IPA or MSO Development Schematic

1) Governance

   a) The group to be formed will be a physician/hospital organization. The independent practitioner model and other association style models seem to be too weak to have an effect in the marketplace.

   b) The board of the organization will be structured as a collaboration between the hospital and the elected physician representatives, with one half of the board representing each. The board size will be relatively small to assure efficient decision making (probably twelve to fourteen members).

      i) Standard complement of officers is balanced between the hospital and the physicians to allow a full spectrum of participation.

      ii) The physician representatives, in order to allow an open and democratic process, will initially hold an open vote for their nominees for board positions. The open ballot will produce a slate of, perhaps, a 12 to 15 nominees from which the final physician board members can be elected.

      iii) Board positions to be staggered with guaranteed overlap on the physicians (democratically elected) side. The hospital may have physician appointees as their representatives.

      iv) There are no board "automatic" designations. Staff, with the possible exception of the executive director, do not hold board seats. Executive committee functions are extremely limited.

      v) Membership voting by proxy will be generally limited. Quorums will be defined by representation needs, especially with super majority issues.

      vi) Meetings, with rare exception, will be open to general membership.

   c) To assure private physician participation and overall trust, the board will make certain decisions only through a vote which allows for the majority of elected physicians to determine the outcome of any action. That is, certain issues will require a "supermajority" in order to effect policy (a vote of eight out of ten for example). The suggested supermajority issues are listed for the committee's consideration.

      i) Acceptance/rejection of any contract for services.

      ii) Ratification of any binding subcommittee action.

      iii) Approval of any budget or significant capital allocation.

      iv) Approval of any membership assessment or fee.

d) The organization will have a staff which will allow it to function as a contracting services organization. This probably implies, at least, an executive director and two or three support personnel, as well as the office space and the support costs one would normally assume with that size organization.

e) The organization will be driven by a published set of goals. At this time, the following goals are generally agreed upon.

   i) The organization will have the primary purpose of maintaining the overall quality of patient care and continuing the mission, tradition, and principles of the practice, its physicians, and staff.

   ii) The organization will be developed to assist the physicians who orient their practices to the care of patients who are served by the hospital with issues relating to the emerging managed care environment.

   iii) The organizational activities will support and enhance the efforts of the private attending medical staff to reorient their practices, should it be their desire and intent, to be better positioned to take advantage of managed care opportunities in the marketplace.

   iv) The organization will direct a coordinated information effort to assure its membership the most accurate and timely information in order to allow the group, or individual members of the group, to make appropriate market decisions.

   v) The organization will coordinate the efforts of the private attending staff, the physicians involved in the faculty practice plan, with the resources and assets of the hospital to provide a managed care response which is integrated and collaborative.

   vi) The organization will design programs and services to reach beyond the managed care marketplace and institute projects which directly service institutional health care consumers (direct contracting) in ways which are innovative and competitive. This may include the direct provision of services, innovative pricing strategies, coordinated (bundled) service arrangements, etc.

   vii) The organization will develop patient centered and program sensitive collateral services such as quality assurance, TQM or CQI, utilization review, survey processes, satisfaction and outcome indicators, comparative efficiency studies, etc., to assist its membership in their collective efforts to gain access to high quality managed care contracts.

viii) The organization will act on behalf of its members, hospital, and physicians to assure that this group is aligned with other groups such as insurance companies and regional, state, and national groups who can assist the members in furthering their goals.

ix) The organization will sponsor projects such as support staffing or information systems to assist the physician membership in the achievement of their practice objectives where these projects also promote the overall organizational objectives.

x) The organization will assume the role of a coordinating body on behalf of its membership to assist in developing the information base necessary to assume responsibility for case management and capitated contracts.

xi) The organization may act on behalf of its members to actually assume risk contracts and manage the relationships which are created between physicians and intermediaries when patients are serviced through capitated programs.

2) Membership/Credentialing

a) On the matter of membership:

i) The group will credential its membership independent of any hospital process.

ii) Providers will have the following standards applied to their application in judging their acceptance as members or in allowing their continued participation in the organization.

(1) Only physicians or professionals with staff appointments, or professionals who have admitting privileges, may be members (at least initially).

(2) Eventually, the group will evaluate continuing membership on the basis of the following standards.

(a) Demonstrated quality.
(b) Contribution to defined need criteria.
(c) Efficiency and cost effectiveness.
(d) Contribution to overall group success and contract compliance.
(e) Participation in business development and contract development which might include case management participation or other access criteria.

b) On the matter of group and individual membership:

   i) Groups may not join, only individual physicians. If a group applies for participation, each member of the group must apply and be accepted.

   ii) There will be no distinction between hospital-based physicians, geographic faculty practice, or in-faculty designations. Physicians must apply, and be accepted, on an individual basis.

c) On the matter of primary care, there will either be a definition process or some kind of self-designation.

d) With respect to contracting, members will be required to coordinate their managed care contracts through this group.

e) There will need to be discussion regarding hospital-based groups and the manner in which their membership status is treated.

3) Services Design

The group has considered several services programs which can be developed for the membership either through this organization, or one which is parallel. This is the listing.

a) Act as an ongoing research and reference source for members of the medical staff, or the organization, who wish to become more informed and active with managed care (through their own individual efforts).

b) Develop educational seminars for the medical staff and the membership which will present information related to the managed care environment and contracting activity in the local metropolitan area.

c) Act as a lobbyist or advocate on behalf of the membership to communicate concerns and issues to managed care groups.

d) Analyze contracts on behalf of private physician practices. Make recommendations regarding participation for the individual practitioner.

e) Analyze physician practices regarding their business structures, cost structures, etc., to assist them with project planning and development.

f) Assist groups of physicians with their efforts to form business relationships and develop projects which support or improve their efforts to maintain strong practices in the managed care market.

g) Provide services (bookkeeping, analysis, actuarial, accounting, etc.) to practices on a contract basis to assist in the monitoring processes connected with managed care (individual practice or physician support).

h) Act as a "messenger service" to inform physicians of the opportunity for contracts and to assist in coordinating the fee structures which make group contracting possible.

i) Act as a unified entity which contracts on behalf of its membership (exclusively) and which is responsible for all the managed care contracting activity for its member practices.

j) Act as a sponsor and coordinator for advertising and promotional efforts of the member practices to create a marketing cooperative which can develop brand or trade status within the community.

k) Act as a broker which can develop a sales force to act on individual members, a group of member practices, or the entire group, in a sales capacity to potential health care purchasers.

l) Develop liaison relationships with other groups which are also involved with the managed care. Essentially, coordinate global efforts of individual practices (horizontal integration).

m) Act as the primary liaison between the hospital and the physicians on all matters relating to managed care contracting. This implies communications and informational exchange, not negotiation.

n) Act as a group which unites the hospital and the physician practices in a unified contracting entity which can coordinate managed care initiatives as an integrated network of services.

o) Act as the sole entity which contracts on behalf of the hospital and member physician groups for the purposes of contracting with managed care entities.

p) Act as a business development unit which allows the hospital and the member physicians to invest in initiatives which might augment the services either group presently provides. The initiatives, or businesses, may, or may not, relate to managed care.

q) Develop services for the member physician practices which can be conceived as consultative or supportive in nature to the physician. The following list might include some of the services which the group might develop for its member practices.

   i) Billing and collection.

   ii) Group purchasing.

   iii) Evaluation and assessment (consulting).

   iv) Personnel pooling.

   v) Benefits pooling.

   vi) Site management.

   vii) Bookkeeping and payroll.

r) Provide group services which might assist or augment contracting efforts. The following services might be included in such an effort.

   i) Compliance review.

   ii) Utilization review.

   iii) Quality assurance or assessment.

   iv) Credentialing or privilege delineation.

   v) Statistical and efficiency reporting.

   vi) Risk pool management analysis.

   vii) Actuarial analysis.

s) Act as a risk assumption vehicle for the members. That is, formulate risk pools, engage in the development of co-insurance funds, catastrophic coverage purchases, etc.

t) Develop the resources necessary for the assumption of non-traditional lines of business (bundled pricing, threshold bids, direct contracting, etc.).

u) Develop the resources and the staff necessary to initiate network and system development activities on behalf of the membership. This might include the development of satellites, the purchase of practices, etc.

4) Finance

To produce an annual budget with revenue, the Finance Committee may suggest a flat fee per member for a specified term and assuming hospital contribution on an equal basis. It may also be suggested that the hospital authorize, or facilitate, a line of credit which could be activated by a supermajority vote of the board.

5) Unresolved Issues

a) There must be a process for resolution of conflict and access to outside mediation. Who will provide this service?

b) How will the organization be capitalized? Member donations? Fees?

c) Are we talking one organization or two? MSO? PHO? Combination?

d) If physician members limit their participation in contracts through this group, is the hospital a "member" for the purposes of this definition?

e) Should members be required to give their "best or most advantageous" price consideration to this organization?

f) How will the present office of managed care integrate its services with this group?

g) What will be the status of medical staff members and non-members of the organization?

h) Must members participate in contracts which the organization receives in order to maintain their participation in the organization itself?

i) What other membership programs might the group require for participation? Some which might be discussed include promotional activities, TQI or CQI, outcome measurement studies, risk pool participation, medical record and registration coordination, etc.

j) Should there be a distinction in funding requirements between primary and specialist?

k) Should members be required to participate in capitation?

l) How will the group integrate its efforts with the planning process?

m) What priorities are there for action or services design and implementation?

6) Issues for Staff Development

a) Determine grievance and conflict procedures and board involvement in staff and member sanction.

b) Develop a definition of officer functions and proposed subcommittee structures.

c) Develop communications protocols for the medical staff, if appropriate, the members, the subcommittees, the staff, and the board.

d) Develop draft bylaws language.

e) Propose an ongoing planning process.

f) Prepare a time line and membership criteria information.

g) Prepare a public relations packet and a questions and answer sheet.

h) Establish a calendar of proposed educational sessions.