

# ❖ Strategic Use of MSOs ❖

By Charles Bond, Esq.

**M**anagement services organizations (MSOs) are a key component of physicians' strategic planning for the future. The following are answers to fundamental questions about MSOs and a pro-physician strategy.

## What changes in health care economics are forcing physicians to reorganize their practices?

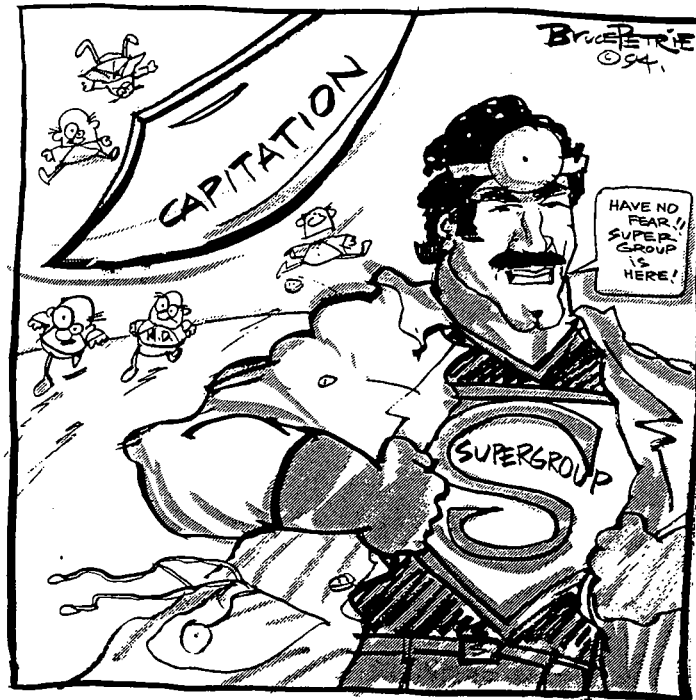
First, health care reform has been born of the crisis of compassion versus the crisis of cost. As a country, we are in the paradoxical position of demanding more health care for a demographically aging population even though there will be less money in the system. Accordingly, physicians must reorganize their practices to achieve greater efficiency.

At the same time, managed care is imposing upon physicians the most revolutionary change any profession or industry can undergo—a change in the way they are paid. With great determination and speed, the health insurers of America, as well as federal and state government payors, are shifting from fee-for-service payments to capitated reimbursement.

In a capitated payment system, physicians receive a fixed sum for each patient every month, regardless of whether the patient receives treatment. Thus, physicians profit during months when fewer services are rendered and lose money when the costs of treatment exceed the monthly allotment.

As a result, the assessment, management and absorption of the patient's health risk now falls to the providers. How well physicians handle that risk will govern how profitable they will be under a capitated system. Consequently, physician groups need to have access to the data, computers and actuaries which third-party payors use to evaluate and manage the risk. Thus, managed care—as its name implies—imposes the need for a new level of management into the practice of medicine. The provision of these management services is obviously an important part of the work of an MSO.

MSOs also help provide the structure for building physician-driven health care delivery systems. As third-party payors and purchasers of care join forces to drive down the cost of health care, physicians need to meet these forces by banding together at



the grass roots level to form organizations with real negotiating clout. Physicians need to become price-makers not price-takers. They are recognizing that their best strategy is to form local integrated groups or clinics-without-walls, professional corporations whose physicians continue to practice in their own offices, and network them into large, geographically diverse groups, or so-called supergroups, supported by physician-owned MSOs.

## What is an MSO?

An MSO provides physician groups with the management services necessary to function as a group in today's

complex medical environment. Full-service MSOs manage all non-medical aspects of the group's medical practice, allowing physicians to focus on providing medical care to their patients.

- MSOs are the vessels for raising capital to form medical groups and ultimately whole health care delivery systems;
- MSOs are the vehicles for managing managed care as they provide physicians the management necessary to assess and negotiate the health care risk being forced on providers;
- MSOs guide physicians through group formation and the reorganization toward greater efficiencies; and
- MSOs provide day-to-day management of the group, spearheading the attack on high physician overhead through group purchasing, centralized administration and the achievement of economies of scale.
- MSOs provide the over-arching structure that assists physicians in forming comfortable local groups, then networking them together to create a larger regional or statewide negotiating unit, thereby preserving the local character of medical practice while building substantial negotiating clout for member physicians.

## Why are physicians forming MSOs?

Physicians want to control their own economic destinies and collectively retain their professional autonomy. They are beginning to realize that they have far more power than they previously imagined to direct the future of the country's health care choices. Whether the health care system is rearranged by market forces, such as managed care, or by governmentally

imposed health care reform, physicians will remain the patient's point of contact with the medical system (i.e., physicians direct the patient's diagnosis and treatment) and the reimbursement system (i.e., physicians direct the economic course of the patient's treatment and document and justify the choices). The reorganization of the health care delivery system, therefore, should logically be centered on physicians. The choice for physicians is manage or be managed, or more accurately, own or be owned. MSOs are an organizing force for physician empowerment.

### How are physician-sponsored MSOs structured?

Because of the power of the MSO over physicians' livelihoods, physicians should insist on physician control of their MSO. Ideally, the majority of the MSO stock should be owned by the physician group it serves (i.e., the professional corporation or IPA whose management services the MSO renders). Ownership of the professional corporation, in turn, should be extended to all physicians working for the group, thereby spreading the benefits of MSO ownership to all whose services make the group and MSO possible.

The stock of the professional corporation or group should, in turn, be democratically owned by physicians working in the group and not held by a few entrepreneurs. I strongly advise that the medical group be organized on the principle of one doctor/one vote, with the physicians electing the group's board of directors, which in turn elects the group's majority of positions on the MSO's board of directors. Democratic ownership of the group and group ownership of the MSO ensure broad-based physician control at all levels of decision-making.

Control of the MSO is critical because it negotiates terms of the group's contracts (i.e., the physicians' revenue source) and frequently controls the physicians' revenue flow by controlling billing and collections. The MSO is also responsible for the management of all non-medical aspects of the group's medical practice. Medical group ownership of the MSOs stock assures that the group controls its own management.

### What are the advantages of a physician-sponsored MSO?

**Capital-Raising Power.** For-profit MSOs can raise capital to manage the medical group it serves. In a physician-sponsored MSO, the majority of the capital comes from the medical group, thus assuring that the medical group holds a majority of the stock in the MSO. There are numerous ways to finance the group's purchase of the MSO stock, including partial bank financing.

If the physician-sponsored MSO is structured as a for-profit corporation, it can raise capital from outside sources as well. These outside sources of investment need not be hospitals, third-party payors or others whose agenda may be to exploit or control physicians. Instead, there are many potential physician-friendly investors who can invest without threatening physicians' autonomy and without affecting patient care.

Furthermore, once formed, the MSO can be structured to raise additional money from the public market (e.g., by a public offering). This additional capital can be used to acquire other health care components (such as surgi-centers and home health agencies) and, ultimately, to finance direct contracts with purchasers of care (e.g., direct employer contracting). In the long run, MSOs represent the vehicle for capitalizing the creation of a physician driven health care delivery system.

**Lowering Physicians' Overhead.** With lower reimbursements a virtual certainty under managed care, an MSO whose loyalties lie with its physicians can and should use every possible means to help physicians lower their overhead. Accordingly, group purchasing, centralized administration, self-insurance pools and every economy of scale should be used to lower costs. These savings can be quite substantial. The cost-saving benefits of group purchasing alone justifies the creation of MSOs, even in totally fee-for service environments.

**Collective Bargaining.** When an MSO is coupled with a large integrated group, it can negotiate on behalf of the member physicians as equals at the bargaining table with hospitals and third-party payors. Collective negotiating clout depends upon the number of physicians in the group as well as the group's structure. An integrated professional corporation (as opposed to an IPA) can prevent competition from within. Unlike an IPA, which is made up of independent practitioners, a professional corporation can insist on solidarity by its members and thereby achieve real collective bargaining power. In an IPA, the third-party payor or the hospital can "go behind the back" of the group and negotiate with individual members. The IPA structure,

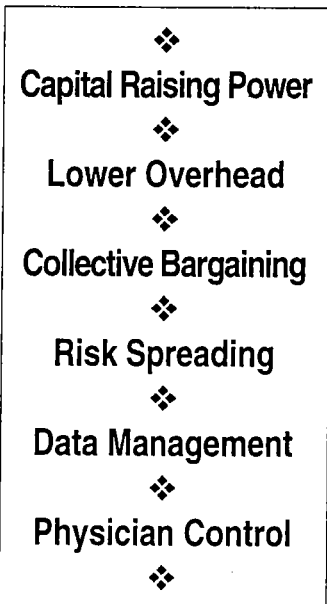
therefore, will always give hospitals and third-party payors the upper hand. For negotiating clout, physicians need to integrate into a professional corporation.

**Risk Assessment and Risk Spreading.** As third-party payors use capitated payments to shift more and more risk to physicians, physicians will need access to the means of managing and spreading that risk. MSOs affiliated with large groups will provide those means.

**Data Management.** Physicians need sophisticated management information services not only for quality assessment and utilization review but also for effective contract negotiation. By generating and controlling the information upon which the negotiations are based (or being able to effectively audit the other party's data), physicians will have far more power. To assess risks, detect trends and manage managed care, physicians will need data

banks and information systems that are beyond the means of even medium-sized groups. Management information systems cost more than one million dollars. An MSO serving a large group of physicians can afford such a system.

**Physician Control of Credentialing, Quality Assessment and Utilization Review.** Under managed care, the medical group's profitability will depend heavily on strong credentialing,



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### Choosing a partner

If you choose to find partners to share start-up costs, choose carefully. The medical group must come to the table as an equal partner to ensure that the new partnership is collaborative rather than adversarial.

There are sound financial reasons for going to the table with strength. Capitated environments have risk pools, and because substantial dollars are at stake, it is important to determine who shares in the risk pool and how it is divided among the parties.

When a risk contract is negotiated, the risk pool is based on a targeted number of in-patient days. For example, if the targeted number of in-patient days is 200 per 1,000 population and the negotiated rate with the hospital is \$800/day, the risk pool will have \$58,400,000 (200/days x \$800/day x 365 days per year) out of which in-patient stays will be paid. If the in-patient days are carefully man-

aged by the physicians and only 180 days are utilized, withdrawals from the risk pool will be \$52,560,000 (180/days x \$800/day x 365 days per year) leaving in the pool \$5,840,000.

Without effective and tight utilization, in-patient days could exceed the target of 200, and in a true risk pool, those who share in the pool would be liable for the shortage of dollars. This is a compelling reason for a good claims tracking system and tight utilization management.

In summary, physicians must understand the managed care arena very well. They should choose skilled advisors, finance their own emerging group and choose their partners carefully. □

*Sally Holloway is a partner in Entremed, a northern California health care consulting firm specializing in positioning physicians in the managed care arena.*

### Capitation Rates for HMO Plans

*Data was derived from a California IPA with 200 physicians and 12,000 patients. It has been in business for more than five years.*

Primary care physicians (PCPs) are pre-paid based on the number of members assigned to the physician each month. Capitation is based on age and gender adjusted rates. Capitation is payment in full for all non-surgical services.

For all in-office surgery, PCPs are paid on a fee-for-service basis according to the pre-determined specialist reimbursement schedule. They are reimbursed at cost for supplies and materials at a set rate for specified immunizations.

All referrals to specialists come from a PCP. Primary care is defined as Family Practice, Internal Medicine and Pediatrics. In some groups, Ob/Gyn is included.

Restricted services (as defined in the guidelines) must be authorized by the Utilization Review staff.

Example of capitation rates: (rounded to nearest .50 or 00)

Age 0 - 2	\$ 44.00 per member per month
Age 2 - 16	\$ 8.50 pmpm
Age 17 - 65	\$ 8.00 pmpm
Age > 65	\$ 14.50 pmpm

When referral is made to specialists, reimbursement is based on the following conversion factors times the 1974 Relative Value Scale unit values. (rounded to nearest .50 or 00)

Medicine	\$6.50	Surgery	\$140.00
Anesthesia	\$39.50	Radiology	\$11.00
Vaginal OB	\$1,400.00	Laboratory	30%
C Section	\$1,600.00		

Procedures without RVS unit values are paid at 70% of the billed charges.

### MSOs (continued from page 29)

quality assessment and utilization review. These are functions the MSO can and should help physicians provide. In the short run, having physicians in the group perform their own QA and UR means more physician control over clinical choices and less frustration in daily practice for physicians; physician-directed UR and QA also provides a more attractive marketing package for the group when negotiating with third-party payors. In the long run, these functions can be coupled with the MSO's management information services to develop outcome measurements and practice guidelines that are developed by physicians and not imposed by payors, governmental regulators or hospitals.

#### Are there business advantages for physicians in setting up MSOs?

Yes. One significant advantage is the preservation of the value of the physicians' medical practices. Currently, individual medical practices are worth very little. When combined in a group, however, practices are worth much more. The larger the group, the greater the value.

MSOs create a vehicle for realizing the equity potential derived from membership in a large group. For example, the Mullikin Group recently sold 25 percent of its MSO for \$50 million. Another MSO has achieved liquidity for its stockholders by going public.

#### Since physicians are often perceived as having difficulty working and organizing together, can they be successful running an MSO?

When professional survival is at stake, physicians will organize and stand united, just as they did during the malpractice crisis of 1975. At that time, the commercial malpractice insurers abandoned the market, leaving physicians to shoulder the risk; the physicians rallied and assumed the risk quite well with physician-sponsored malpractice companies. A similar set of forces is at work today. Physicians are being asked to assume new risks and the physician-sponsored MSO can help physicians take their economic destiny into their own hands.

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### Who should capitalize an MSO?

A physician-sponsored MSO should be primarily capitalized by the medical group it serves, thus ensuring physician control. Additional minority capital can be contributed by investors and, in some cases, by vendors providing services to the MSO.

When hospitals capitalize MSOs, they expect to control them even though they have no experience or expertise in managing medical practices. Plus, there are inherent conflicts between hospital and physician interests in a MSO. Economically, within the framework of capitated contracts, there is a conflict about how the capitated dollar will be divided between hospitals and physicians. There is frequently

a substantial difference in the capitated rate a hospital gives a physician-sponsored group and the capitated rate the hospital charges a captive physician group.

More subtly there are potential conflicts in how the comprehensive care pack-

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### Be wary of giving control to any entity that is not physician-controlled.

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age is put together. The use of surgi-centers, home health care and other non-hospital alternatives may be in the best competitive interests of physicians and their MSO. If the hospital is a party to

these negotiations or in any way controls the utilization or reimbursement of non-hospital alternatives, there may be subtle disincentives to their effective use.

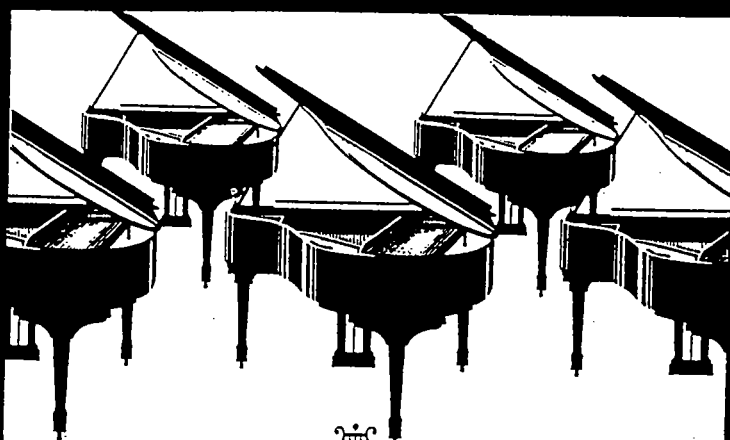
From a marketing standpoint, physicians should be wary of hitching their wagon to the hospital's star. If the hospital is not attractive to a third-party payor, the physician's alliance could cause the physician to lose a contracting opportunity. In a worst case scenario, the hospital may not survive in this competitive environment. Therefore, physicians should retain maximum marketing flexibility.

Physicians should also avoid hospital capitalization of their MSO because of numerous potential legal complications (e.g., private inurement, as well as fraud and abuse regulations). Furthermore, interjecting hospitals into the MSO structure is dangerous. As the physicians' agent, the MSO negotiates terms of managed care contracts, which can control the physician's income. If the MSO also does billing and collections, then it can control both the source of physician revenues (contracts) and cash flow (collections).

Be wary of giving control to any entity that is not physician-controlled. Some MSOs are structured so that hospitals and physicians share ownership on an equal basis. Aside from any question of conflicts of interest, 50-50 relationships are difficult to manage. Neither side has control, but both sides have veto power.

Furthermore, from the physician's point of view, when the hospital owns 50 percent of the MSO, it exerts practical control because physicians often do not have a well-developed corporate sense. The hospital's directors usually attend board meetings and vote as a block, whereas physician directors often cannot make key meetings because of emergencies, patient demands, etc. Even if the physician directors do attend, they usually do not vote as a single block. There have also been instances reported in which the hospital subsequently employs the MSO's physician-directors, thereby coopting them.

Accordingly, I do not urge power-sharing arrangements. Physicians and hospitals should be linked by contract, not by control. Their interests are complementary and parallel, and they should remain parallel, not vertical. Verticality allows one to control another, and control should not be a part of the physician-hospital relationship.



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### Must physicians turn over their assets to the MSO?

Most hospital-based MSOs require sale of the physician's assets to the MSO so that if the physician leaves the group or is terminated, the physician is left with nothing. This can devastate physicians, and any physician considering parting with his or her practice should have his or her own independent lawyer and accountant review the deal carefully.

In a pro-physician MSO, the physician's practice assets need not be turned over to the MSO immediately but may be incrementally integrated into the medical group. For example, the MSO might lease equipment from the physician until it is eventually purchased from for a nominal sum. If the arrangement does not work well, physicians can opt out with their practice assets intact.

With this flexible approach, the physician's membership in the clinic-without-walls or in the supergroup resembles membership in an IPA. In fact, because of its flexibility most strategic planners consider the clinic-without-walls or supergroup to be the next generation of IPA. The increased sharing of risk required by managed care is moving IPAs toward tighter and tighter integration. Using a clinic-without-walls or a supergroup structure, integration can occur gradually and with minimal disruption to the physician's practice arrangements.

This evolution to clinics-without-walls or supergroups appears to represent the best strategy for physicians to position themselves for the coming changes of managed care and health care reform. Indeed, this evolution presents a substantial opportunity for physicians using MSOs, which they control, to develop their own doctor-driven health care delivery systems which will assure their proper place in the future of patient care and overall health policy in America. □

*Charles Bond is an attorney and strategic planner from Berkeley, California. For nearly 20 years he has advised physicians and medical groups nationwide in all aspects of practice organization and management. He has been actively involved in the development of physician-driven health care delivery systems and other strategies for physicians dealing with managed care and health care reform.*

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