



## **THE MANAGEMENT SERVICE ORGANIZATION AND ITS ROLE IN INTEGRATED HEALTH CARE DELIVERY SYSTEM DESIGN AND DEVELOPMENT**

The Management Service Organization (MSO) is an administrative structure used to manage and direct the activities of a Group Practice Without Walls (GPWW).

### **WHAT IS A GROUP PRACTICE WITHOUT WALLS?**

It is the delivery system for ambulatory care that is designed to permit independent and small group practices to operate like large multi-specialty group practices.

### **WHY?**

Large group practices are able to commit to agreements with private payers to increase dollars and market share. This ability allows for the large group to manage capacity for expanded inpatient services and reduce duplicated costs of individual private practices. There is also evidence to support that the group practice collaborative process is more cost effective, because as a group, it insures better rates of successful diagnosis. It is also able to maintain consistency of quality to large volumes of patients, because it assures more consistent outcomes. It is also convenient for consumers, because it operates with a variety of services available at specific locations. It is in a stable environment for physicians and patients, because it has a better chance of long term survival as an operating business. Finally, the group practice can meet and anticipate the needs of the market because the group has access to recruitment markets that private physicians cannot enter, which means that the group practice also has access to large amounts of capital, because of its consistent private payer income sources. This means that the Group Practice Without Walls individual practices could enjoy these same features and strengths, without giving up total autonomy as an employee of a corporate entity or a hospital.

### **HOW DOES THIS WORK?**

Individual physicians or partnerships come together in a loose-knit form to discuss common issues. These issues may be philosophical, in terms of wanting to redefine managed care in their service area or technical problems, such as expenses for billing services, staff overhead, and other costs that could be pooled into a physician-owned organization.

## **WHY SHOULD THIS BE A PHYSICIAN-OWNED ORGANIZATION?**

There are some GPWWs being proposed by hospitals that are just another form of acquiring practices and putting them on salary to work for the hospital. In the absence of a physician initiative, this may be the only alternative for many primary and some specialty care physicians who wish to get out from under the hassle of daily practice administration, but are unwilling or unable to relocate. Our experience with these hospital-owned ventures is that it separates and fragments medical staff into the haves and have-nots, and the purchase price offered by the hospital does not accurately reflect the 10 or 20 years of training and effort put forth by successful physicians. Most experienced hospital administrators see the value in supporting a local team of physicians who determine their own leadership and governance rules, as well as membership and selection criteria. In other words, it is a buffer to operate the physician organization.

## **WHAT'S THE NEXT STEP IN SETTING UP A GROUP PRACTICE WITHOUT WALLS?**

The physicians need to determine a common mission that should state a purpose and attitude of why they are choosing to work together and set forth points as to why they are unique as a group from other physicians in a region or local area. This bond may be based on the type of specialty they practice, or may be a common attitude concerning the future practice of medicine, or simply a need to create a better leverage with third party payors. This mission is formalized into a set of bylaws and reflected in articles of incorporation for a for-profit or not-for-profit corporation. A core group of leaders are nominated and selected by the group to act as officers of the corporation.

## **WHAT'S THE HARDEST PART OF THIS STEP?**

Finding doctors who will subordinate their own self-interest to the group and elect a team of their peers to guide the effort of the many. If this is not done, then the group will never make a decision or create a recommendation for ratification by the group.

## **IN OTHER WORDS, IT'S NOT JUST A BIG COMMITTEE?**

That's correct. A GPWW is an entity designed to deliver care to a segment of the patient population by a panel of specific physicians with a common vision. It is not a committee.

## **WHY IS THIS HAPPENING NOW? HOW ABOUT THE MSO?**

Right now, a private practitioner is faced with more risk than at any time in history. Everything from OSHA requirements to government pay systems for Medicare, to managed care, there is a need to trim operating expenses and pool resources, or face potential extinction as an independent. The future will favor the practitioner who can operate under capitation or under RBRVS, and still generate a profit.

## **IN OTHER WORDS, TRIM THE OPERATING EXPENSES TO MAKE A BIGGER**

## **PROFIT?**

That's part of the goal of most Group Practices Without Walls, but the real key here is that pooling resources creates capacity. Capacity to see more patients, yes, but also capacity to have time at home with the family, or pursue additional clinical studies, or even prepare for an alternative career, once the practitioner nears retirement. In short, it creates options for the practitioner versus feeling overwhelmed or out of control due to the desperation of a situation.

## **SO THE MSO ENABLES THE PRACTITIONER TO LOWER OPERATING COSTS, TO BE ATTRACTIVE TO PRIVATE PAY ARRANGEMENTS, AND ALSO BUILD CAPACITY THAT GIVES THE PRACTITIONER MORE OPTIONS FOR THE FUTURE?**

That's correct, and I want to underscore the fact that there are as many types of MSOs as there are doctor groups and Group Practices Without Walls.

## **YES. LET'S HAVE SOME EXAMPLES.**

### TRADITIONAL

There are the old-fashioned groups that make the decision to sell their practices to this group entity and then run out and get a medical office building to operate in. The partners operate just like a law firm or management consulting firm, with senior level and junior level buy-ins, and when a partner retires, they sell the stock back and get a retirement bonus in addition to the years of production minus expense formulas that have guaranteed the practitioner an income. In these cases, you could buy in for about \$5,000, financed by production withholds, and at the end of, say, 20-25 years, you could retire out with a lump sum and an annuity that can be close to the average of the last 10 years' production of revenue. In other words, \$400-500,000 would not be uncommon.

### NEW AGE

There is the New Age Group that operates like a franchise, where you sell some or all of the assets and practice operations, for a fee, back to the practitioner who gets to pool retirement and earn bonuses, based upon production goals. This is like an income guarantee against earned receipts, and many hospitals use this similar formula technique when they're setting up relations with physicians.

### MENU

Then there's the menu approach that gives groups options as the practitioner matures through professional lifestyle changes. That is to say, the practitioner may decide to buy some services from the GPWW through its MSO but not sell its practice. The physician next to him might say he needs to have his operations managed by the MSO but does not want to integrate or consolidate his income. The physician next to him wants to sell his practice

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against an income guarantee, but wants greater voice in the MSO operations because he has transferred the control to the MSO as his manager; and the fourth physician may decide to buy limited clinic consulting services or managed care negotiation services, but really does not see a need, at least at this point in his life, to become more involved.

At specific time periods, people can opt in or out of agreements, depending upon their level of agreement within the GPWW.

### **IS THERE A PENALTY?**

Sometimes they may be required to sell back some or all of their stock if they refuse to move on a specific date, or if they want out of a specific service, but that's the risk.

### **SOUNDS LIKE THIS MSO COULD BE ATTRACTIVE, BUT DON'T YOU NEED STAFF AND COMPUTERS, AND OTHER RESOURCES?**

The answer is yes, and most of the time the start-up costs can come from a commercial note that each physician signs with the bank, or a loan from the hospital, or a combination of both. The ongoing revenue to the MSO comes from a percentage of practice revenue, or the savings created by the MSO versus the practice indicators of the practice before it joined the GPWW.

The percentage savings, like dropping doctors' expenses by 25%, and some portion of this goes to the MSO, and some portion back to the GPWW for income distribution.

### **SO BASICALLY, THE GPWW OPERATES WITH LITTLE EXPENSES BUT ACTS AS THE INCOME DISTRIBUTION AND INVESTMENT VEHICLE, WHILE THE MSO IS A SERVICE BUREAU THAT OPERATES SUCCESSFULLY BY CONSOLIDATING EXPENSE?**

There are tax rules and employee retirement rules, as well as rules concerning administrative loans and services, but you have the concept exactly right.

### **I HAVE HEARD THAT SOME PHYSICIAN GROUPS JOINT VENTURE WITH THE HOSPITAL FOR PRIVATE PAY NEGOTIATIONS, OR TO LEVERAGE MANAGED CARE COMPANIES BY USING THEIR MSO AS THE CENTRAL REPRESENTATIVE OF THE PHYSICIAN GROUP, AND PREPARING AMBULATORY CARE PRODUCTS FOR INDUSTRY AND INSURERS.**

That is, in many cases, a leading theme of the GPWW, and the consolidation of all managed care negotiations under the MSO is not uncommon. What's happening is that as managed care gets more pressured to cut costs, and as the White House works more towards reform, the coupling of hospital and physician billings together becomes the product of the future, and physicians who are organized and can work with their hospital counterparts to

present a leading edge product while working towards expense reduction and income enhancement, have an opportunity.

This joint venture is a physician hospital organization or PHO. It should be pointed out here that if HPO is a corporation the hospital owns and subcontracts the ambulatory care to physicians through an IPA arrangement. This is a totally different entity than a PHO, where the physicians have equal rights to review each private payor agreement or decline agreements based upon criteria set by the GPWW board.

### **THIS SOUNDS POWERFUL. BUT LET ME ASK, CAN A PHO BE AN MSO?**

In some cases, the two entities are separate, and in some cases, the GPWW buys its services through the PHO, which again, is governed jointly by the physicians and hospitals.

### **UNDER WHAT CIRCUMSTANCES SHOULD AN MSO BE USED INSTEAD OF A PHO?**

There are some situations where the physicians do not feel confident about a full joint venture with the hospital, so the MSO becomes an excellent transitional vehicle between the physicians, and acting as an organized group for managed care negotiations, as well as clinic management.

### **HOW ABOUT THE REVERSE? SHOULD A PHO DOMINATE THE MSO?**

There are hospitals that really have very good practice management and physician relations staff. They have already negotiated bulk discounts on everything from cellular phones to computers, and usually have technical staff that can install and support the office management systems. I guess the question you are really asking is what services would physicians not buy from a hospital? The answer depends on the intentions of the physicians and the values their group culture is trying to inspire. For instance, if autonomy, as a separate medical group is a goal, then giving the billing system for their practice to the hospital will probably create a conflict, as will merging in retirement benefits supervised by a hospital.

### **SO THE GPWW IS GOING TO NEED SOME STAFF, REGARDLESS OF WHETHER AN MSO OR PHO IS PLANNED?**

Yes, and I know what you're going to ask. You're going to ask me about dollars. Let's say a clinic administrator is hired. The background for a group practice manager, and the years of experience it takes to learn many of the issues that are involved with group practice management, can vary, and the average compensation package depends a lot on what the intentions are of the group, in terms of having someone who is a tremendous practice

manager, or someone who is a tremendous financial person, or someone who is a very good managed care negotiator. On the average, group practice administrators are paid about \$82,000 per year, plus benefits and moving expenses. That is, of course, if you have to recruit out of town. There's a secretary and a budget for consulting on such things as practice assessment, retirement, legal accounting - all important things to budget for. In addition to that, you need an office for them to be in; usually you have an office of 3 or more, and when you get that all added up, you are running about \$265-275,000. Now, if you have 10 practices, and let's take a standard internal medicine practice whose gross receipts are about \$250,000, then you have \$2.5 million to work with. Your administrative start-up is not difficult to finance, realizing that within one year, the overhead will be financed by the consolidated overhead of 10 or more practices. The economies and breakeven point are always difficult to guarantee, because it depends so very much on the market and how many physicians are willing to move with a single-minded determination in this specific direction. The ultimate return on investment is to have all 10 or 20 practices jump at once, because you can get instant cash flow to the company, and the market changes cannot sabotage your decision making. But reality is usually a step-by-step process.

#### **WHAT ABOUT COMPUTERS AND ACCOUNTANTS AND A MEDICAL DIRECTOR?**

Computerization is half a generation ahead of most businessmen, and medical claims and billing is about two generations behind where it could be. What I am saying is that the services needed to run 20 offices could be networked and done on a cost per claim, or percentage of recovery, meaning there is no need for enormous computers sitting in the next room for the administrator to look at. This can be negotiated. All that needs to be done is to have trained office staff at each of the physician offices, so they can submit bills to a central claims office in a uniform manner, and then the group administrator submits and verifies all the submissions for payment and recovery through a standardized credit policy that's agreed to by the group.

#### **WHAT ABOUT COMPUTERS IN THE DOCTORS' OFFICES?**

All they need is a modem. If they do not have state-of-the-art in terms of hardware, then the group negotiates the price with the biller as a group, and takes the old computer away as an asset, and sells it to another member of the group or recycles it through a charitable donation and it is taken as a tax deduction if the group is, in fact, a non taxable group.

#### **ARE THERE ADVANTAGES OF TAXABLE OR NON-TAXABLE GROUPS?**

The group can be the means towards capital formation or the MSO could be a vehicle to raise capital for the group. You need to answer the question, what are you going to do over the

next 5 years? That will tell you how much capital you actually really need. For example, if you are going to go for bonds to raise a medical office building owned by the partners of the group, then you need to structure the group accordingly. If the MSO is permitted to be a service bureau to several groups, not just yours, then you will need money for staff and offices and computer cabling, etc. If you want a nice, home-grown delivery system that covers a specific network of doctors' offices, you can probably send a good message to the community that your MSO is not-for-profit, and any retained earnings of the medical group goes to adding physicians or funding retirement. A not-for-profit taxable entity could accomplish this. The lawyers are more important in this answer, but the question he or she will ask is, "What do you want this company to do, and how quickly?"

**LET'S SUMMARIZE: THE REVENUE IS THINNING, AND GROUP PRACTICES ARE AN ATTRACTIVE MEANS FOR MANAGED CARE COMPANIES TO MAKE ARRANGEMENTS FOR THEIR PREPAID POPULATIONS. IN THE EVENT THAT AN INDEPENDENT PRACTICE PHYSICIAN WANTS TO FORM A GROUP AND COMPETE EFFECTIVELY FOR PRIVATE PAY DOLLARS, THERE ARE SOME COSTS AND SOME LIABILITIES, AND MOST IMPORTANT, THERE ARE SOME PHILOSOPHICAL ISSUES THAT HE OR SHE NEEDS TO WRESTLE WITH TO GET THE GROUP GOING.**

That is correct. The real issue here has to do with directions. In my work I have found that there are really four key elements that can make or break an MOS or a GPWW.

#### **WHAT ARE THOSE ISSUES?**

Leadership and governance is the first and foremost that comes to mind. The group-think process is very important for physicians but is very difficult, because, again, they must subordinate their own self-interest to a core group of their peers, otherwise they will form a committee and they will never get work done. This means that there needs to be some accountability between each of them, kind of a peer accountability, but there also needs to be some responsibility invested in terms of various group activities, committee work, all of that type of arrangement.

#### **YOU MEAN, EVEN AFTER YOU'VE HIRED AN ADMINISTRATOR THERE IS STILL WORK FOR THE PHYSICIANS TO DO?**

Yes, indeed. A group practice does not function because one administrator is hired, or a secretary, or any number of staff. A group practice works because the physicians are willing to spend some time and invest some time in learning about some of the issues which make them better both as a practitioner as well as a business person.

#### **WHAT ARE THE OTHER ISSUES?**

The second issue is really a view of the environment. One of the most important things in group practice management is that unless the group thinks in a strategic sense and is able to interpret things, such as performance or trends or the effects the environment will have on the medical group and its long-term direction, then there will be no change, and the group practice could sabotage its sincere intent by not being able to stay ahead of the needs of the market. There are issues such as does the group need marketing services or not? Which managed care company to sign up with? What is the definition of efficiency and effectiveness, and how should performance be rewarded? These are all group-think areas that need to change over a period of time, because the group, and/or its environment will change.

### **WHAT'S THE THIRD ELEMENT?**

The third element is reimbursement. This ties to the fact that performance payment systems, as well as what performance is, has to be linked to some sort of a paid program, and if, in fact, the entire group practice has a production-based mentality, the managed care environment will contradict all of the sincere efforts of the medical group.

### **HOW DOES THIS WORK?**

In terms of building capacity through reduction of medical group expenses, the freedom a physician enjoys can be applied to a number of areas, not the least of which is in the area of seeing more patients. If the managed care company's incentives are based upon a reduction of the number of services rendered per patient, then the physician who is using their capacity to create more production may, in fact, cost the group, not add to the group's revenue base. By the same token, if the physicians clearly understand capitation, that is, what they're at risk for and what they are not at risk for on a per-patient, per-member, per-month basis, then, in fact, they have a standardized protocol that is used not just for the capitated patients, but also for all fee-for-service patients. That allows the physicians to determine what their performance and their outcomes have been over a period of time, with each individual case.

### **WHAT IS THE FOURTH ISSUE?**

The fourth issue is pooled compensation and retirement, and this relates to not just standard fee for production or fee-for-service, nor does it relate to profitability per group practice physician. It relates to really the lifestyle of the group.

### **CAN YOU EXPLAIN THIS MORE THOROUGHLY?**

Each of the physicians in a group practice setting go through various lifestyle changes, based upon their age, or their maturity level, or their ability to emulate, perhaps, a physician or

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group of physicians, that they admire. That is, a senior practice may decide to hire junior physicians and bring them into the Group Practice Without Walls, but the needs of the group practice physicians that are in their senior years, may have to do with retirement and perhaps even time off for medical leave, whereas, the younger physician is looking for time off with his or her family, or the ability to travel, or the ability to perhaps determine whether they should develop a sub-specialty in various areas. All of these things can conflict unless there is a clear understanding and respect for the fact that age differences, maturity levels, and the ability to think in a group fashion, really affect one another. As a physician grows into his 40's and 50's, he/she starts looking at his family growing, he starts to look at building his security, and he may decide to cut back on production a little bit to be able to, again, look at other options, maybe even alternative career and lifestyle, as we talked about earlier. Finally, when the physician is past his 50's, he's looking at how he can protect his deferred compensation pool and withdraw as much from the group as possible to retire. His production may or may not be at a predictable level, and in some cases, he may decide prematurely to move to a more traditional role as an instructor or professor at a local university or medical school. Unless these arrangements are discussed in advance, and unless there is some contractual language that supports or at least encourages some discussion along these lines, there can be serious problems in a GPWW in the beginning stages, as well as in the more mature stages of development.