Physician Service Networks and the Future for Psychiatrists

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Physicians are responding to payers' demand for one-stop shopping and providers' desire for increased autonomy by creating physician service networks. These provider-owned and -operated delivery systems offer psychiatrists a model for creating their own behavioral health care organizations. The author describes features of these integrated delivery systems that can enable physicians to regain some of the control they have lost to managed care organizations. He encourages psychiatrists to view physician service networks as a valuable survival strategy in an era of change and uncertainty. Physicians who become involved in provider-owned networks must work to ensure that these organizations do not become indistinguishable from the managed care systems they replace. (*Psychiatric Services* 50: 415–416, 1999)

Managed care organizations are reshaping the health care marketplace. The consolidation of Green Spring Health Services, Merit Behavioral Care Corporation, Human Affairs International, and CMG under Magellan Behavioral Health concentrates the care of approximately 62 million "covered lives" in the hands of a single managed behavioral health care vendor. The more recent creation of ValueOptions brings another 20 million lives into the hands of one more large organization. Together, Magellan and ValueOptions control over 50 percent of the managed behavioral health market.

Consolidations such as these are having a profound effect on practicing psychiatrists who no longer feel assured of job satisfaction or financial security (1). Psychiatrists' traditional referral relationships are disrupted by exclusive managed care contracting. Large numbers of patients vanish from clinicians' caseloads when employers switch from one managed care organization to another. Because the merger of two managed care organizations inevitably results in a larger provider panel than the newly created entity needs, the preferred providers in each organization's panel are at risk for being eliminated as the network is downsized.

When one or more managed care organizations dominate a marketplace, psychiatrists become vulnerable to a divide-and-conquer strategy that forces clinicians to steeply discount fees in the often unfulfilled hope of increased volume. Even the chosen few clinicians who actually receive a sizable number of referrals from a managed care organization can be held hostage when they are forced to accept increased unreimbursed administrative and communication responsibilities or are subjected to long delays before payment is made for services rendered.

This paper describes some features of physician service networks that can enable physicians to regain some of the autonomy they have lost to managed care organizations.

Psychiatrists and integrated delivery systems

Can psychiatrists and other mental health professionals regain control and enhance their bargaining position in this highly competitive marketplace (2)? In the early years of managed care, industry spokesmen disparagingly referred to psychiatry as a "cottage industry" in contrast to managed care, which promised efficiency, accountability, and administrative competence. In truth, the lack of organization and integration in the old mental health system created fertile ground for the growth of the for-profit organizations. But when clinicians develop integrated delivery systems and learn to manage risk, there is reason to believe they can regain some control of health care.

To achieve this goal, clinicians must unite to form group practices and integrated delivery systems. In doing so, they must be willing to trade autonomy for survival. When clinicians act alone, they have complete independence and total control of their revenue stream but limited options and opportunity in the marketplace. Large group practices can create services, market products, and negotiate from a position of greater strength.

One example of a psychiatrist-owned delivery system that has grown sizable enough to determine its own destiny is Psych Care of Connecticut (3). Under the leadership of a visionary psychiatrist, 30 local psychiatrists organized in 14 group practices formed a statewide not-for-profit independent practitioners association (IPA), Psych Care, and a for-profit management services organization (MSO), Psych Management.

The IPA provides a vehicle for 800 clinicians, practicing in their own offices, to assume responsibility for 200,000 covered lives on a contractual basis. Although IPA ownership is limited to psychiatrists, participating

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providers include representatives of all the mental health disciplines in order to offer the range of services and fee schedules that payers demand. Providers participate in Psych Care as independent clinicians, behavioral group practices, and hospital-based departments of inpatient services or services at a lower level of care.

Paralleling the provider network with an MSO solved a number of problems that confront provider networks. The Psych Care provider network is already large and growing larger. Its size makes it cumbersome and indecisive in contrast to the leaner MSO governance structure. The IPA cannot accept investment from parties other than the participant-owners, limiting its ability to raise cash for start-up and growth as well as its potential value as an equity holding. The MSO faces none of these restrictions. In its bylaws, Psych Management has restricted the sale of the stock to ensure that the organization remains in the hands of physicians.

Integrated delivery systems such as Psych Care have numerous points of entry into the managed and unmanaged marketplaces (4). They can continue to offer fee-for-service care to self-pay patients and those with traditional indemnity or point-of-service insurance plans. They can bid directly for carve-out business in competition with behavioral managed care organizations. Or they can partner with behavioral managed care organizations to become the clinical component of a delivery system in which the managed care organization takes responsibility for selling the product, managing the relationship with the payer, and contributing all the nonclinical management and administrative services. Psychiatric integrated delivery systems are also ideally positioned to serve as departments of psychiatry for multispecialty medical-surgical group practices, health maintenance organizations, and hospital systems.

Physician service networks

Growing numbers of integrated medical practices have grown large enough to assume prominence in their geographic markets. The Marshfield Clinic, Mayo Clinic, Oxner Clinic, and Lahey Clinic are but a few whose size permits them to contract directly with employers. Organizations of this size and complexity have been labeled physicians service networks (PSNs). They link physicians, other health care providers, hospitals, pharmacies, and administrative services.

These large highly integrated practices provide services to populations of patients scattered over wide geographic areas under a variety of payment arrangements including capitation. Direct contracting with payers enables PSNs to eliminate the managed care middleman, returning clinical decision making to the providers of care and gaining for them the profits that have previously gone to industry. Networks of this kind became possible when, during the compromises required to ensure passage of the budget in the 104th Congress, the federal government agreed to alter its position that most forms of medical organizations are illegal monopolies under antitrust laws.

The future for psychiatrists

Many—including Paul Ellwood (5), the "father of HMOs"—believe that physician-owned networks will compete successfully against for-profit managed care enterprises and return control of health care to physicians. However, gaining payer confidence and contracts is only one step in the process of reinventing the American health care system. Physicians who become involved in large provider-owned networks must answer some fundamental questions.

First, clinicians must determine the place for profit in their new endeavors. Will they use their newly gained control to improve quality and access, or will they seek only to maximize financial rewards? Will provider-owned organizations become indistinguishable from the systems they replace, or will they reinvest dollars in patient care, training, and program development?

Second, will provider-owned systems make the necessary commitment to professional management, management information systems, and the administrative services that have been subsumed under the label of infrastructure? Traditionally, physicians have been reluctant to commit the necessary human and financial resources to these crucial services.

Third, can physicians regain the trust of the American people? Throughout the 1980s, Arnold Relman, M.D., the emeritus editor-in-chief of the *New England Journal of Medicine,* sounded the alarm that American physicians were trading their position as respected healers for increased income and profit. To Relman (6), physicians were becoming just another financially motivated special-interest group. If provider service networks are to succeed, physicians must convince the American consumer that the public's best interest is their primary concern.

Finally, can physicians design an organizational structure that is stable enough to achieve their goals (7)? The answer is important because, if successful, PSNs will become attractive investment opportunities for Wall Street, which will encourage partners to "sell out" to the highest bidder. How physicians respond to this enticement will be pivotal in determining who will maintain control of the organizations they are working so hard to create. ♦

References

1. It's no myth: psychiatrists' earnings, satisfaction have fallen under managed care. Psychiatric News, July 18, 1997, pp 1, 28–29
2. Reinhardt UE: Why doctors will take back health care. Medical Economics, Dec 26, 1995, pp 72–87
3. Blues award contract to psychiatry group to provide mental health services in Connecticut. Psychiatric News, Nov 1, 1996, pp 8,36
4. Davis J, Freeman MA (eds): Marketing for Therapists. San Francisco, Jossey-Bass, 1996
5. Ellwood P: How doctors can regain control of health care. Medical Economics, May 13, 1996, pp 178–187
6. Relman A: What market values are doing to medicine. Atlantic Monthly, Mar 1992, pp 96–106
7. Reinhardt UE: Physician-sponsored networks: will physicians take back medicine? Physician Executive, Aug 1996, pp 10–15