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Jessica L. Bailey-Wheaton, Esq., Editor
Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, Publisher

Valuation of MSOs: Introduction & Competitive Environment

Management service organizations (MSOs) can be defined as "a healthcare specific administrative and management engine that provides a host of administrative and management functions necessary to be successful in the ever changing healthcare environment."[1] MSOs are primarily utilized by non-physicians as a vehicle to legally owning an entity that provides administrative support to a medical practice's operations.[2] These entities carry out a variety of duties, including (but not limited to) those related to:

(1) Financial Management;
(2) Business Operations;
(3) Human Resources Management;
(4) Staff Education/Training;
(5) Coding, Billing, and Collections;
(6) Office Space Management;
(7) Provision of Electronic Health Records (EHRs) and Medical Equipment;
(8) Regulatory Compliance Oversight/Management;
(9) Contract Management; and,
(10) Risk Management.[3]

MSOs are typically formed to transfer the non-clinical business functions of a medical practice to a separate (although often friendly/related) business entity that may be owned by non-physicians.[4] Most states only allow medical practices to be owned by physicians, which can limit the number of investors in a medical practice, as well as the financial value of the practice.[5] MSOs are a way for non-physicians to receive revenue from a medical practice's operation.

MSOs can be formed as a general business corporation or a limited liability company, a decision that is typically guided by accounting and legal considerations.[6] MSO entities can be formed outside of the state or inside the state a medical practice operates in.[7] After the MSO is formed, the MSO will enter into a management services agreement (MSA) with one or more medical facilities or practices, which serves as the start of a business relationship.[8] The MSA will include details of all the services which the MSO will provide, as well as services that an MSO may not provide (e.g., clinical services).[9] While MSOs are not required to provide a minimum number of services, they commonly provide financial services, utilization and care management services, information systems support, administrative and actuarial services, network development services, and quality improvement and reporting.[10]

The formation of an MSO can benefit medical practices or health systems in multiple ways, including:

(1) Improved cost and quality;
(2) Increased efficiency due to centralization of management and administrative function; and
(3) Enticement to attract partnerships or expand.[11]

Joining an MSO will often provide access to the best pricing on services and supplies and allow practices to outsource as many non-clinical services as they wish. MSOs (particularly large ones) can obtain preferred pricing on healthcare insurance and medical supplies, and pass those benefits on to practices. Many MSOs also provide services for billing and/or discounted electronic health record (EHR) systems where members can all utilize the same platform.[12] These services provide cost efficiencies and increased purchasing power that can result in a competitive advantage for smaller medical practices.[13]

The rapid growth of managed care and the increased integration among providers in the mid-1990s led to the acceleration in the growth of MSOs; however, by the early 2000s, this trend reversed, effectively breaking up most of the MSOs in the healthcare industry.[14] The 2010 passage of the *Patient Protection and Affordable Care Act* (ACA) set off MSOs' modern popularity,[15] becoming ubiquitous in recent years among healthcare entities, due to pressures within the healthcare industry to reduce costs, implement new technologies, and comply with increasingly complex regulations.[16] In particular, MSOs are becoming increasingly popular among healthcare entities seeking to better manage costs, implement new technologies, negotiate with payors, and comply with changing federal and state regulations.[17] The scope of services typically provided by an MSO may be characterized by two classifications, either: (1) a *comprehensive* MSO, or (2) a *limited* MSO. The various levels along the spectrum of MSO activities, ranging from comprehensive to limited, are set forth in the below exhibit.

The scope of MSO services may also reflect the specific needs and concerns of the healthcare entity contracting with the MSO. For example, as fraud and abuse scrutiny increases and the claims submission process for reimbursement becomes significantly more complex, MSOs may choose to focus their services on coding, billing, and other revenue cycle management tasks. Consequently, future installments in this three-part series on the valuation of MSOs will review the reimbursement and regulatory environments in which MSOs operate and the technological advancements being leveraged by MSOs.

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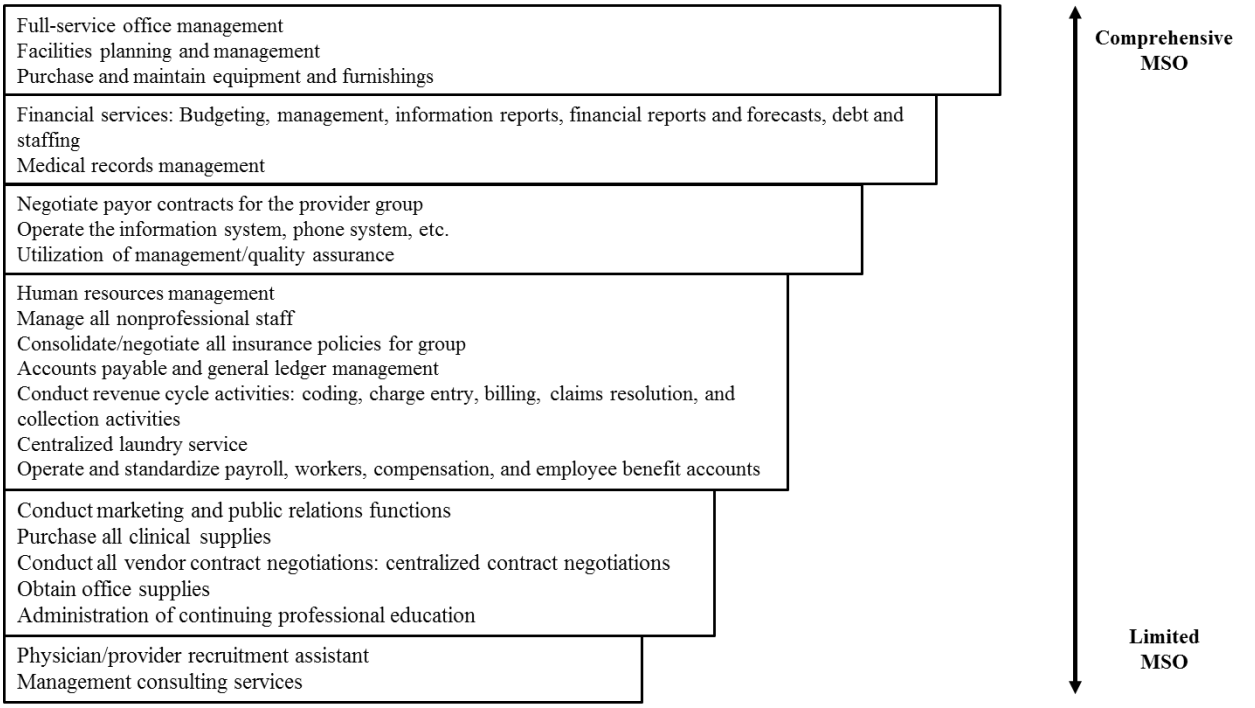
Exhibit: Range of MSO Services



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Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, ABV, is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 25 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 2,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (FACHE) and holds the Certified Valuation Analyst (CVA) designation from NACVA. Mr. Zigrang also holds the Accredited Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter. He is also a member of the America Association of Provider Compensation Professionals (AAPCP), AHLA, AICPA, NACVA, NSCHBC, and, the Society of OMS Administrators (SOMSA).

Jessica L. Bailey-Wheaton, Esq., is Senior Vice President and General Counsel of HCC. Her work focuses on the areas of Certificate of Need (CON) preparation and consulting, as well as project management and consulting services related to the impact of both federal and state regulations on healthcare transactions. In that role, Ms. Bailey-Wheaton provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services.

Additionally, Ms. Bailey-Wheaton heads HCC's CON and regulatory consulting service line. In this role, she prepares CON applications, including providing services such as: health planning; researching, developing, documenting, and reporting the market utilization demand and "need" for the proposed services in the subject market service area(s); researching and assisting legal counsel in meeting regulatory requirements relating to licensing and CON application development; and, providing any requested support services required in litigation challenging rules or decisions promulgated by a state agency. Ms. Bailey-Wheaton has also been engaged by both state government agencies and CON applicants to conduct an independent review of one or more CON applications and provide opinions on a variety of areas related to healthcare planning. She has been certified as an expert in healthcare planning in the State of Alabama.

Ms. Bailey-Wheaton is the co-author of numerous peer-reviewed and industry articles in publications such as: The Health Lawyer; Physician Leadership Journal; The Journal of Vascular Surgery; St. Louis Metropolitan Medicine; Chicago Medicine; The Value Examiner; and QuickRead. She has previously presented before the ABA, the NACVA, and the NSCHBC. She serves on the editorial boards of NACVA's QuickRead and AHLA's Journal of Health & Life Sciences Law.

Janvi R. Shah, MBA, MSF, serves as Senior Financial Analyst of HCC. Mrs. Shah holds a M.S. in Finance from Washington University Saint Louis. She develops fair market value and commercial reasonableness opinions related to healthcare enterprises, assets, and services. In addition she prepares, reviews and analyzes forecasted and pro forma financial statements to determine the most probable future net economic benefit related to healthcare enterprises, assets, and services and applies utilization demand and reimbursement trends to project professional medical revenue streams and ancillary services and technical component (ASTC) revenue streams.

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