ownership of the physician's practice, the foundation can invest liberally in the practice and allow physicians a share in the resultant revenue growth. Since 100 percent of the group's revenues come from the health system, physicians tend to support a shared destiny.

While physician autonomy is retained to the maximum extent possible, there is the potential for physician infighting. This is typically found in models that are heavily dependent on specialists but whose ultimate business objectives are focused on building a primary care delivery system. Because the model depends on tight integration, individual physician needs are sacrificed for the greater goal of the foundation.

This model is excellent for those physicians who are committed to hospital/physician integration as the way to control costs and obtain managed care contracts. When joining a foundation model, the physicians in many respects are moving beyond the limits of a physician organization and into the arms of an integrated health care system.

Staff model. In the staff model, physicians are direct employees of the acquiring entity. They sign employment contracts, earn a negotiated salary with perhaps a performance bonus, and usually work on a negotiated schedule. This model offers more direct control over physicians by the employer through management of salaries and the ability to intervene one-on-one. However, physician productivity can suffer if appropriate productivity and incentive compensation plans are not put into effect, particularly for a physician who has spent extraordinary hours working to build a practice. Once he or she has sold that practice to someone else, the incentives are usually to enjoy the proceeds of the sale and develop a more stable personal life. This model works well for someone who wants only to care for patients, is not interested in becoming involved in the management of the practice any longer, or is approaching retirement and sees this as a way to transition out of the practice.

FINAL WORDS

As health care costs skyrocket, both employers and insurers are searching for ways to provide more cost-efficient models of care. Organizations are springing up to provide the skills and data management systems necessary to compete, and physicians are flocking to them. Which model the physician selects is more than just a matter of personal preference. It is the result of a detailed, well thought-out approach to the future of one's practice. With proper planning and a clear understanding of both short- and long-term objectives, physicians can move into the future and take advantage of the opportunities that this revolution in health care is creating.