

# PHYSICIAN PRACTICE OPTIONS™

April 1998

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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## Seeking Job Alternatives and More Income, Physicians Pursue Advanced Degrees

**M**ore physicians are pursuing graduate business degrees, spurred by the market domination of managed care organizations, an increase in the number of medical group practices, and the growing prevalence of physician practice management companies (PPMCs). Some doctors are seeking a business education out of frustration with how managed care, with its emphasis on cost control, is affecting the way they practice medicine, and they want to change what they do for a living. Others want the increased income that comes with employment in the business side of health care.

"This is becoming an attractive option," says Roger Rathert, MD, a consultant with Cejka & Co., an executive search firm in St. Louis. Cejka seeks physician executives to lead PPMCs, HMOs, independent practice associations (IPAs), large medical groups, and other health care organizations. The search for medical directors, vice presidents of medical affairs, and chief medical officers—a few of the positions held by physicians with business degrees—has escalated significantly in recent years. "More such positions are available to doctors all the time, especially those with both clinical and administrative experience," Rathert says.

Some physicians are returning to school to add a Master's in Business Administration (MBA) or other health care-related advanced degree to their medical certification, while some undergraduates who want to become doctors are entering MD-MBA programs that qualify them as both physicians and health care administrators upon graduation. Other advanced degrees avail-

able to physicians include a Master's in Medical Management (MMM) and a Master's in Health Administration (MHA). These degrees differ from an MBA in that they emphasize health care administration rather than more general business skills, but the MBA degree is the preferred postgraduate credential for physician executives, according to *The 1997 Physician Executive Compensation Survey* conducted by Cejka for the American College of Physician Executives (ACPE), in Tampa.

The AMA does not keep records of how many physicians seek postgraduate business degrees, but one measure of the increasing attractiveness of administrative professional options for physicians may be the growth in ACPE membership. The association currently has 13,000 members, up from 10,000 in 1996. More than 4,000 of those ACPE physicians have or are pursuing a postgraduate business degree, and the number is increasing annually, ACPE officials say.

"We are seeing a large growth in our membership because an increasing number of physicians would rather be involved in making the decisions that govern their lives than be told how to practice medicine," says Susan Sasnick, managing editor of *Physician Executive Journal*, published by the college. The idea of a physician pursuing a business education is becoming "more mainstream. Physicians see a managed care market environment that requires business expertise and want to be able to meet the demands of that market."

ACPE membership director Judy Rochell agrees. "The marketplace is

(Continued on page 7)

## We're Hearing About Uncertainty Among Physicians

Every day, we hear from some six to eight physicians on our toll-free telephone line. Many of them are expressing uncertainty about their economic future in mature managed care markets.

To hear this theme so often is intriguing. In my long career as a physician, I've learned that physicians rarely talk to each other about business matters; in fact, career uncertainties, corporate restructuring, and solutions to economic problems historically have not been issues for them. So, this lack of communication about business concerns is understandable. Until recently, an MD degree was a passport to a reasonable income and high prestige. Why talk about economics when your future is assured?

Today, an MD degree comes with no such guarantees. Calls from specialists in southern Florida indicate their annual income has declined by as much as 40 percent, mostly because of the dramatic growth of Medicare-risk HMOs in the state.

A caller from Minnesota sent me the results of a survey of almost 1,000 Minnesota physicians that was published in December in the Minneapolis *Star Tribune*. The survey showed that about one quarter of Minnesota physicians have lost more than 25% of their income over the last five years.

Another caller, the former president of a California medical association, said that about 3,500 specialists are fleeing his state every year. Often they're returning to their out-of-state home towns or to rural areas where managed care has not yet captured large numbers of patients.

This economic distress is causing physicians to change their career strategies. Many who are over age 50 are striving to reestablish themselves in new locations or in administrative positions.

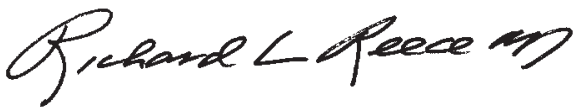
### Keeping Track

From the records we keep on the calls we receive, we know that a surprising number of our callers are between the ages of 35 and 55. Many are seeking or completing MBA degrees and call to ask if we know of executive search firms looking for MD-MBAs. (See "Seeking Job Alternatives and More Income, Physicians Pursue Advanced Degrees," page 1.)

Many readers also call seeking information about practice valuations, either because the caller is in a practice that is merging with another practice, or the caller is selling shares of a practice, or is anticipating the sale of his or her practice to a hospital or physician practice management company (PPMC).

Other physicians call because a physician group may have a deal pending with a PPMC and they want to ask our opinion about the reliability and history of the newly formed or expanding single-specialty or multispecialty PPMCs.

We endeavor to stay informed about these issues so that we can offer the appropriate advice. But, frankly, we don't know everything, which is why we have an editorial Advisory Board of capable and experienced professionals whom we turn to for assistance. If we don't know the answer to your questions, it's highly likely that we know someone who does. In either case, we welcome your calls.



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*Physician Practice Options* is published monthly by Premier Healthcare Resource, Inc., Parsippany, N.J.

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Subscription Price: \$299, 12 issues  
Issue Price: \$25 each

# States Tinkering With Health Plan Liability

By Richard L. Reece, MD, editor-in-chief

Dozens of state legislatures are debating proposals this year that would amend laws prohibiting patients from suing health plans. By early summer, these legislatures may pass laws that allow patients greater access to courts when they are injured by a decision of an HMO, observers say.

Patients in many states can sue managed care plans for actions that injure them, according to Patricia A. Butler, a lawyer and health policy consultant in Boulder, Colo. But in many states, managed care plans can avoid such lawsuits under the "corporate practice of medicine" laws, which prohibit organizations not owned by physicians from employing physicians, Butler said in a recent report. "These laws have been interpreted by many courts as barring suits against HMOs and other health plans on the ground that HMOs and other corporations cannot be sued for medical malpractice if they are prohibited from practicing medicine," Butler wrote in the report, *Managed Care Plan Liability: An Analysis of Texas and Missouri Legislation*, published by the Kaiser Family Foundation, a health care philanthropy in Menlo Park, Calif.

Legislation passed last year in Texas and Missouri allows patients to sue health plans directly, and these laws are being used as models in legislatures considering the issue this year, Butler said in an interview.

"By allowing plan participants to sue their health plans, as they can currently sue their physicians, lawmakers hope managed care plans will become more responsive to consumers," Butler wrote in the report. "Health plans, on the other hand, oppose such laws in the belief they will drive up costs."

While the new laws in Texas and Missouri eliminate the corporate practice of medicine defense to a suit against managed care plans, the Texas law goes further in two important ways, according to the report:

1. The Texas law creates an explicit new legal claim allowing managed care plan participants to assert in a lawsuit that a plan failed to use "ordinary care" by denying or delaying payment for care recommended by a physician or other

provider. Texas thus became the first state to define a specific standard of liability for managed care plan decisions. The new law in Missouri removes the corporate practice of medicine defense to suits against health plans but does not create an explicit claim, leaving it to the state courts to decide what plan misconduct may result in liability, Butler wrote.

2. The Texas law creates "independent review organizations" to which managed care plan enrollees can appeal disputes over plan coverage.

Whenever a patient appeals a coverage denial, health plans face a significant perception of bias, says Al Lewis, a lawyer and consultant in Boston who has studied the review procedures of health plans. Even if coverage denials are based on sound medical evidence, many health plans have internal physicians review the decisions of colleagues, leading consumers to suspect bias, Lewis says. Since their mission is to contain costs, health plans cannot guarantee that their internal review process will be fair, he says. What's more, many health plans have such cumbersome review procedures that delays are common.

## Federal Issues

Proposals to expand or clarify the liability of managed care plans have been considered in several other states, such as California and New York, Butler wrote. In Congress, the Patient Access to Responsible Care Act of 1997, a bill sponsored by Sens. Alfonse D'Amato (R-N.Y.) and Charlie Norwood (R-Ga.), would revise the appeals process and amend the Employee Retirement Income Security Act of 1974 (ERISA) to allow patients greater access to the courts.

Under ERISA, patients injured as a result of coverage denied by a health plan cannot sue an employer-sponsored health plan in state court. Plan participants can sue in federal court but only for the cost of the benefit denied, Butler wrote. ERISA affects most American families, since 85% of all workers are enrolled in managed care plans. Health plans do not want Congress to amend ERISA, saying any changes in the law are

likely to make managed health plans more expensive. The Texas law creates a challenge to ERISA and has been contested in a pending federal case filed by Aetna US Healthcare, a managed care organization in Hartford, Conn.

## Issues for Physicians

The Texas and Missouri laws were passed as a result of an alliance of state medical societies and consumer groups in each state. The societies and consumer groups supported the liability legislation, Butler wrote, to achieve several objectives to regulate managed care plans:

- *Health plan accountability.* Supporters in both states asserted that managed care plans' decisions to deny or delay coverage influence physicians' willingness to provide treatment. When these decisions injure plan participants, plans should be held accountable, supporters said.
- *Equitable treatment.* Supporters of both bills saw no justification for treating managed care plans differently from other businesses, which can be held responsible for conduct that injures customers.
- *Injury prevention and compensation.* Supporters of both bills hope the threat of litigation will encourage more appropriate managed care decisions about what is medically necessary. Also, the new external review procedure in Texas is intended to avoid litigation and provide quicker resolution of disputes.
- *Consistency with tort reform.* Legislators who had supported previous state tort reforms, such as limits on jury awards, attorneys' fees, and time to file lawsuits, believed it was appropriate to impose responsibility proportionate to the actual conduct of organizations and individuals. Consequently, they argued that health plans should be held responsible for decisions that affect physicians' medical care decisions.

In both states, the bills were opposed by health insurers, managed care plans, and some businesses. Opponents raised concerns about liability expansion, fearing more suits and increased health costs. ■

# Medicare Fraud: It's Costly for the Government and Risky for Physicians

By Patricia McClelland

## First of two parts

Few physicians scheme to defraud the Medicare program. A physician's intent, however, doesn't interest the government in Medicare fraud and abuse investigations because, to indict or convict, the federal government doesn't need to prove intent.

Since more than \$500 million pours into Medicare annually, the federal government has promised to commit significant resources to combating fraud and abuse and has added investigators and agents to audit and investigate potential Medicare violations. "Let the message be very, very clear," U.S. Attorney General Janet Reno has said. "We have made health care fraud a priority and will pursue it as vigorously as we can." Nancy-Ann DeParle, the new chief of the federal Health Care Financing Administration (HCFA), which operates the Medicare and Medicaid programs, has said the agency will conduct payment-focused medical audits and reviews to increase its efforts to combat Medicare fraud and abuse.

## Physicians Beware

In most cases of fraud and abuse, physicians are not the culprits, but under the government's current crackdown, a physician may be viewed as guilty. Therefore, physicians and group practices should not view the government's investigative actions as simply business as usual. Doing so could result in serious monetary penalties and jail time if a violation is discovered. Whether in private practice or a group practice, any physician under contract with a managed care

*Patricia McClelland is a health care compliance consultant with Milliman & Robertson, in Vienna, Va. In 17 years working in health insurance, she has focused on regulatory and operational compliance issues. She is a member of the National Health Lawyers Association and American Academy of Healthcare Attorneys.*

organization is at risk of running afoul of Medicare fraud and abuse laws. What's more, any physician participating in Medicare may be at increased risk. Therefore, all physicians must be knowledgeable about the government's Medicare fraud and abuse laws and requirements in order to comply and to avoid an investigation or civil or criminal penalties. For any physician, and particularly for those participating in Medicare, understanding what the federal government looks for when seeking to uncover fraud and abuse can be an effective shield.

- uncovered service was provided
- Incorrect dates of services
- Billing for medically unnecessary services
- Duplicate billing (billing Medicare and the patient)
- Misrepresentation of medical credentials
- Quackery and failing to provide adequate or providing substandard health services
- Workers' compensation fraud.

It doesn't matter whether a physician has an employee manage the Medicare billing or has contracted with a third party to do so, his or her financial and personal risks are

**"Let the message be very, very clear. We have made health care fraud a priority and will pursue it as vigorously as we can."**

**— U.S. Attorney General Janet Reno**

Currently, billing fraud is high on the government's surveillance list. The types of billing fraud the government looks into include:

- Billing for services not rendered
- Upcoding (such as altering a claim form for a more complex service that was not provided)
- Billing for "no shows"
- Forged physician signatures
- Billing for auxiliary personnel services when not under the direct supervision of the physician
- Gang visits to nursing homes (which occur when a physician visits a nursing home and provides unnecessary services to all residents or provides medically necessary services to several residents but bills Medicare for providing services to all residents)
- Premature discharge information
- Acceptance of an incentive to discharge prematurely
- Billing for covered services when an

the same in both situations. The particular danger in outsourcing to a third party is that the physician is legally responsible for the proper performance of the billing function even though he or she may not directly supervise the activity.

Having an internal compliance program in place, or requiring the third party to have such a program, is one way to ensure proper Medicare billing. Regardless of who develops it, the compliance program should be designed to detect, prevent, correct, and eliminate the potential risk for the physician to commit Medicare fraud and abuse unknowingly.

The government also is focusing on abuse violations in skilled nursing facilities, home health care agencies, and long-term care facilities. Some of the care given in these facilities could be viewed as inadequate, thus falling under the "abuse realm" of several laws. Moreover, aging baby boomers will soon increase the Medicare population substantially and, since Congress is already

focusing on the rights of consumers in health care, Medicare abuse issues are likely to generate more interest among federal regulators and lawmakers.

### Teaching Hospitals

Teaching clinics and hospitals are another target of the government's investigative efforts. Teaching physicians need to know that the Medicare definition of an "attending physician" determines eligibility for reimbursement services under Medicare Part B, and that personal involvement is key in determining whether a physician is an attending physician.

A group of teaching physicians at the University of Virginia, known as the University of Virginia Health Services Foundation, initiated a self-audit of the school's Medicare billing practices. After completing the audit, the physicians contacted the U.S. Attorney General's office to verify the physicians' self-audit. After sending an audit team from the federal Department of Health and Human Services Office of the Inspector General, the government found billing errors and inadequate documentation of involvement by teaching physicians for services rendered by residents and interns. Although the school's voluntary self-audit carried some weight under the Federal Sentencing Guidelines, the university's physician practice agreed to pay an \$8.6 million settlement, a hefty sum for a group attempting to be a good corporate citizen.

In a December 1995 settlement agreement, the clinical practices of the University of Pennsylvania agreed to pay the federal government over \$30 million because of inadequate documentation and violations of billing requirements for attending physician services and other errors in billing services under Medicare Part B. The university's clinical practices consisted of 600 individual physicians collectively billing Medicare. The settlement represents \$10 million for alleged improper billing and \$20 million in penalties under the False Claims Act. The government alleged three types of billing violations:

- Inpatient consultations without reference to services performed
- Services performed by residents and billed by faculty physicians
- Inadequately documented claims.

Another clinical physician practice that recently settled with the government is the Jefferson Faculty Foundation (JeFF) of the Thomas Jefferson University in Philadelphia. All physicians who were members of JeFF were brought into this action for Medicare Part B billings, and a government audit was done to determine if the billings submitted for professional services followed Medicare regulations. They did not. The settlement for improper billing was \$12 million.

All three group practice settlement agreements dealt with alleged improper Medicare billing of teaching physicians, and each settlement required the offenders to develop a compliance program to eliminate future billing problems.

### Laws That Apply

An overview of all the laws, regulations, and guidelines the federal government relies on to uncover Medicare fraud and abuse violations would fill several volumes. At minimum, physicians need to have a basic understanding of the following:

- The Federal Self-Referral Act, commonly known as the Stark Law
- The anti-kickback provisions of the Social Security Act

*(Continued on page 6)*

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- The False Claims Act
- The False Statements Statute
- The Mail Fraud Act.

*The Federal Self Referral Act.* Because Congress believed ownership creates the incentive to commit fraud against the government, it passed this law to prohibit physicians from gaming the Medicare system to reap financial rewards improperly.

Part One of the Stark Law prohibits a physician or a member of a physician's immediate family from providing a referral to a clinical laboratory if the physician or family member has a financial relationship with the entity for which payment may be made by Medicare. It also states that a physician may not bill Medicare or a Medicare beneficiary based on a referral.

Advancements in medical technology and the suspicion in Congress that entrepreneurial physicians may be abusing the system led Congress to add the following 10 health-related services and equipment under Part Two of the Stark Law:

1. Physical therapy
2. Occupational therapy
3. Radiology services
4. Radiation therapy services and supplies
5. Durable medical equipment and supplies
6. Parenteral and enteral nutrients
7. Prosthetics and orthotics
8. Home health services
9. Outpatient prescription drugs
10. Inpatient and outpatient hospital care.

There are exceptions as to when a financial relationship would violate the Stark Law, but there is also ambiguity about the exceptions because HCFA has not yet provided the guidance necessary to understand fully when referrals are legal. Violation of the Stark Law is not a criminal offense, but can result in civil penalties and possible exclusion from the Medicare Program. (See, "To Avoid Penalties, Group Practices Need to Know the Self-referral Laws," *Physician Practice Options*, March.)

*The Social Security Act.* The Social Security Act also includes a provision that prohibits a physician from receiving kickbacks based on referrals. Generally, the law prohibits two types of health kickback payments. The first is when a payment is made based on a referral of a patient. The payment need not be monetary; it also can

## Government Increases Funding to Fight Health Care Fraud

Two years ago, when President Clinton signed the Health Insurance Portability and Accountability Act of 1996 (HIPAA), into law, hundreds of millions of dollars were allocated to combat Medicare fraud and abuse. The allocation for fiscal 1997 for the Inspector General's office of the federal Department of Health and Human Services was \$60 million to \$70 million, three times the amount of prior funding. This funding is to increase by \$10 million to \$20 million each year until 2002. Under HIPAA, the FBI was allocated \$47 million in fiscal 1997 to combat health care fraud, and an increase to \$114 million is scheduled by fiscal 2002. Part of this funding will be used to hire more investigators and agents.

In addition to this dramatic surge in funding, HIPAA created a "collection pot" for the Fraud and Abuse Control Account. The funds collected in this account will be used to coordinate the anti-fraud activities of federal, state, and local governments to maximize law enforcement efforts. Criminal fines and penalties, forfeitures, civil judgments and settlements, and administrative monetary penalties will be deposited into the Federal Hospital Insurance Trust Fund. The secretary of HHS and the attorney general will then allocate these funds into the Fraud and Abuse Control Account.

Prior to HIPAA, fiscal intermediaries, such as insurers, conducted Medicare audits and medical and utilization review and supervised fraud units. After government audits uncovered poor documentation and poor policies and procedures by most of the fiscal intermediaries, Congress established the Medicare Integrity Program under HIPAA.

What's more, HIPAA established specific theft and embezzlement fines and imprisonment penalties for up to ten years. For false statements relating to health care matters, there are fines of as much as \$10,000 and imprisonment for as long as five years.

include free rent, free equipment, or other gifts and items. The second type of payment is the self-referral kickback in which the physician reaps financial gain by referring a patient to a facility in which he or she has a financial interest. A prohibited kickback would exist, for example, if a clinical laboratory rents space in a physician-owned building and the monthly lease amount includes the rent payment and an additional amount to the physician owners in exchange for clinical laboratory referrals.

Another example is where a hospital refers patients to hospital-based physicians, who then pay the hospital for the referrals or where a hospital does not pay the physicians based on fair market value but rather pays them based on their patient billings.

*The False Claims Act.* This law makes it illegal to present fraudulent payment requests to the government. The civil provisions provide for payment of not less than \$5,000 and not more than \$10,000 per claim and triple payment of the actual loss to the federal government.

*The False Statements Statute.* This law pro-

hibits any false, fictitious, or fraudulent statement to be made to the federal government in connection with the delivery or payment of health care services, items, or benefits. The penalty for violations is five years in prison, as much as \$10,000 in fines, or both.

*The Mail Fraud Act.* Construed broadly, this law prohibits anyone from using the U.S. Postal Service as part of a scheme to defraud the government. Sending by mail fraudulent insurance claims or payments that violate Medicare reimbursement rules also violates this act. The penalty could be a \$250,000 fine or as long as five years in prison.

How a physician practices medicine under Medicare will determine how exposed he or she is to violating Medicare fraud and abuse laws. Physicians can reduce this exposure by becoming and remaining knowledgeable about the government's law enforcement actions and by initiating proactive compliance programs.

*Editor's note:* Next month, anti-fraud lawsuits and how to develop a compliance program.

(Continued from page 1)

demanding an increasing number of administrators," says Rochell. "Physicians are responding to that need."

The Cejka-ACPE survey shows that physician executives with advanced acade-

mic degrees earn more than those without such degrees. Median compensation ranged from \$160,000 to \$240,000 for physicians without a master's degree; from \$166,000 to \$290,000 for physicians with an MBA; and

from \$192,000 to \$240,000 for physicians with an MMM degree. (See sidebar, "Advanced Study Improves Income.")

"Physicians who wish to be administra-

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## The Typical MD-MBA Curriculum

The Master's in Business Administration Program in the School of Business at the University of St. Thomas in Minneapolis is a typical MD-MBA program. The program costs about \$25,000 for 50 credits, not including the cost of books, other materials, and travel. Thomas Gilliam, the program's director, says the total cost is about \$30,000, depending on how far away students live.

The program takes two and one-half years to complete, and students spend one week in the fall and one week in the spring at the Minneapolis campus. Much of the course work and testing is done on the Internet and through the mail. "The physicians in our program make a significant commitment in time and resources," Gilliam says. "We estimate that course work consumes about 20 hours a week."

Admission is based on academic capabilities, as demonstrated through prior scholastic performance and test scores. St. Thomas looks for candidates with experience in health care administration and a desire to emphasize administrative responsibilities in their future career. "The work is difficult and demanding," says William Peterson, MD, program director for the Center for Health and Medical Affairs at St. Thomas' Graduate School of Business. "Our students need to be motivated to spend their careers primarily in the business side of medicine. It is a serious commitment to change for many of them."

The St. Thomas curriculum includes traditional accounting, financial management, operations, marketing, statistics, administration, and economics courses. It is typical of the types of academic information disseminated in such programs and includes medically oriented business courses, such as the following:

- Alternative Models of Health Care Delivery covers relationships between medical groups, hospitals, insurers, and integrated health systems.
- Biomedical and Management Ethics covers the basic principles inherent in medicine as they relate to the business of health care.
- Data and Information Management includes an overview of information technology and outcomes data.
- Health Status in the Community looks at factors that determine the frequency and distribution of diseases in a community, including epidemiological factors and disease management technology.
- Facility Planning for Medical Group Management focuses on program planning, architectural schematics for medical group management, and the selection and management of building contractors.

- Financial Accounting for Medical Group Management involves collecting, processing, and reporting the types of financial data generated by medical groups.
- Health Care Economics looks at how pricing, market structures, cost-benefit analysis, and other economic factors relate to health care business cycles.
- Health Care Policy and Medical Group Management covers the socioeconomic, political, ethical, and practical issues of national and regional health care legislation.
- Transformational Leadership focuses on the role of physician executives in transforming the practices and performance of health care organizations.
- Insurance Management covers the principles and practices of health care insurers, including malpractice insurance and the evolving role of risk management.
- Human Resource Management focuses on the hiring and training of physicians in a group setting.
- Legal Issues in Medical Group Management covers liability, contracts, and recordkeeping as applied to medicine.
- Managed Care involves the study of managed care models and the history and economics of managed care.
- Managerial Accounting for Medical Group Management applies accounting principles to medical group management.
- Medical Group Financial Management looks at the basic principles of risk, return, and valuation, as applied to decisions about the availability and use of funds in changing financial markets.
- Marketing for Medical Group Management covers market planning, target marketing, channels of distribution, competitive analysis, and other market principles as applied to medical group settings.
- Operations Research covers market formations and modeling, decision theory, and demand forecasting.
- Organizational Communication and Behavior looks at organizational development, motivation, leadership, and interpersonal relationships in medical group settings.
- Problem Solving in Medical Group Management involves the analysis of case studies, while emphasizing ethical standards and considerations.
- Overview of Health Care Organization and Delivery
- Policy Formulation and Implementation for Medical Group Managers
- Statistical Decision Making in Health Care
- Strategic Planning for Medical Group Management
- Independent Study

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tors or to participate in the entrepreneurial revolution in health care need to have MBA degrees," says Regina Herzlinger, PhD, a Harvard Business School professor who has written *Market-Driven Health Care: Who Wins and Who Loses in the Transformation of America's Largest Industry* (Addison-Wesley, Reading, Mass., 1997). "The MBA degree enables them to see how administrators and entrepreneurs in other sectors of the economy meet the challenges that now are facing health care, such as activist consumers, demands for quality and low cost, and innovative technology."

### Not for Every Doctor

However appealing business degrees may be for some physicians, "an MBA, or any health care business degree, clearly is not for every doctor," says Thomas Gilliam, director of the MBA and medical group management program in the School of Business at the University of St. Thomas, in Minneapolis. "It is for only a select group of physicians who want to do administrative work. It appeals to physicians who, because of managed care and other economic factors, find themselves suddenly working as employees rather than as independent agents, which was part of why many of them got into medicine to begin with. They believe an MBA degree will return to them control of their professional lives. But before physicians make such a career choice, they should ask themselves whether they want to spend the time and money necessary to secure a business degree, and whether they want to give up much of their clinical practice."

Peter Kongstvedt, MD, a partner with Ernst & Young LLP, health care consultants and CPAs in Washington, D.C., and a member of the *Physician Practice Options* editorial Advisory Board, says the trade-off between the practice of clinical medicine and a life in the business world is what physicians need to consider when they decide whether to pursue an MBA degree or any advanced business degree. "They need to look at opportunity costs," Kongstvedt says, "that is, the time they will lose in the practice of medicine, and an associated loss of income, as they make the transition. If they want a business career,

## Advanced Study Improves Income

A 1997 study by Cejka & Co., a St. Louis health care consulting and executive search firm, of more than 12,000 members of the American College of Physician Executives (ACPE), in Tampa, Fla., showed that physician executives in single-specialty groups and physician practice management companies (PPMCs) are the highest paid, earning an average of \$240,000. The study, *The 1997 Physician Executive Compensation Survey*, profiled about 4,000 ACPE members, about one-third of whom serve as medical directors in group settings.

Physician executives with advanced academic degrees earned higher pay than those without such degrees. Median compensation ranged from \$160,000 to \$240,000 for physicians without a master's degree, from \$166,000 to \$290,000 for physicians with an MBA, and from \$192,000 to \$240,000 for physicians with a Master's in Medical Management degree. Medical directors earned median compensation of \$175,000 to \$227,500.

Physician executives who are medical specialists earned more than executives who are primary care physicians, although almost half of all physician executives are PCPs. Specialists earned an average of \$200,000, and PCPs an average of \$175,000. Among physician executives who are specialists, radiation oncologists were the highest paid, at \$350,000. The lowest paid, on the average, were aerospace medicine specialists, at an average of \$115,000.

In the survey, the average time devoted to administrative duties, as compared to the practice of clinical medicine, was 67%, but vice presidents for medical affairs spent nearly 90% of their time in administration. The median compensation for new physician executives was \$174,000, and physician executives with 16 years of experience or more earned an average of \$203,000. Of the survey respondents, about 90% were men.

the move is probably worth it. But an MBA degree is of marginal value for the practice of clinical medicine."

Edward Hanton, MD, a consultant in Cejka's Atlanta office, earned an MBA degree in 1989 from Tufts University, at the age of 53. "A physician who wants to get an MBA degree simply to learn how to better deal with managed care organizations and negotiate better contracts is making a big mistake," Hanton says. "It is not a way to get out of something, like dealing with managed care. A doctor needs to ask what he or she plans to be doing in three or five years. If the answer is administration, an MBA makes sense."

Hanton's motivation for seeking a business degree came from his experience as a member of a physician group in Minneapolis. "I saw our business begin to change and realized that for our group to survive, someone in it would have to learn the business side of medicine; that is, how the companies we found ourselves doing business with did business. I found I loved

the work. The more information I sought, the more interesting it became."

Some physicians become administrative leaders in their groups without earning advanced degrees. They develop the skills they need through experience. William Carter, MD, is president and chief executive officer of Fairfax Family Practice Centers, a group of 55 primary care physicians in Fairfax, Va. He joined the group in 1979, and moved into a leadership position in the early 1980s. Since then, the group has developed managed care contracts, including risk-based reimbursement contracts, and expanded its operations throughout northern Virginia. "We looked at the world changing in the 1980s and knew we had to adjust," Carter says. "Developing the business skills to make those changes was a necessity. Physicians are consummate learners, and I learned what I needed to know through reading and seeking out experienced physicians and business leaders. I don't have an MBA degree, but I believe at this point, based on

my experience, I could easily pass the courses necessary to get one.”

For physicians who have demonstrated a desire to become involved in the business side of medicine, the pursuit of an advanced degree can be professionally rewarding, says William Peterson, MD, program director for the Center for Health and Medical Affairs at St. Thomas' Graduate School of Business. But, a physician should not pursue such a degree “out of anger, or from some desire to preserve a fee-for-service status quo,” he says. “Physicians need to clearly know that this decision is a major commitment of time, energy, and professional change.”

### Educational Options

Enrollment in the MD-MBA program at St. Thomas has been increasing annually since the program began five years ago. In that time, the demographics of the student population have been changing. When the graduate program began, for example, few women were enrolled; in the 1997-98 MD-MBA program, 50% of the enrollees are women. The average age of students in the program is 43 and appears to be rising. “All of our current students have some background in administration. Some are department chairs in university settings, others run small to medium-size group practices. At this point in the development of our program, we have enough applicants that we can require prior experience,” Gilliam says.

Joint degree programs are offered at universities nationwide, such as the ACPE MMM program at Tulane University in New Orleans and the MD-MBA program at the University of California's Davis campus. Joint MD-MBA programs generally take six years. The first three are spent in medical school, followed by a two-year MBA program. (See sidebar, “Many Educational Opportunities Are Open to Physicians.”)

Physicians who want to develop their business skills have other options besides an MBA or other master's degree. St. Thomas offers a Certificate Program in Management for Physicians, which is an intensive one-week residential program or a 13-week evening program that covers basic administrative management and financial planning for physicians for about \$1,300. The ACPE

## Many Educational Opportunities Are Open to Physicians

There are a variety of educational opportunities open to physicians seeking advanced business degrees. *The 1997 Physician Executive Compensation Survey*, by Cejka & Co. and the American College of Physician Executives (ACPE), in Tampa, lists the following available advanced degrees and the percentage of survey respondents who work as physician executives with each degree. The survey showed that physician executives in single-specialty groups and physician practice management companies (PPMCs) are the highest paid, earning an average of \$240,000. The study profiled about 4,000 ACPE members, about one-third of whom serve as medical directors in group settings.

The administrative responsibilities associated with physician executives are varied and include:

- **General management:** organization policy and compliance, contracting with payers, finance and budgeting, strategic planning, and marketing
- **Quality management:** cost management, quality improvement, utilization review, and medical protocol development
- **Recruitment:** network development, physician recruitment, and credentialing
- **Liasion:** serving as liaison between physicians and management, the organization and its board of directors, other businesses, and the community
- **Personnel management:** compensation and medical personnel management
- **Educational:** supervision of clinical or basic science research, teaching, and supervision of residents and fellows
- **Other:** information systems management, research, physician leadership development, and consulting

### Physicians Who Have Postgraduate Degrees

Degree	Percentage of all responding physicians
Master's of Business Administration (MBA)	11
Master's of Science (MS)	4
Master's of Public Health (MPH)	7
Master's of Hospital Administration (MHA)	2
Master's of Public Administration (MPA)	1
Doctor of Philosophy or Psychology (PhD)	2
Master's of Medical Management (MMM)	1
Juris Doctorate (JD)	1
Other	2

Source: *The 1997 Physician Executive Compensation Survey*, Cejka & Co., St. Louis, and the American College of Physician Executives, Tampa.

offers a similar program for about \$2,000.

Regardless of the option chosen, physicians who want to become administrators or group leaders should consider advanced degrees, says Harvard's Herzlinger. “Bill Gates, Sam Walton, and Ray Krock all

have important lessons for physicians who wish to emulate their entrepreneurial success,” she says. “These lessons can best be learned in a business school.”

—Reported and written by Martin Sipkoff, a health care writer in Gettysburg, PA.

# GE Health Director Calls for More Interaction Between Purchasers, Providers



**Robert S. Galvin, MD,** is director of corporate health care and medical programs for General Electric Co., in Fairfield, Conn. He is responsible for managing the design, and financial and quality performances of GE's health benefits internationally, which cost over \$1.3 billion annually. A graduate of the University of Pennsylvania School of Medicine, Galvin also oversees GE's international medical services.

**Q:** Dr. Galvin, please tell us how your background led you from medical school to become director of corporate health care for a huge multinational corporation.

**A:** After graduating from medical school, I trained as a general internist in Boston and stayed there during six years of practice. While I was in practice, the managed care movement took hold in the Boston area. I became involved in managed care contracting, and later in doing utilization management at a hospital in Salem, Mass. In 1990, the opportunity arose to join GE, and because I wanted to expand what I was doing in the business side of medicine, moving to the purchaser side seemed to be where a physician could have a lot of influence on the health care system, versus staying on the provider or the health plan side.

My first position with GE was as local medical director of the company's aircraft engine plant in Lynn, Mass. Next, I became the regional health care manager, and later the health care manager for all of GE's aircraft engine business, which is based in Cincinnati and involved about \$200 million in health care spending.

**Q:** You have compared the quality of making jet engines to the quality of care delivered in treating cardiac disease. Could you expand on that comparison here?

**A:** I think we have to be very careful with any comparison between a people-ori-

ented industry like health care and a manufacturing industry like jet engines. But there are still some lessons to be learned, and I ask physicians to keep an open mind about them.

The analogy I use captures what I would like to see the health system achieve, which is much more interaction and much more contracting between the real payers—that is, the purchasers or employers—and physicians and hospitals. For that to happen, we need to be speaking the same language. Unfortunately, we have a language problem involving the word “quality.” Physicians believe that employers like GE buy health care based on price and don't care about quality. But that's not true.

One way I try to get that message across is to draw cost and quality comparisons between non-health-care and health care

where I think the provider system has done a good job, to address more structural health care issues, such as too many empty hospital beds and the excess capacity among specialists. So, I try to push the analogy to show that we believe that as quality increases price goes down, not vice-versa.

**Q:** In one of your talks, you sought to debunk the myth that corporations are interested in only primary care gatekeepers, leaving specialists an endangered species. Would you elaborate on that here?

**A:** This morning, as it turns out, I spoke with two people who have fairly bad diagnoses. Neither asked me for a gatekeeper or about the health plan, but rather about who would be the best person to deal with their particular situation, which, in both cases, happened to be specialists. About

**“We want what our employees and their families want—and that is high-quality, appropriate health care.”**

relationships. I use jet engines in my analogy because people tend to care very much that jet engines function properly and they also care that their surgeon or internist is doing the right thing. In other words, both situations involve things that are important to people. And in neither situation, can you go cheap. On the jet engine side, we are now building engines that have more capacity and are of better quality than ever before—for essentially 5% less every year. And we're doing it with almost 40% fewer employees. Some of these reductions are the result of technological breakthroughs, but rigorous management of costs and an understanding of how to deliver a product are also important factors.

Turning to the health care side, data show, for example, that length of stay for heart surgery used to be two to three weeks; now it is four to five days. But I want to move beyond the topic of length of stay,

10% of our population spends about 70% of the population's health care dollars, although they aren't the same people every year and the diseases could be cancer, heart disease, or trauma, all of which are better handled by specialists. So, the argument that employers want a gatekeeper not a specialist isn't true because we want what our employees and their families want—and that is high-quality, appropriate health care.

**Q:** You have said that corporations would like to engage in a direct dialogue with doctors without necessarily having to go through an HMO intermediary. Is that true?

**A:** That is very true. The only entity that has tried to organize the health care system in a way that we, as customers, want is the HMO industry. What we've generally heard from physicians and hospitals is, “We know what we're doing, so leave us alone and stop hassling us about cost.” When we present them with data showing that only

50% of our people are getting beta blockers after heart surgery, that the drug error rate in the hospital exceeds 4%, that only 60% of our eligible women get mammograms, and that only 20% of our asthmatics who go to the emergency room or get health care are on inhaled steroids—in effect, when we show them what we think are quality problems, what we hear back is basically, “They’re bad data,” or “We know what we’re doing,” or “Stay out of our business.”

The only entities that have said that they believe they can apply basic organizational structure are the HMOs. And the reason we’ve been with the HMOs is that there has been no one else in town. But it has become clear to us that the first generation of managed care, which has been this kind of HMO, is just not going to get us where we want to be. We do need to have a direct dialogue with physicians and hospitals, but to do so we need to be speaking the same language.

**Q.** *You have said that if integrated groups with performance guidelines and measured outcomes were established, purchasers would come to them. Are you waiting, then, for doctors to form organized groups that talk the same language as the purchasers?*

**A.** That not only talk the same language but also show value. Currently, we have only two direct contracts with provider organizations. What frequently happens during our initial conversations with other provider organizations is that these organizations take the same doctors we have been using through HMOs and put them into an organization that develops practice guidelines but doesn’t enforce them. What we generally end up with are proposals that don’t guarantee us anything in terms of better quality but will increase our costs by 10% to 15%.

**Q.** *Describe for us some good relationships that GE has had with physicians, if any.*

**A.** The best we’ve had is the modified direct contract with a provider group in western Massachusetts. But before I go further, let me talk about what I mean by a more direct relationship with physicians.

We aren’t talking about pure direct contracting or cutting out the HMO. In fact, we believe that in almost every case we need the HMO to do what it does best—pay claims, sometimes organize information

the total dollars began to exceed the cap rate, the physicians said, “We didn’t know what we were getting into,” and gave us two weeks’ notice that they were no longer going to honor the contract. Although we

**“The reason we’ve been with the HMOs is that there has been no one else in town.”**

systems, and certainly help us with out-of-network services. We keep the HMO in, but try to move the medical management functions to the provider group. With our group in western Massachusetts, we agreed on a rate and made a long-term deal. The group is realizing that it has a lot of challenges—mainly because it has not taken any active steps either to narrow its network or to apply practice guidelines and so it has exceeded its negotiated cap rate. But even so, the dialogue between us has been excellent. Rather than saying, “We know

were able to salvage the situation by raising the cap rate, it worried us that our employees might have lost access to their doctors.

**Q.** *How important and how big are health care costs to companies like GE, and are those costs eroding these companies’ international competitive position?*

**A.** Those are excellent questions, but they must be looked at in perspective. What’s really important to companies like GE is that we ship our products on time; if we don’t, a competitor can out-position us in a market. Health care is not the business

**“Health care is not the business of our business; it’s an indirect cost, but it’s our largest indirect cost.”**

what we’re doing, leave us alone,” it has said, “Can we figure out together how we make this work?” And that’s been good.

**Q.** *Can you describe a bad relationship?*

**A.** An example of a bad relationship is the capitated contract we have in the Midwest. Even such as it is, we would be reluctant to get out of the relationship because we deal with as many as 50 different HMOs right now, and we’re not interested in having the number of HMO contracts go up into the thousands. However, we have, in such unsatisfactory relationships, directed HMOs to hand over the medical management and have worked out a deal with the groups, thereby dividing the functions of who is doing what. With the group in the Midwest, for example, when

of the business; it’s an indirect cost, but it’s our largest indirect cost. At a couple of billion dollars, it eats up the domestic after-tax profits of two or three of GE’s 12 businesses.

So, in the big picture, the importance of health care costs pales in comparison to what’s going on in, for example, the Asian markets right now. But having said that, when you have a cost that eats up the profits of several businesses and represents spending that involves waste and inefficiency, it becomes an important issue.

As for whether GE’s health care costs are eroding our international competitive business, you have to realize that our market basket of prices goes down every year. In other words, people today are buying refrigerators, for example, for less than they

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bought them for 20 years ago. So, to the extent that we need to continue to increase profits as all public companies do, the cost of doing business is a big issue. And to the extent that health care costs are higher, it means our products cost more.

**Q.** Can you help physicians to understand more fully the problems you—as a purchaser—see in the current health care situation?

**A.** There is overuse, underuse, and misuse—those are the three parts of the quality triangle. It's a myth to think that we, in the employer world, are more upset about overuse than we are about underuse or misuse.

**Q.** So, you're really concerned about appropriate use?

**A.** Very much so. Again, it's the cost-quality issue. To the extent that we're not diagnosing breast cancers at early stages, for example, it's a quality problem that causes the overall cost of breast cancer to go up. It's the same quality issue involved in prescribing beta blockers after heart surgery. Everyone who ought to be getting them isn't, and because they aren't, some of them could have another cardiac event. That's the cost-quality link. Now, we can also find the same problem is involved in the overuse of medical services, but it is more prevalent in instances of underuse or misuse.

**Q.** So, you have to analyze overuse, misuse, and underuse issues in context, right?

**A.** Absolutely. For example, when new technologies are developed or new pharmaceuticals come out, everyone loves them and we want our employees to have them. But to be able to afford them, we have to get rid of the inefficiencies in the system and address the other quality issues.

**Q.** What, then, is GE's future overall health strategy?

**A.** We're going in two directions strategically. One way is to try to maximize first-generation managed care. We have over 70% of our people in these point-of-service networks, and we're pretty much on a plateau there. It's a better system than the indemnity system, but it isn't progressing very fast. To measure and drive quality, we survey our employees to understand their needs and then develop scorecards to measure how well our health plans are meeting those needs. Of the 100 points on a scorecard, only 40 are based on cost and price; 60 deal with quality issues. So, we're trying to

push the first-generation managed care forward through the use of these scorecards.

The second strategic direction is in its exploratory phase, and that is to work out a second-generation health care strategy, and we are exploring numerous ways of doing this. One is to establish a more direct relationship with providers, and going to more carve-outs is not particularly the direction in which we'd like to move. We would rather integrate than disintegrate the system. And our ideal would be to go with a provider health system that we could do a single contract with. But within that system, certain carve-outs would be possible, such as heart disease being carved out to a local group consisting of specialists. So, we're not seeking to dissolve the system by going to carve-outs, but to the extent that we're in a transitional stage and because we can't find such provider systems yet, that's where we are.

If we find organized groups that know how to deal with the intense cases that are eating up our costs, we'd be interested in figuring out how to arrange relationships with them, but we're not seeking them out.

**“When you have a cost that eats up the profits of several businesses and represents spending that involves waste and inefficiency, it becomes an important issue.”**

We're seeking out overall provider systems. But, because they are not there yet, we would be very interested if we could get a compelling story from a specialty group.

**Q.** Are you using scorecards to achieve measurable consistency across the spectrum?

**A.** No, it's not about reducing variation around the mean as much as it is about establishing benchmarks and creating incentives for providers we contract with to reach those benchmarks. One measure we use is the Health Plan Employer Data and Information Set [HEDIS], developed by the National Committee for Quality Assurance, an organization in Washington, D.C., that accredits health plans. What we're looking for in HEDIS measures, for example, is a higher rate of mammography screening. That isn't simply reducing variation as much as it is driving people to a benchmark.

**Q.** Would you prefer to deal with large, integrated organizations that have all of the pieces, including catastrophic care, but if they do not exist, be willing to go to a specialty network that provides, say, superior cardiac care?

**A.** Yes. I would hesitate, however, on the word “large” because usually when you get large, you get slow and inefficient. I don't want to give the impression that what we want is “large.” What we want is a provider to meet the various needs that we have.

**Q.** Do you think the system is moving in that direction?

**A.** The system is definitely moving, and a lot of consolidation is going on. Right now the system is at a branching point. Either it's going to consolidate into what will become true integration that gets rid of excess capacity and meets customers' needs or it will consolidate into a system that dominates an area but doesn't solve the excess capacity problems or address quality issues. In this early stage, the health care system is moving more toward the latter than the former.

**Q.** You mean that the system is moving toward a large, dominant, critical mass

without delivering on the quality and performance side?

**A.** That's right. And in that regard, what's happening in health care isn't any different than what has happened in other industries. When an industry tries to transform itself, it is the natural first step for the participants to try to dominate either geographically or by size. If the market works, the buyers—that is, employers and perhaps some day public purchasers—will become clear about what they want. If that happens, the market will experience innovation, meaning smaller breakout systems will form that can meet purchasers' needs better than larger systems can. So, it isn't particularly negative that health care is moving as it is, but it isn't yet moving in the direction we're interested in, which is toward provider systems that decrease, not increase, our costs. ■

# Committee Creates Two New Safe Harbors

By Katherine A. Nino, JD, and Edward B. Hirshfeld, JD

Earlier this year, a committee of federal officials and health care policy experts agreed on an outline for a rule that would create two safe harbors to the federal Anti-kickback Statute. When the rule is issued, it is expected that its content will be based on the committee's outline.

These new safe harbors will give meaning to the shared-risk exception to the Anti-kickback Statute. Physicians should understand these safe harbors because, by structuring their managed care contracts with health plans and with other health care providers according to the safe-harbor requirements, they can shield themselves from liability under the federal Anti-kickback Statute.

The Federal Anti-kickback Statute Under the federal Anti-kickback Statute, it is illegal to receive remuneration in exchange for, or to offer or pay remuneration to induce, the referral of Medicare or Medicaid beneficiaries. Remuneration includes that which is received, offered, or paid "directly or indirectly, overtly or covertly, in cash or in kind." Under this definition, all managed care contracts involving Medicare or Medicaid beneficiaries technically violate the Anti-kickback Statute because discounts, and other such managed care payment mechanisms, are a form of remuneration to health plans and other entities functioning as a referral source for Medicare and Medicaid patients. Federal fraud enforcers have not targeted managed care arrangements for prosecution under the Anti-kickback Statute because these arrangements typically are not accompanied by incentives to overutilize Medicare and Medicaid services, but rather are usually designed to promote the cost-efficient use of services.

Most managed care arrangements are legitimate and do not involve kickbacks.

*Katherine A. Nino, JD, is a staff attorney and Edward B. Hirshfeld, JD, is a vice president in the AMA's Health Law Division.*

## Health Plan Requirements Under Safe Harbor No. 2

An arrangement between providers and a health plan comes within the scope of the second safe harbor if the health plan provides a full range of health services and includes within every provider contract each of the following:

- Reasonable utilization goals
- An operational utilization review program
- A quality assurance program
- Grievance and hearing procedures
- Protection for members from incurring financial liability
- Treatment for federal health care program beneficiaries that is no different from that furnished to other enrollees because of their status as federal health care program beneficiaries
- Where the plan is self-funded under the federal Employee Retirement Income Security Act of 1974, Medicare beneficiaries account for no more than 10% of enrollees where Medicare is primary (or account for less than 50% where Medicare is not primary), and payments for premiums by the plan are received periodically and do not take into account when and how many services are provided.

Even so, only those that are structured so that it is virtually impossible to abuse Medicare and Medicaid are guaranteed immunity from anti-kickback liability.

### Safe Harbor No. 1

The first safe harbor applies to a broad array of arrangements between managed care organizations (MCOs) and providers, including individual physicians and physician organizations, such as IPAs, groups, and networks. Under this safe harbor, providers are not subject to anti-kickback liability for arrangements through which they provide health care items and services to MCOs that receive set, prospective payments from the government, such as:

- Risk-based HMOs and competitive medical plans (CMPs) with Medicare contracts
- Cost-based HMOs and CMPs with Medicare contracts
- Federally qualified HMOs for their capitated enrollees
- Any Medicare Part C health plan that receives a capitated Medicare payment and that has its total Medicare beneficiary cost-sharing approved by the federal

Health Care Financing Administration (HCFA), excluding Medicare+Choice fee-for-service (FFS) providers and medical savings account (MSA) plans

- Certain Medicaid MCOs under section 1903(m), except for FFS or MSA plans
- Certain health plans receiving section 1115 waivers
- The Program of All-inclusive Care for the Elderly (PACE), except for certain for-profit demonstrations
- TriCare, the Department of Defense's managed care program.

This safe harbor also protects contractual arrangements between these providers and all the providers with which they contract as long as the health plan with which the initial provider contracts is not a federally qualified health center receiving supplemental payments, a cost-based HMO, or a federally qualified HMO.

### Safe Harbor No. 2

The second safe harbor is narrowly drawn and applies in only a few situations; that is, to arrangements involving providers and commercial health plans that have

*(Continued on page 14)*

**Complying with one of the safe harbors guarantees that an arrangement will not be prosecuted under the Anti-kickback Statute. Failing to qualify for a safe harbor, however, does not mean a particular arrangement is illegal.**

(Continued from page 13)

Medicare-eligible enrollees, and in which the plan is reimbursed by the Medicare or Medicaid program on a FFS basis. Also, the plans of such arrangements must meet several requirements that need to be spelled out in every provider contract. (See sidebar, "Health Plan Requirements Under Safe Harbor No. 2.") An example of a situation within the reach of this safe harbor is one in which a 65-year-old retiree is enrolled in an HMO offered by his former employer and the HMO is reimbursed by Medicare on a FFS basis for services furnished to the retiree by a physician who has a contract with the HMO.

The concept of "substantial financial risk" is at the core of the second safe harbor. It protects managed care arrangements if the plan passes substantial financial risk to the provider (such as an individual physician, group, or IPA) for the cost or utilization of items and services the provider is obligated to provide. To determine whether such risk is present in a particular managed care arrangement, the safe harbor offers three tests: the Payment Methodology Standard, the Numeric Standard, and the Physician Incentive Plan Standard. If substantial financial risk is found to exist under any of these standards, the arrangement will qualify for safe-harbor protection.

**Payment Methodology Standard.** This standard focuses on how the physician (or group or IPA) is paid by the plan. If the payment arrangement fits a specified category, it will not be scrutinized under the Anti-kickback Statute. Payments made on the following basis will meet this standard:

- Full capitation
- Percentage of premium
- Inpatient federal health care program diagnosis-related groups, except those for psychiatric services.

**Numeric Standard.** Most arrangements falling outside of the categories listed above will be analyzed according to the Numeric Standard. To satisfy this standard, the amount

a physician, group, or IPA receives upon meeting a specified utilization target (or range of targets) must be at least 20% greater than the amount the provider would receive if the utilization target were not achieved.

Here's an example: A contract with an HMO sets a physician's annual salary at \$120,000, of which the HMO withholds \$20,000 to be returned to the physician at year end if he meets certain utilization targets. In this situation, the physician is guaranteed to receive \$100,000, but has the potential to receive \$120,000. Because the amount he could receive (\$120,000) is 20% greater than the amount he would receive without modifying his behavior to meet specified utilization goals (\$100,000), the physician is at substantial financial risk for the items and services he furnishes to the HMO.

**Physician Incentive Plan Standard.** If a health plan places a physician or group at risk for referral services such that the risk-sharing arrangement has the potential to make the physician or group responsible for more than 25% of potential payments by the plan, the physician or group is at substantial financial risk as long as the plan:

- Provides stop-loss protection for the physician or group that is adequate and appropriate; and
- Conducts periodic surveys of both previous and current enrollees to determine the degree of access to and quality of services provided by the plan.

If the patient panel consists of 25,000 or more covered lives, however, the provider would not be considered to be at substantial financial risk.

As with the first safe harbor, this safe harbor extends anti-kickback protection to managed care arrangements between providers along the contracting chain of a physician, group, or IPA that assumes substantial financial risk from a health plan. The same tests—the Payment Methodology Standard, the Numeric Standard, and the Physician Incentive Plan Standard—are applied to determine

whether substantial financial risk exists in the downstream contractual arrangements. But even if substantial financial risk exists in a particular risk-sharing arrangement, safe-harbor protection would be granted to that arrangement only if substantial financial risk exists in the arrangement immediately preceding the one in question.

#### The Trading Business Provision

Physicians should be aware of the "trading business" provision in both safe harbors. This provision disqualifies from safe-harbor protection managed care arrangements in which the contracting parties specifically intended to "swap" Medicare FFS business for lower payment rates on other lines of business. If an IPA accepts low capitation rates, for example, from a Medicare-risk HMO specifically to induce the health plan to direct to the IPA Medicare beneficiaries from another line of business for which the HMO is reimbursed by the Medicare program on a FFS basis, the arrangement would not receive anti-kickback protection under the first safe harbor. Physicians should not assume, however, that this provision automatically disqualifies them from safe-harbor protection in all situations in which physicians participate in multiple lines of business with an MCO.

Complying with one of the safe harbors guarantees that an arrangement will not be prosecuted under the Anti-kickback Statute. Failing to qualify for a safe harbor, however, does not mean a particular arrangement is illegal. Illegality under the Anti-kickback Statute requires the government to show that the parties in an arrangement intended to induce Medicare and Medicaid referrals. Physicians entering a managed care arrangement involving Medicare and Medicaid patients should consult a qualified attorney to determine whether the arrangement will be protected under a safe harbor. If the arrangement fails to qualify for safe-harbor protection, physicians can ask HCFA to issue an advisory opinion as to its legality. ■

# PPMC Acquisition Pace Remains Strong

By W.L. Douglas Townsend Jr. and Jill S. Frew

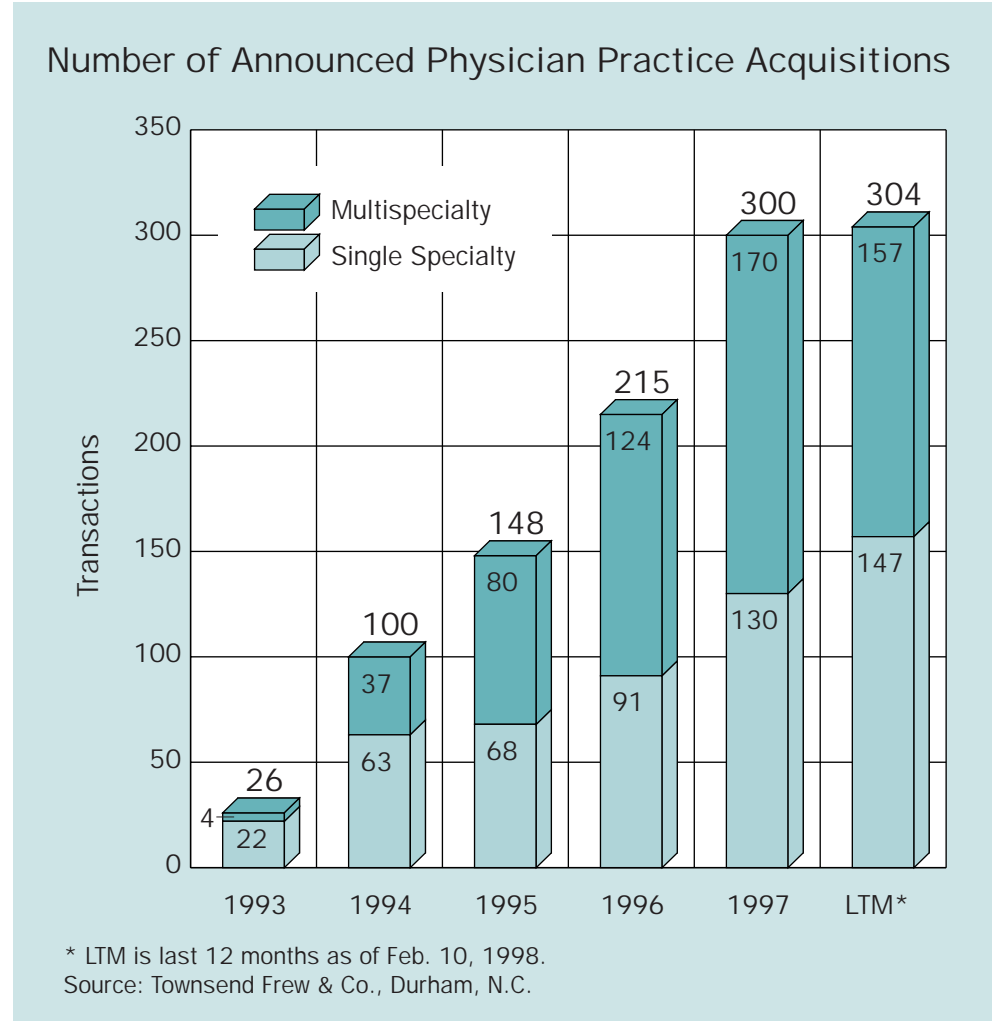
The pace of acquisitions among physician practice management companies has not been slowed by recent negative news about PPMCs. Through Feb. 10, these companies have announced 54 clinic affiliations this year; roughly 80% involved multispecialty or primary care clinics. Oak Tree Medical Inc., in Flushing, N.Y., accounted for almost 60% of these multispecialty or primary care acquisitions. On Jan. 13, Oak Tree signed a letter of intent to acquire 21 medical practices and MRI centers in the New York metropolitan area. These practices and centers had combined revenue of \$65 million and pretax profit of \$19 million. Other 1998 transactions are highlighted below.

## Transaction Highlights

On Jan. 27, American Physician Partners Inc., in Dallas, affiliated with Community Radiology Associates Inc., a 10-physician radiology practice in Rockville, Md., that generated \$16.7 million in revenue last year. The acquisition gives American Physician Partners a total of 97 radiologists and 36 imaging centers in the Baltimore-Washington area. Also on Jan. 27, American Physician Partners acquired four imaging centers in Northern California with combined 1997 revenue of \$6.3 million.

On Jan. 26, ProMedCo Management Co., in Fort Worth, acquired HealthStar Inc., a private PPMC in Knoxville, Tenn. Under the agreement, ProMedCo will manage HealthStar Physicians PC, a 13-physician multispecialty group. The transaction will be accounted for as a pooling-of-interests.

On Jan. 22, FPA Medical Management Inc., in San Diego, acquired Orange Coast Managed Care Services Inc. and St. Joseph



Medical Corp., both in Orange County, Calif., in a stock-for-stock transaction. Orange Coast Managed Care Services manages the St. Joseph Medical Corp., which is comprised of the St. Joseph IPA with 200 primary care and 370 specialty care physicians and the St. Joseph Medical Group with 50 primary care physicians. The transaction

is expected to add 120,000 capitated HMO members to FPA's California operations.

These transactions help to illustrate the various segments of the physician market that PPMCs are targeting and show that physicians in many specialties are continuing to seek strategic partners to help them compete more effectively in evolving markets. ■

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### Study Shows Health Cost Increases Accelerate

Health care costs rose at a 3.8% annual rate for the 12 months ending in September 1997, the latest period for which figures are available, according to the Milliman & Robertson Health Cost Index. But for the quarter that ended September 1997, health care costs rose by 4.4%, up from 3.7% for the quarter that ended June 1997, M&R said.

M&R's forecasters said health care costs will rise more rapidly this year. For the 12 months ending September 1998, health care costs are expected to rise by 4.6%, M&R said. Among the factors contributing to rising costs are increases in hospital outpatient and physician costs, M&R said.

**Comment:** *Low inflation and the fact that so many Americans are enrolled in managed care has helped to moderate the factors that cause health care costs to rise, said Peter Reilly, an M&R actuary.*

### Physicians Who Treat Uninsured Excluded by HMOs

A survey of 947 primary care physicians in California shows that physicians who were not hired by managed care plans had spent much of their time treating uninsured and nonwhite patients. "Physicians in managed care had significantly lower percentages of uninsured and nonwhite patients in their practices," according to the report of the survey. The findings were reported in the March 4 issue of JAMA. Rather than rewarding physicians for being socially responsible, the health care market seems to be excluding them, said the study's authors.

**Comment:** *One reason HMOs exclude such physicians may be that HMOs are not interested in charity work; another reason may be that uninsured patients are drawn to physicians who are not busy treating HMO patients, said the study's authors.*

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April 1998



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