

Beyond MSOs –

The Physician Services Company (PSC) as a ‘turnkey’ solution for a Market-wide Hospital-Physician Integration Strategy

Cost-effective Development and Bonding with Employed, Affiliated and Independent Doctors

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Abstract:

Management Services Organizations (MSOs) peaked and fell as a hospital-physician integration strategy in the 1990s not because the concept was unsound, but because many hospitals lacked adequate physician management expertise and resources. The Physician Services Company (PSC) is different. Backed by experienced medical practice managers and consultants, and advanced electronic medical records and practice management systems, the PSC provides the strategic planning, management resources, and operational flexibility required to profitably support physicians market-wide, whether they are employed, affiliated, or independent in a “turnkey” program.

I. Why a Physician Support Strategy?

Background – The rise and fall of hospital-physician integration

With the exception of a few large, integrated multi-specialty groups, academic faculty practice plans and a handful of hospital-based specialties, the majority of U.S. physicians were historically organized as independent solo or small group practices. Under a reimbursement system mostly characterized by fee-for-service indemnity payments, there was little financial incentive for hospitals or physicians to integrate, and relationships between the two tended to be strictly voluntary (1).

The rise of managed care and risk-bearing payment methodologies including DRGs, global procedure fees and capitated contracts in the 1980s and 1990s changed that. Suddenly physicians and hospitals had to collaborate both to negotiate potentially profitable contract terms and to manage operating costs to generate actual profits. These market incentives created huge pressure on physicians and hospitals to integrate their finances and operations.

Doing so, however, required management expertise and resources well beyond the reach of the typical small physician practice. With their larger management teams, scale and financial resources, hospitals enthusiastically leapt into the void. Hospitals across the country bought up practices wherever they could. Bidding wars broke out to tie up referral networks. Looser organizations, such as physician-hospital organizations (PHOs), also were formed to engage independent practices for joint contracting purposes. And both hospital-owned and independent affiliated practices received financial and

operational management support through newly formed management services organizations (MSOs).

What many hospitals didn't realize, though, was that managing physicians is very different from managing hospitals. Physicians trained to exercise independent judgment responded poorly to hierarchical hospital management techniques. Many hospitals failed to provide incentives for physicians to maintain productivity. The result often – but not always – was poor morale, even worse productivity and huge financial losses. As the reimbursement pendulum swung back toward fee-for-service, many hospital-owned groups, PHOs and the MSOs set up to serve them disbanded.

Toughening reimbursement demands new solution

Now, pressure is again building for physicians and hospitals to integrate operations. This time it is driven as much by new demands for clinical quality data as financial risk. Consumer-directed health plans, private and public pay-for-performance schemes and the federal government's new policy of nonpayment for cases involving specific "medical errors" create tremendous incentives for integration of both clinical and financial functions. It will be necessary to survive as both individuals and payors increasingly demand detailed information on outcomes and compliance with evidence-based care processes before buying. Downward pressure on both physician and hospital reimbursement rates only intensify the pressure, creating added incentives to seek new operating economies.

As a result, many hospitals are again in practice-buying mode – despite the risk and even previous failures. And as in the 1990s integration boom, a lot of the buying is defensive – once one system starts buying practices, others jump in to preserve their referral bases.

But bitter experience dies hard, as it should. While buying physician practices may make sense in some circumstances, it is an almost sure bet that a primary care network will lose money. Employing multi-specialty groups also can be unprofitable without proper attention to specialty and service mix, and referral and productivity management.

In any case, buying practices is at best a solution that addresses only a fraction of physicians in most communities. It may even create unanticipated disruptions in existing referral relationships as independent doctors can be reluctant to refer to captive groups they view as competitors, or to hospitals they think might steer patients to in-house groups. In short, purchasing physician groups carries substantial financial and strategic risk.

It is no wonder, then, that hospitals are looking for ways to integrate information and operations with referring physicians without taking on the liabilities and potential productivity issues of ownership. The advantages of sharing clinical and administrative records for improving outcomes and complying with emerging payment documentation requirements are compelling. What's more, recent changes to federal anti-kickback laws and new developments in information system technology make it much easier for

hospitals to assist physician practices in implementing shared electronic health records and practice management systems. With these developments and the benefit of experience with successful MSOs, it is possible to structure physician support short of employment that is incredibly effective in engaging physicians community-wide with hospital systems.

One such structure is the Physician Services Company (PSC) described below. A successful hospital physician strategy requires a level of integration with physicians that extends to operations, information systems, medical records, communications, management and ultimately patient service. The PSC provides consistent infrastructure and operational at the physician practice level which increases opportunities for physician-hospital collaboration, thereby improving the hospital's ability to deliver services to the community and increase patient satisfaction.

II. MSOs Didn't Work. What's the Alternative?

The decline of the MSO as a physician engagement strategy closely parallels the decline of hospital ownership of medical practices. Many MSOs were formed by hospitals specifically to provide management services, IT support, group purchasing and human resources for practices they owned or operated through affiliated groups. As the groups disappeared, so did the service organizations that supported them.

More fundamentally, though, the weaknesses of MSOs contributed to, or were even the proximal cause of, the failure of hospital-owned physician groups.

MSOs often were controlled and staffed by managers with hospital, rather than group practice, management experience. Not only were these managers ill prepared technically to operate group practices, they typically looked to their hospitals to set strategic priorities and operational policies, which often did not meet the business needs of their groups or physicians.

Moreover, many MSOs relied on hospital resources exclusively to provide things like IT and staffing services. This resulted in many organizations trying to impose hospital systems ill suited to medical practice needs onto captive groups. It also often resulted in medical groups falling to the bottom of the hospital budget priority list – particularly for groups that lost money, which most of them did. But then again, many of these MSOs simply lacked the management expertise and practice support resources required to run a medical group profitably.

However, not all MSOs failed. Some not only survived, they thrive today. The more successful examples don't just supply day-to-day operating services. They also provide strategic planning, practice assessment and other customized consulting support (2). They succeed because they improve the financial and operational performance of the practices they serve. Some have even broken away from their original hospital supporters to better focus on addressing medical practice needs.

The Physician Service Company (PSC) model takes the best of the successful MSO, and amplifies and augments it. Just as important, the PSC is structured to provide high-end, physician-specific management and consulting services without breaking the link with the hospital sponsor. This is a crucial differentiator that favors both physicians and hospitals. Today's – and tomorrow's – reimbursement environments demand that both parties actively collaborate to leverage their mutual strengths to demonstrate continuity and quality of care of care. The PSC does just that.

III. The Physician Services Company (PSC) – A *Successful* MSO on Steroids

The real difference between an MSO and a PSC is the backing. MSOs may or may not have the expertise and experience to run or even advise a medical practice. And the MSO may or may not have a governance structure that ensures that both physicians and hospitals have a voice ensuring that the organization promotes their vital interests. A PSC, on the other hand, provides assurances to both parties that their tactical and strategic business needs will be met.

The PSC, as envisioned by PivotHealth, is backed by a national network of working practice administrators and medical practice management consultants with extensive experience in every operational and strategic area. This expertise goes well beyond what most local organizations can provide. Among the services the PSC delivers:

- Practice assessment – The first step to improving practice performance is to determine how the practice operates and where the opportunities for improvement lie. This service not only demonstrates to physicians the value of PSC services in improving the bottom line, it becomes the baseline for successfully integrating physician and hospital operations. The service is provided by a team of practice consultants with national experience.
- Strategic and service planning – The result of a practice assessment is a plan that specifies where the medical practices can improve performance – and how their success can be amplified by collaboration with the hospital system. The result is a true win-win scenario that ensures continued participation of the hospital sponsor.
- Operational efficiency – Untutored, most medical practices present huge opportunities for improving operational efficiency. The results go directly to the physicians' bottom line, creating a powerful incentive to join up.
- Electronic health records (EHR) – Under a new safe harbor of the Stark anti-kickback law, hospitals are allowed to offer physicians EHR and practice management systems with just a 15 percent contribution by the physician. The PSC allows hospitals to offer such services through a centralized system that requires nothing from the physician but a computer that supports a Web browser.

- Coding and documentation – Merely accurately documenting what physicians already do typically improves reimbursement significantly. The PSC offers documentation and coding resources well beyond those available through most local MSOs and consulting companies.
- Billing and claims processing – The PSC model takes advantage of the most advanced practice management software centrally maintained and updated to provide all physicians with the financial benefits of the most up-to-date billing and claims requirements by all national and regional payors.
- HR – Hiring, benefits and other human resources tasks present small practices with a morass of non-productive administrative work. The PSC can take over all these tasks. Where state law allows, physician employees can be transferred to a Professional Employee Organization run by the PSC, which allows the PSC not only to take over substantially all HR functions, but to provide employees with large group rates on health insurance, disability coverage and other benefits beyond the ability of most small practices to provide.
- Med-Mal and risk management – Not only can PSC members benefit from group professional liability rates, they can lower premiums through participation in expert risk management programs.
- Group purchasing – Supplies and services cost less when practices buy in bulk.

Note that the PSC can provide a range of services, from full management of employed groups to ala carte services to affiliated or independent physicians. The services can even vary over time, depending on physician desires and needs.

For example, a PSC allows hospitals to extend extensive practice support to physicians entering practice. As they develop a panel, they can move away from hospital support into fully independent practice, or to any intermediate arrangement that meets their personal and practice needs.

Note also that the current safe harbor for offering physicians support with electronic records is set to expire at the end of 2013. This creates an opportunity to bind physicians through shared medical and practice management systems that may close in the foreseeable future.

While these services are primarily directed at assuring that physician practices succeed – and produce income increases for doctors – they are also congruent with health system goals. Improving physician income and practice throughput not only increase physician income, it helps foster a collaborative relationship with the hospital. Sharing data on a common format makes it easier and more efficient to coordinate care across a spectrum of services. This encourages and enables development of disease management programs and risk-sharing contracting arrangements. Integrating physician and hospital services

also ensures that system capabilities better match community needs without wasteful duplication of services.

Also, a PSC standardizes administration across many large and small practices, improving the health system's ability to capture data and manage care regardless of what providers are involved. The concept allows hospital systems, no matter how small or large, to successfully collaborate with physician groups of all sizes, whether they are employed, affiliated or independent.

IV. The PSC – A Local, Collaborative Effort Backed by National Resources

One advantage the PSC has over local MSOs, no matter how competent, is governance structure. The PSC corporate board includes representatives of the hospital, the groups involved and the national organization providing management resources. This structure ensures accountability to hospital and physician interests, enlightened by the perspective and experience of a national physician management and consulting firm. Physicians and hospitals maintain a say in their destiny. And when knotty questions arise on either side, deep national experience and resources are available to work them out. PivotHealth provides individual practice assessments, financial monitoring and expert assistance to correct issues as identified. This ensures that local organizations can aspire and reach national performance levels.

Most important, the PSC model ensures that employed, affiliated and independent physician relationships can be maintained and improved as your needs dictate. The uniformity of services and management processes implemented ensures alignment of incentives of diverse parties generating overall financial success.

Conclusion:

A PSC provides a flexible and cost effective strategy to engage physicians in a variety of practice settings by providing services that generate real value for physicians and health systems alike. The concept allows systems to engage practices of all types without the need to take on the financial and productivity risks of buying practices. The expertise of the national practice management firm backing the venture ensures advanced physician management skills will be available to properly structure ventures, and address operational and strategic issues as they arise. As such, the PSC fulfills the promise of the MSO to effectively commit physicians to health systems in a cost-effective and productive manner.

Footnotes

(1) American Medical Association Physician Socioeconomic Statistics, various years

(2) K. Terry. Can an MSO help you? Medical Economics, Nov. 3, 2006

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