An alternative to hospital-dominated groups

By Charles Bond, J.D.

Has your hospital approached you or your colleagues to form medical groups that are tied to hospital-controlled management services organizations (MSOs) or affiliated with hospital-linked IPAs, HMOs, or contracting committees? If they have, stop, look, and listen. California has seen a virtual tidal wave of hospital efforts to bring physicians under their control and capture their patient bases.

Before signing any hospital-initiated proposal, consider its terms very carefully: You might be signing away your practice and your future, and there are better alternatives. One alternative is for physicians to take the future into their own hands by affiliating with a pro-physician MSO that answers their needs and preserves the sanctity of physician-patient relationships.

Hospital MSOs aren't the answer

Do not be surprised if your hospital exerts considerable pressure to create an "integrated health system." Hospital tactics for forming captive groups are strikingly similar from institution to institution. Administrators solicit and, in some cases, pay for key medical staff members' support. In turn, these physicians—without necessarily disclosing that they are shilling for the hospital—recruit other group members. Administrators also use high-pressure tactics and promise special hospital benefits to founding members. One administrator recently told potential group members that, "It's five to midnight and the bar is closing, so you'd better sign up." Often, hospitals discourage physicians' specific questions. Physicians intimidated or paid by the administration fall into line and encourage others to do so quietly. Physicians who ask too many questions are not invited to future meetings.

Yet, questions are in order. Hospital-based MSOs frequently ask physicians to help fund the operation's start-up by buying stock in the group's new professional corporation and signing over to the group their current practice assets, including their accounts receivable. The hospital-based MSO takes over the physicians' scheduling and their contracting with third-party payers, thereby taking total control of their income-producing capacity. If the hospital controls when physicians see their patients, which patients they see, and the amount of reimbursement, what is left of the physicians' practice? In effect, physicians are "selling" their practices' assets, patient base, and control to the group, while retaining their overhead obligations, and paying potentially tens of thousands of dollars for the privilege.

California physicians should understand the potential consequences of signing over their practice management and contracting powers to a hospital-controlled entity.

A fundamental conflict of interest

There is an inherent conflict of interest between the hospital's administrative concerns and physicians' concerns. Hospital-controlled MSOs will naturally seek contracts that maximize hospital profitability, possibly at the expense of group profitability. For example, if the hospital can negotiate a higher reimbursement per diem for in-patient admissions by offering lower physician reimbursement, is there a question of how the physician group will fare in the negotiations? If physician groups remain independent, however, they can negotiate freely to form and re-form affiliations as

New physician-oriented management organizations are becoming a popular way to preserve MD-patient ties

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market conditions change, even creating regional physician networks that might be impossible if the group were tied to a single hospital. Physician flexibility and independence in the marketplace are obviously what hospitals do not want.

There are potential conflicts between hospitals and physicians over the growth of hospital-controlled groups. For example, every time the group expands, not only is the patient-base diluted (i.e., more competition within the group for managed care patients), but the individual group member's equity (i.e., the value of their shares) also is diluted. Although some groups might guarantee founding members that the group will not expand for a year or two, the commitment is insignificant in the long run. There are usually no provisions preventing the hospital-controlled group from eventually bringing in more and more physicians.

Physicians should recognize that in the future it will be economically more important for the hospital to bring new physicians into the group to expand their patient base than it would be to protect the economic well-being of physicians already in the group. In other words, physicians should expect hospital-controlled groups to expand to serve the hospital's interests, not necessarily the physicians' interests.

Takeover without compensation

Physicians should also consider the possible impact of hospital control over their private-payer mix and their "traditional" practices. As hospital-based MSOs use their contracting and scheduling power to exercise more control over individual physicians' patient mix, any vestiges of their private practice would be eroded and eventually lost altogether. Then what would physicians have left if they wanted to withdraw from the group?

A surprising number of hospital-sponsored groups make little or no effort to evaluate each physician's practice; they form the group on the premise that all practices are of equal value, issuing the same amount of stock to each group member at the same nominal price. Obviously, all practices are not equal, but to speed up and "simplify" the group formation process, the hospital urges physicians to accept this equal-evaluation formula. The shortcut might be simple going in, but what if a physician wants to get out?

Physicians also should be wary of termination provisions. Many hospital-backed contracts provide for physician termination without cause with three to six months' notice. So, after capturing the physician's patient base, the hospital-controlled MSO can cut the physician loose with a pittance and no practice. At a minimum, therefore, physicians should insist that the MSO evaluate their practices at the time of contribution to the group and agree upon a buy-out formula in advance with written guarantees sufficient to compensate the physician for the practice. In addition, physician termination should be for cause, with adequate rights of appeal.

Even provisions for voluntary withdrawal or retirement from the group are often unfavorable to physicians. Usually the terminated, withdrawing, or retiring physicians are guaranteed little or no payment for the practice they are leaving behind. Some programs guarantee only stock buy-back at the original purchase price, (which is usually a nominal sum) without reimbursing physicians for their accounts-receivable contributed or their accounts-receivable earned for the group, not to mention the value of the physician's original patient base.

Sharing financial projections

In recruiting physicians, hospitals generally do not share any of the hospital's financial projections for the group (if any exist) with potential physician members. Hospitals often circulate entire documents bearing such titles as "Business Plan" and "Prospectus" that contain no projection of potential physician income or the MSO's expected management costs. Many contracts provide for additional withholding from physicians' future earnings (typically $15,000 or more) to cover unforeseen expenses.

The MSO does not assume or pay for the physicians' liabilities (such as office rent, telephone, or other overhead). At the same time, the hospital offers no guarantees for physicians' future income.

In some instances, future expenses remain vague because the MSO does not reveal the terms of contract with the hospital-controlled MSO until after the group is already irrevocably formed (i.e., after physicians have transferred their practices). At that point, physicians who do not like the deal have no choice but to remain or to leave the group with no practice. It goes without saying that any physician contemplating an alliance with a hospital-controlled MSO should first find out the contract's precise terms.

The need for legal advice

Physicians who are approached by such an MSO should seek independent legal advice, and in selecting their own attorneys, physicians should choose recognized, experienced, pro-physician counsel. Normally, hospitals offer to furnish an attorney to the group rather than the individual physicians interested in joining the group. Without exception, the attorneys hired by hospitals to form these captive groups have long represented hospitals and are not historically physician-friendly. Hospitals do not often disclose the potential conflict of interest and place little emphasis on the ethical rule requiring lawyers to advise parties forming a new business—which is what a group is—of their right to separate representation.

Physicians need their own counsel in such transactions. The decisions and contractual relations in these transactions are too complex and too significant for physicians not to have the benefit of individual legal and accounting advice.

A new alternative: the physician-focused MSO

An important alternative to hospital-initiated efforts is evolving: a management services contract offered by physician-oriented and physician-friendly MSOs.

One such organization, based in Berkeley but offering services statewide, is "Physicians' Advocates." As its name implies, Physicians' Advocates is dedicated to preserving physicians' independence by helping them create well-managed groups that meet hospitals and third-party payers on an equal footing.

The physician-oriented MSO will take over the headaches of forming and running the group practice

Pro-physician MSOs are not controlled by any hospital or third-party payer. Dedicated to physicians' independence, they succeed only if the physician groups they manage succeed. They offer "soup-to-nuts" services for physicians forming and running groups:

- assistance in forming the group, including model legal agreements and practice evaluation for all incoming group members
- acquisition of, and contracting for, office space, equipment, and supplies for the group practice
- hiring of office personnel and contracting for support services, such as billing, accounting, and scheduling
- retirement and benefit services
- arrangements for providing access to capital for group expansion or buy-out of retiring partners (after a minimum number of years of service)
- perhaps most important, expert contract negotiation with third-party payers and hospitals, including tracking of managed care contracts to determine profitability

In short, the physician-oriented MSO will take over the headaches of forming and running the group practice, so that all physicians have to do is treat patients and rotate on reasonable call.

Physician-friendly MSO benefits

What are the benefits of the physician-oriented MSO as opposed to the hospital-sponsored foundation, group, or MSO? First and foremost are loyalty and accountability. Physicians are the natural guardians of, and advocates for, good patient care and should align themselves with their patients' interests. The physician-friendly MSO facilitates this role. In the systems of the future, with their disincentives to diagnose and treat (e.g., in capitated managed care, HMOs, etc., where profit is enhanced by withholding patient care), physicians will inevitably face a conflict between patient well-being and the entity's monetary interests. Conflicts between physicians advocating proper patient care and third-party payers seeking to limit expenditures already are skyrocketing in number and severity. If physicians surrender control of their practices to hospital-oriented managers, who will stand up for the patient? The question of hospital-versus-physician control of medicine goes to the heart of what our society expects of its healers, and more importantly what physicians expect of themselves.

Although physician-friendly MSOs' principal motive is to allow physicians to control their practices and their patients' care, the hospital-controlled group's principal motive is to capture the physician's patient base. Primary care physicians are the hospital's particular targets. The hospital's purpose in creating the group is to co-opt physicians' contracting power and to control their ability to schedule patients. Ultimately, if physicians cede those powers to the hospital, they will become wholly dependent on the MSO for their livelihood. Hospital-controlled groups make little or no provision for the physician's future. Generally speaking, such groups are not particularly interested in group physicians' long-term well-being, their personal qualities, or their medical skills. Hospital MSOs' main concern is physician patient base size.

By contrast, physician-oriented MSOs provide organizational and management services to help physicians form and run groups, but are dedicated to physician independence. Such MSOs

are designed to help those physicians who do not want to be tied to one hospital, but would rather have the freedom to be an equal player in future health care negotiations. Indeed, as health care becomes regionalized, physicians who are too closely linked to a single hospital might be at a disadvantage.

Physician-oriented MSOs have a critical structural difference as well. They are not backed by hospitals, so they depend on physician investment and the value of their services. In other words, physician-oriented MSOs succeed only if their physician groups succeed, and so, like doctor-owned insurance companies, are prime examples of physicians controlling their own destiny.

Groups necessary for survival

In the face of reforms that the Clinton administration no doubt will propose and Congress ultimately will pass, physicians need to position themselves to survive. Most physicians cannot turn the clock back or, as so many wish, just hold on for a few more years. The driving engine of change is upon us. With Medicare capitation and the continuing shift to managed care, physicians—even those already in groups—need to look at their practices' structure to see if they will be viable in the new economic environment.

Physician-focused MSOs offer physicians the means to end the cottage industry model of medical practice: Private practitioners who face ever-increasing overhead and ever-decreasing reimbursements need little convincing that small offices with redundant systems, personnel, and other overhead costs are not the most efficient, cost-effective or profitable form of practice. Physicians need the economies of scale offered by medical group participation: They need the consolidation of support services (such as billing and scheduling), and the discounts of group purchasing.

Physicians also need the sophisticated management that only a group can afford. As intelligent and capable as physicians generally are, all their years of medical training do not include a whit of management, accounting, or business education, and little, if any, health care economics. Furthermore, the style of decision-making that works so well in treating many patients in a short time (rapid assessment based on key indicators) is not the same style used by experienced business managers. Physicians are trained to take care of people, not balance sheets.

Physician-oriented MSOs succeed only if their physician groups succeed

Finally, physicians need the contractual clout that only a group can provide. Physicians have far more power than they realize to direct the country's future health care choices. After all, physicians are the patient's point of contact—not only with the medical system (physicians direct clinical and diagnostic choices), but with the reimbursement system as well (physicians act as patients' intermediary, documenting and justifying reimbursement for their care). As Russell C. Coile, Jr., a futurist normally associated with hospital planning, wrote in the preface to his book, *The New Medicine: Reshaping Medical Practice and Health Care Management:*

> "Doctors are at the pivot point when it comes to changing tomorrow's health system. Hospitals are retreating from marketing health services on the retail model. They made an important discovery about health care marketing in the 1980s: Physicians still control patients and drive the health system. That fundamental truth is becoming widely recognized by hospitals, insurance companies, managed care plans, and government officials. All reforms to be made in tomorrow's health industry will involve changing physicians' behavior. Physicians occupy the high ground at the mouth of the channel, and any alterations of the U.S. health system must take this into account."

Thus, physicians have enormous power and should meet hospitals and third-party payers as equals, not as supplicants. Physicians can only do that in groups with sufficient size and management savvy.

An important business decision

Physicians face what is probably their professional career's most important business decision: whether to turn control of their practice over to a hospital-based group or a physician-oriented organization. As hospitals see their economic bases eroding (by such trends as more outpatient surgery, shorter lengths of stay, DRGs, and other fixed payment forms), it is no wonder that they are trying to absorb medical practices through the formation of captive medical groups. Physicians should beware of these entities' pitfalls and should consider instead forming their own independent medical groups and acquiring the professional management help they need through physician-oriented MSOs.

A good, pro-physician MSO should offer physicians the following services:

- a clear business plan that spells out the relationships of all the players
- practice evaluations for all incoming group members
- model legal documents
- access to capital
- access to necessary physical assets
- skilled day-to-day practice management
- personnel hiring
- billing and accounting services
- group scheduling
- expert, pro-physician reimbursement negotiation, coupled with a system to track contract profitability

Above all, the physician-oriented MSO should offer physicians an attitude dedicated to physician empowerment in the interest of good patient care. CP

Mr. Bond is an attorney with Charles Bond & Associates, a Berkeley law firm. He has represented physicians' interests for more than 18 years.