

# PHYSICIAN PRACTICE OPTIONS™

July 15, 2000

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

## CONTENTS

### Features

**Commentary**  
Physicians Challenged  
To Treat Obesity 3

**Organizational Options**  
Unorthodox Faculty  
Group Aims High 10

**Interview**  
AAPS Director Calls  
for Changes in  
Medicare To  
Protect Physicians 12

### Departments

**Editorial**  
Doctor Solomon's  
Dilemma Resonates  
Across the Nation 2

**Strategy**  
Being Lean Can  
Also Be Mean 6

**Capital Ideas**  
Lenders Avoiding  
Health Investments 15

## Physicians Drop HMOs, Yet See Revenue Rise

Last January, Edward Ezrick, MD, did something he never thought he would do. The internist from Brooklyn, N.Y., told one of his six HMO insurers he could no longer afford to be a provider. It was a bold move that followed months of hand wringing.

Last year, Harris Goldberg, MD, a gastroenterologist in Miami, dispensed with seven of the 30 HMOs his 11-physician gastroenterology group had accepted for years. Goldberg is negotiating with another HMO, the income from which totals 10% of the group's annual revenue. "If they don't increase reimbursement and reduce the hassle factor, we'll get rid of them too," Goldberg says defiantly.

Ezrick and Goldberg are like many physicians who once feared facing empty waiting rooms if they did not sign up and remain with multiple HMOs. Yet they and others have reduced their HMO contracts and found their fears unwarranted.

Ezrick inherited patients from another physician's practice. Goldberg's group took on more patients from the group's better-paying HMOs. For both, there was no drop in practice revenue. Instead, they discovered their newly opened schedules permitted slots for better paying patients. Plus, a healthy percentage of their former HMO patients continued their care, switching to plans the doctors accepted or paying for their visits out of pocket. In short, some patients felt more allegiance to their doctors than to their HMOs.

"Physicians who previously thought they needed to get 'in' are now realizing they can survive on a limited number of plans, or they can make it without being on plans at all," says Brian Biles, MD, MPH, chairman, George

Washington University department of health services management and policy, in Washington, D.C.

Ezrick and Goldberg are among a growing number of low-profile, community-based doctors who are either quietly disenrolling from their least profitable plans or leaving all HMOs, according to published reports. It is an about-face from the last decade when physicians hurried to sign up with HMOs, often without reading contracts. If the fees seemed low, they figured they would make up the difference in volume. In some well publicized cases, doctors who felt themselves at the mercy of HMOs filed lawsuits over exclusion from panels or for arbitrary termination.

### An Inevitable Shakeout

Today, a different trend is emerging. Not only are doctors reading the contracts, they also are analyzing financial data and making hard business decisions. In a grass roots revolt that signals physicians' desire to regain control over their practices, some of the same doctors who fought to join HMO panels are retrenching and challenging health plans. Physician lawsuits involving HMOs are more likely to be over low or slow payments rather than over deselection.

The trend toward relinquishing some contracts is still developing and so new that statistics to prove it won't likely appear for five years, says Uwe Reinhardt, a health care economist at Princeton University. Health insurers' trade groups, such as the Health Insurance Association of America, in Washington, D.C., will not admit it is happening. "We can't acknowledge a trend unless there is data,"

(Continued on page 8)

## Doctor Solomon's Dilemma Resonates Across the Nation

In April, the PBS news program *Frontline* aired a documentary, "Dr. Solomon's Dilemma," featuring Marty Solomon, MD, a primary care physician employed by CareGroup, a network of seven hospitals and 3,000 doctors in Boston. Last year CareGroup delivered \$1 billion worth of health care to 400,000 patients and lost \$100 million.

Every day Solomon fields 100 phone calls and answers 50 e-mail messages, while carrying a full patient load and serving as his group's leader. He works in "Pod 11," a small group that meets frequently to review the cost of every pill, test, injection, and day of hospitalization. The group produces a report on the costs each individual doctor generates. The group reviews the numbers and sees how each physician compares with other pod members and how Pod 11 compares with other pods.

These comparisons sometimes embarrass Solomon because they raise questions about his performance. He spends \$12 a month on radiology services per patient, \$2 more than other pod members do, for example. Solomon knows that if other CareGroup doctors used radiology services as Solomon does, CareGroup would be spending \$12 million more on radiology than it does now.

"In the moral, real world, we don't have a choice," Solomon says of his practice patterns. "We have to provide the care, but we can't go on forever for everybody."

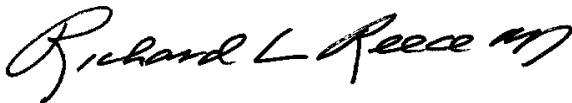
Solomon's dilemma? Professionalism compels him to provide the best care. Yet a constrained budget forces him to give more care for less money. So he does everything faster. His patients are "not people anymore," he says, they're "units of care" and he is required to move each one through the system faster than he has in the past. The system forces Solomon to spend as little as seven minutes with patients in his office and to discharge heart bypass patients after three days.

James Reinertsen, MD, the CEO of CareGroup Health Care System, says, "Federal cuts in payment, decreased rates of payment in managed care contracts, and rapidly rising costs for new, exciting technologies—that's the triple threat we have faced and has caused the red ink in the Boston market."

"We should be making decisions solely based on what's best for the patient," says Solomon. In an ideal world, the mission ought to be more important than the margin. But, in Boston, where health costs are among the highest in the nation, and in other cities and towns nationwide, the margin becomes the mission.

Since costs are so important, physicians must get over grieving about the way things used to be, says Reinertsen, adding, "We need to start building the new institutions. We can't go back to the old."

No, we cannot. But we can work at removing HMOs as fiscal intermediaries, offering consumers free choice of health plans, giving consumers a designated amount of money to spend on health care, and providing physicians with Internet-based business support to cut overhead and promote productivity. To do so, we will need to rebuild the system from the bottom up and put consumers and physicians in control and hold them accountable for the cost of care.



Richard L. Reece, MD  
Editor-in-Chief  
Toll-free phone: 888/457-8800  
E-mail: rreece@moptions.com

Daniel Beckham  
*President*  
The Beckham Co.  
Physician and Hospital Consultants  
Whitefish Bay, Wis.

Thomas M. Gorey, JD  
*President and CEO*  
Policy Planning Associates  
Crystal Lake, Ill.

Michael B. Guthrie, MD, MBA  
*Executive Vice President, Director*  
Center for Clinical Innovation  
Premier, Inc.  
San Diego

Harold B. Kaiser, MD  
Allergy & Asthma Specialists, P.A.  
Minneapolis

Nathan Kaufman  
*President*  
The Kaufman Group  
Division of Superior Consultant Co. Inc.  
Physician and Hospital Consultants  
San Diego

Paul H. Keckley  
*President and CEO*  
webEBM  
Nashville, Tenn.

Peter R. Kongstvedt, MD  
*Partner*  
Ernst & Young  
Washington

Richard Liliedahl, MD  
*Health Care Consultant*  
Milliman & Robertson Inc.  
Seattle

Lee Newcomer, MD  
*Executive Vice President*  
Vivius Inc.  
St. Louis Park, Minn.

James G. Nuckolls, MD  
*Medical Director*  
Carilion Healthcare Corp.  
Roanoke, Va.

Brooks G. O'Neil  
*Managing Director*  
Piper Jaffray Inc.  
Minneapolis

Bernard Rineberg, MD  
*Physician Consultant*  
BAR Health Strategies  
New Brunswick, N.J.

Carl Schramm  
*President*  
Greenspring Advisors, Inc.  
Towson, Md.

Jacque Sokolov, MD  
*Chairman*  
Sokolov Schwab Bennett  
Los Angeles

W.L. Douglas Townsend Jr.  
*Managing Director and CEO*  
Townsend Frew & Co., LLC  
Investment Banking  
Durham, N.C.

This newsletter is published by Premier Healthcare Resource, Inc., Parsippany, N.J.

© Copyright strictly reserved. This newsletter may not be reproduced in whole or in part without the written permission of Premier Healthcare Resource, Inc. The advice and opinions in this publication are not necessarily those of the editor, advisory board, publishing staff, or the views of Premier Healthcare Resource, Inc., but instead are exclusively the opinions of the authors. Readers are urged to seek individual counsel and advice for their unique experiences.

**Publisher**  
Premier Healthcare Resource, Inc.  
888/457-8800  
E-mail: publisher@moptions.com  
Publishing Address: Premier Healthcare Resource, Inc.  
Suite 300, 99 Cherry Hill Road  
Parsippany, NJ 07054

**Editor**  
Joseph Burns  
508/495-0246  
E-mail: editor@moptions.com

# Physicians Challenged To Treat Obesity

By Richard L. Reece, MD, Editor-in-Chief

Last fall, the federal Centers for Disease Control and Prevention (CDC), in Atlanta, reported that obesity is an epidemic in this country. By analyzing measures of body mass index (BMI), the CDC calculated that 22% of all Americans—97 million people—are obese, and 33% are overweight. The CDC characterized this circumstance as a national health crisis.

The CDC report and studies published by the *New England Journal of Medicine* and *JAMA* have helped to put the spotlight on obesity as a disease. In the past, the specialty of bariatrics, which focuses on the treatment of obesity, had not been considered by the physician community to be a mainstream field of study. The new focus on obesity is legitimizing the treatment of obesity as an important contribution private physicians can make toward improving the health of patients.

Richard Dickey, MD, a practicing endocrinologist in Hickory, N.C., believes that the time has come for physicians to treat obesity as a serious chronic disease and incorporate weight counseling as a crucial mainline practice activity. In so doing, they will help improve the quality of care and the health of their patients, who, if seriously overweight, face complications from diseases such as diabetes and hypertension and possibly premature death.

"It is incumbent upon us to accept the challenge of controlling the obesity epidemic," says Dickey, who is also the president of the American Association of Clinical Endocrinologists (AACE) in Jacksonville, Fla.

In addition to helping patients improve overall health, physicians may find that treating obesity can be a practical practice option. A study last year by Scott-Levin, researchers in Newtown, Pa., showed that 78% of patients pay out-of-pocket for weight management services, some of which are developed and offered by physicians out of their own offices. In addition, most of these patients—70%—are women between

the ages of 26 and 55. Women, of course, serve as important referral sources, making health care decisions for their families, guiding their husbands and children to particular providers. Therefore, physicians can generate revenue by offering weight management programs or providing services that increase the number of referrals from other physicians.

## A New Focus

As an endocrinologist, Dickey is well aware of the national battle against obesity. "Ninety-seven million Americans are obese, and 150 million are overweight," he says.

The focus on obesity as an epidemic is a relatively recent phenomenon. "The fact that a worldwide epidemic of obesity exists has been well established by the World Health Organization, which highlighted the issue in a 1997 report," Dickey says. Also in 1997, the American College of Endocrinology (ACE) and the AACE published a position paper on obesity, recognizing it as a widespread health hazard. Then, in 1998, the National Heart Lung and Blood Institute at the National Institutes of Health, in

weight or prevent obesity, then drug therapy may help them. Occasionally, patients who are severely obese may be candidates for surgery, either gastric stapling or intestinal bypass."

Each year, more than 350,000 deaths can be attributed to obesity, a statistic published in an article in *NEJM* last year. "One year ago, statistics showed that 350,000 deaths annually in this country could be attributed to lifestyle and eating habit disorders," Dickey says. "We have seen a progressive increase in the percentage of Americans who are overweight or obese as defined by body mass index and this percentage continues to increase. A national goal, set 10 years ago, to get this epidemic under control by the year 2000 by reducing overweight and obesity to only 20% of the population has obviously not been achieved. In fact, the prevalence of overweight and obesity continues to increase."

The medical community's interest in the problem is growing. Three weeks after an article titled "Body Mass Index and Mortality in a Prospective Cohort of US Adults" was published in *NEJM*, Oct. 7, *JAMA* devoted an entire issue to the

**Almost 80% of patients pay out-of-pocket for weight management services, and most of these patients are women who make health care decisions for their families.**

Bethesda, Md., published an evidence-based report on obesity.

"As a result, the medical community has come to recognize that obesity is a disease that we haven't acknowledged or treated very effectively over the past few decades," Dickey explains. "Obesity is just like hypertension or diabetes. It is a chronic disorder and requires chronic treatment. If patients can't adhere to the caloric restriction, increased physical activity, and behavioral changes necessary to reduce and hold their reduced

topic (Vol. 282, Oct. 27). In addition, several leading medical institutions have joined forces in a project to establish the Centers for Obesity Research and Education (CORE), in New York.

"Finally, forces are converging to fight the obesity epidemic," Dickey says. "The Centers for Obesity Research and Education have designed programs to educate physicians about how to care for overweight and obese patients. Several of these centers have begun their pilot pro-

(Continued on page 4)

(Continued from page 3)

grams within the last year or two, bringing physicians together for a short, intensive educational course on obesity.”

### A Lack of Understanding

Weight loss is difficult because it requires changes in a patient's behavior and lifestyle. Most of the patients who visit physicians for weight management are women, although as many men are overweight as well, Dickey notes. “In addition, we have an increasing problem with adolescent obesity, but adolescents don't go to the doctor for treatment,” he says. “Obesity is a serious problem for them. If we could get to those children and help them to address the problem and stop the weight gain, we could ameliorate the high rate of obesity in adults.”

A growing number of obese teenagers have developed diabetes due to weight gain and obesity related to poor eating habits and lack of physical activity. “These children have Type 2, rather than Type 1, diabetes,” he says.

Moreover, Americans fail to recognize that many low-fat diets provide just as many calories as a regular diet. Therefore, although a person on a low-fat diet would be eating less fat, he or she may still be getting heavier. “A person can eat a larger volume of foods that are less dense in calories but get the same number of calories,” Dickey adds.

Dickey regularly seeks to address over-

weight and obesity in his own practice. “I determine the BMI of every patient I see,” he says. “It's easy. To make the determination quickly, we use BMI charts, which show BMI for various height and weight combinations. Then, we share this information with the patient and the consulting physician, educating both in the process.”

A healthy BMI ranges from 19 to 25. A person who is overweight or who has an unhealthy weight will have a BMI above 25. Obesity is defined as a BMI of 30 or greater.

“At a BMI of between 25 and 30, patients are at increased risk of many diseases, including those that are causes of premature death and disability or morbidity, such as hypertension, diabetes, or heart disease,” Dickey explains.

If a patient is significantly overweight, Dickey advises caloric restrictions. Generally, people who want to lose weight should consume between 1,000 and 1,500 calories per day, he says. “I provide them with a pyramid system diet, which suggests an appropriate level of calories for their activity level,” he explains. The top of the pyramid consists of foods to avoid, if possible, such as fats, sugar, and sugar-based products, which offer more caloric than nutritional value. Below are meats and milk, which should be consumed in small portions. Larger portions of fruits and vegetables are below these, and at the bottom of the pyramid are starchy carbohydrates such as breads and cereals, which should com-

prise the largest portion of food intake.

Dickey also offers advice to patients regarding exercise. “I tell my overweight and obese patients that they need to increase their physical activity no matter what they are doing,” he says. “There are many simple little ways to do it. For example, they can choose to park at the far end of the parking lot at the mall. They can take daily walks. They can walk up and down one flight of stairs. In general, I tell them to find an activity to do at least three times a week that makes them short of breath for 20 or 30 minutes. That's the minimal level of activity they should strive for.”

While Dickey does not offer any services personally other than physician supervision and one-on-one counseling, he does refer patients to other groups. “Without group support, patients generally don't succeed at losing weight,” he says. “I often refer them to area programs at the YMCA or Weight Watchers that can teach them how to eat properly. Such groups provide very good support, and they are very economical.” More intensive weight management programs might include several components needed to achieve a healthy BMI: counseling about diet, lifestyle changes, physical activities, and pharmacological therapy.

Given the number of overweight and obese Americans, it is safe to say that all primary care physicians have patients with weight problems. In fact, most obese patients are treated by PCPs who can adopt some of the same diet and exercise

## Specialist Finds Success in a Small Town

Since 1991, Richard A. Dickey, MD, has been practicing endocrinology in Hickory, N.C., a town of 28,000 residents in the western part of the state.

He markets his practice to both consulting physicians and patients. “When I first came to Hickory and started a solo practice, I visited and wrote letters to physicians telling them what assistance I could offer to their patients,” Dickey says. “I also gave talks, not only to physicians but to lay people as well. When another endocrinologist joined my practice last fall, we put some ads in the paper, wrote letters to and visited the physicians in the area. But physicians, in general, are not that great at marketing. As a specialty practitioner, it's really reputation that draws patients to you, both from consulting

physicians and through patient-to-patient referrals.”

Practicing a subspecialty such as endocrinology in a small community like Hickory is exciting, Dickey says. “It is challenging but fun to help bring a high level of care for patients with endocrine disease to such an area,” he says. The need for such care was obvious to him from earlier in his career when he worked in the area as a general internist. Meeting that need was the primary reason for his return to the area many years later. “The opportunity to help others, the main reason most doctors go into medicine, has been fulfilled by practicing in nonurban North Carolina,” he says.

—DJN

**“The prevalence of overweight and obesity continues to increase.”**

**—Richard Dickey, MD**

counseling techniques that Dickey offers.

“Unfortunately, though, most PCPs don’t have enough time to spend with patients to do thorough counseling with regard to weight and exercise issues,” Dickey says. “In most cases, PCPs should talk about the health risks of being overweight and then send the patients to a focused program. Still, it is possible for physicians to offer an effective, focused, multicomponent weight loss and control program in their own facilities if they wish.” (See, for example, “Niche Programs, Careful Marketing Help Seasonal Practice Succeed,” *Practice Options*, May 30, available on our website.)

**Pharmacological Therapies**

Patients who cannot control their weight by limiting their calorie intake, increasing their physical activity, and making lifestyle changes may be candidates for pharmacological therapy. Dickey acknowledges that there have been health scares in regard to several weight-loss drugs, but believes that both physicians and the public have become overly conservative with regard to the use of effective and safe drugs for overweight and obesity.

Of course, pharmacological therapy is appropriate only in certain cases, and about 20% of Dickey’s obese patients are prescribed such medications. “Most patients are perfectly willing to try caloric restrictions and increased activity,” he says. “Only when that fails is pharmacological therapy used.” More of his patients could benefit, however, if more health insurers were willing to pay for these therapies, he says.

“Most of the insurance companies have not caught on to the fact that they are good therapy,” Dickey says. “In many cases, patients have to pay out of pocket for these medications.” Managed care companies reimburse for drug therapy for about 20% of patients, he adds.

Regardless of the use of pharmacological therapies, Dickey is pleased that the treatment of obesity in clinical practice has achieved genuine legitimacy. “The treatment of obesity should not be a practice option,” Dickey asserts. “Physicians should be required to address the patient’s needs or refer the patient for care if they see patients with overweight and obesity. That’s part of our obligation as physicians.”

—Additional reporting and writing by Deborah J. Neveleff, in North Potomac, Md. More information on practice strategies is available on our Web site (see page 16).

# Want to make certain that you receive each month’s issue?

## SUBSCRIBE TO PHYSICIAN PRACTICE OPTIONS

**OUR ARTICLES FOCUS ON:**

- Understanding the dynamics of managed care
- How to strategically position your practice for success in today’s health care market
- Effective organizational options
- Maximizing your practice through health care informatics



**1 year (12 issues) - \$110**

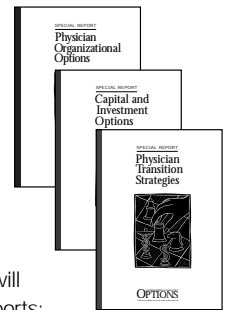
A 50% savings off the regular price. Act now and you will receive one free Special Report of your choice:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES

**2 years (24 issues) - \$170**

An additional \$50 savings off the special 1 year subscription rate. Act now and you will receive a complete set of three Special Reports:

- PHYSICIAN ORGANIZATIONAL OPTIONS
- CAPITAL AND INVESTMENT OPTIONS
- PHYSICIAN TRANSITION STRATEGIES



**Please call 888-457-8800 to order your subscription now, or fax this order form to 973-316-5989 or mail to:**

Physician Practice Options  
99 Cherry Hill Road Suite 300  
Parsippany, NJ 07054

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

Payment method:  Check enclosed  Bill me  Credit card.

If paying by credit card, please fill in the following information:

Credit Card (type) \_\_\_\_\_ Exp. Date \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Name on card \_\_\_\_\_

Billing address \_\_\_\_\_

Signature \_\_\_\_\_

Checks should be made payable to: Physician Practice Options

EXPIRES: 12/00

#FSR110.170

# Being Lean Can Also Be Mean

By Neil Baum, MD

As physicians seek ways to downsize, cut costs, and re-engineer their practices to increase profit, there is an inherent risk that they will also reduce services to patients, which, ultimately, can affect a practice negatively.

A physician group that reduces overhead costs too much may fail to recognize the damage done to the stability of the operation. Inefficiency, inaccuracy, and poor patient service can affect profitability and long-term stability just as seriously as excess overhead can.

To be sure, some budget cutting is necessary and desirable. Every practice contains fat that should be cut to improve efficiency and to increase profit. There is a point, however, when becoming lean can translate into becoming mean with regard to patient care.

## Patient Service

Practices that fail to call patients back in a timely fashion with lab results or to answer questions from patients because the staff is overworked will not be providing high-quality service. Primary care doctors who have not received a timely referral letter from a specialist and have to contact the specialist because the patient called with a question about a recommendation will soon find another referral source. These are just two of the signs your practice may be too lean and too mean.

Physicians seeking to cut costs may want to answer some of the following questions to identify the signs of becoming too lean so that patient-care service does not become impaired. The first place to look for symptoms that you are getting too lean is in the area of patient care. Ask questions such as these: Are patients waiting more than two weeks to

get a routine appointment? Are you or a nurse returning all calls to patients within 24 hours? Are patients placed on hold for more than 60 seconds or do they need to negotiate a patient-unfriendly phone system to speak with someone in your office? Are patients frequently arriving without prior authorization from a primary care physician, causing delays in your

the attitude of the staff toward patients. We must never forget that we are competing for patients, and patient-staff interaction is a key factor. When you become too lean you are unable to focus on providing patients with a positive health care experience. Stellar practices can ensure that the practice meets or exceeds the expectations of every

**Every practice contains fat that should be cut to improve efficiency. There is a point, however, when becoming lean can translate into becoming mean with regard to patient care.**

schedule? Are patients reporting on surveys that your staff members are not taking enough time to answer their questions and seem hassled and overworked? If you answered yes to any of these questions, you are probably running too lean.

To determine the extent of the problems in your office, conduct a semi-annual or at least an annual patient survey and ask these very questions. When you ask 50 existing patients and 50 inactive patients about their experience with your office you will easily have the answers to the above questions about your patient services. Then you need to make every effort to correct them.

If the staff's morale has deteriorated, then you can be certain that their interaction with patients will be affected negatively. You can assess the morale of your practice by answering these questions: Do you have excessive turnover of employees? Is there a noticeable amount of absenteeism among the staff? Does the staff meeting serve as a gripe session rather than an opportunity to fine-tune the practice? Has the number of full-time equivalents (FTEs) been cut so severely that the remainder of the employees feel overworked and stressed? Do employees complain about not being appreciated or rewarded appropriately for their efforts?

One of the easiest problems to solve is

patient. The best advice is that stellar service and a highly motivated staff must begin at the top, meaning the physician or physicians themselves. You can't expect your staff to be positive if you or other physicians are negative.

## The Financial Exposure

Cutting expenses usually means a reduction in the resources necessary for financial management. When a practice cuts back on staff and increases the responsibilities of those remaining, you can expect that adhering to standard accounting and financial management policies will become difficult or impossible. It is likely that a lean staff will not be as attentive to asking patients to pay their co-payment or to collecting the deductible early in the year.

Moreover, physician practices are facing increased scrutiny over regulatory requirements, and maintaining compliance adds responsibilities that were not required just a few years ago. A lean staff may not have time to follow proper coding procedures and thus could leave the practice at risk for costly penalties in the event of an audit. What's more, overworked staff members may leave the practice short of cash due to undercoding. Also, when expenses are cut, the usual internal controls tend to be lax,

*Neil Baum, MD, is a urologist in New Orleans and the author of Marketing Your Medical Practice—Ethically, Effectively, and Economically. (Gaithersburg, Md.: Aspen Publishers, Inc., 1991).*

increasing the likelihood of theft and embezzlement.

To ensure compliance, be certain you have enough staff to follow sound financial practices. Make sure your attorney or accountant has implemented a compliance plan for your practice so that you can survive a chart audit by the federal Health Care Financing Administration or other monitoring agency.

Generally, employees want to do a good job and enjoy helping physicians take care of patients. When the workload exceeds the employees' capacity to care for patients, however, staff members will experience increased stress and patient care will deteriorate. When stress increases and morale falls, quality of care will suffer. The end result is poor performance,

high employee turnover, and a decline among your patients in their confidence in your practice. If this downward spiral begins, it can be followed by a loss of patients and a decline in income.

To solve the problem, you should look at the quality of care that you are providing your patients. Start collecting data on outcomes, disease management, and the cost-effectiveness of care.

Lean and mean may apply to sports and manufacturing but it doesn't have a place in health care. It is necessary for all of us to identify the warning signs of deterioration in the care we are providing our patients and then take action on our findings.

In addition, physicians should do time and motion studies to find out how long

patients are waiting to see a doctor. Keep in mind that most patients will tolerate waiting for a physician for no more than about 20 minutes. We need to be certain that patients have adequate access to the practice. Certainly, a patient who calls to see a doctor and is told that the next available appointment "unless it is an emergency" is three months will not appreciate how lean and mean your staff is and will find another provider.

It is far better to have the appropriate resources, staff, and services to give your patients a stellar health care experience than to focus on cutting the overhead and reducing the staff and the services you offer. Getting too lean may mean that you lose your patients and your patience as well. ■

## Are We Caring for Patients or Customers?

Business publications extol the virtues of value-added services and exceeding customers' expectations. As physicians, if we follow this advice, we might begin to blur the distinction between patients and customers, and while it's important to deliver high-quality customer care, we must never forget that we are treating patients.

It is difficult for patients to measure the quality of the care they receive or understand the statistics of outcomes and disease management. But nearly every patient can distinguish poor, average, and stellar quality of services.

Consider these two patient cases, which are taken from a typical urology practice, but serve as examples for a variety of physicians. The first involves a 57-year-old man seen in the emergency room who is unable to urinate and his bladder is palpable above the pubic symphysis. A rectal exam reveals a moderately enlarged, benign prostate gland. Diagnosis: acute urinary retention. Is he a customer or a patient?

The second case is that of a 45-year-old female who presents in the office with frequency, urgency, and pelvic pain. A physical exam reveals a tender anterior vaginal area. The urinalysis is within normal limits. Previously, she has been seen by four other urologists and treated unsuccessfully. Diagnosis: interstitial cystitis. Is she a customer or a patient?

Patients have been defined as anyone receiving services from a physician. Perhaps the distinction between patients and customers can be easily defined by the physical position of patients at the time they are seen by the physician. That is, the more horizontal, the more they are a patient; the more vertical, the more they are a customer.

Patients seen by a urologist in acute urinary retention care little about the courtesy of your receptionist, the decor of the office, or the number of diplomas on the wall. These patients

want your expertise and immediate relief of their discomfort. At this time, customer service is a low priority.

Conversely, the female patient cares about the services offered by the physician and his or her staff. This patient wants kindness on the part of the staff, timely return of her phone calls, and appropriate educational materials.

Patients who make up the majority of our practices fall somewhere between the two extremes of either all customer or all patient. Most of those in our clinical practices are part customer and part patient. The patient is asking for our clinical skills but also is expecting kindness and courtesy on the part of the doctor and his or her staff. Even the patient in the emergency room who is passing a kidney stone has a family and friends who are waiting to know the status of your patient. This patient will most likely be seen in your office on multiple occasions, will interact with your staff, or will be interested in educational material on preventing kidney stones. He or she will likely want access to your Web site or other useful information pertaining to his or her condition.

Every urologist can treat a man with urinary retention. But how many physicians add customer service to our outstanding clinical services? The exceptional doctor will call the patient at home after discharge, will provide educational material to the patient and family on the signs and symptoms of the patient's condition, or will send a nurse to the patient's home if necessary. Outstanding physicians pay attention to these details.

Only when we think of those who receive our care as both customers and patients, albeit at different levels of intensity, do we become complete physicians. The complete physician has more personal and professional satisfaction and also has a full appointment book and financial success as well. —NB

(Continued from page 1)

says spokesperson Richard Coorsh.

Yet, Mark Bloomberg, MD, a managed care consultant in Sudbury, Mass., has noticed it. "Physicians are becoming increasingly critical of which plans they belong to," he says. "It's been evolving for a few years as a natural follow-up to a period when they joined all plans. It's not hard with simple financial systems to determine which health plans are more remunerative."

The shakeout was inevitable, according to Rosalie Phillips, executive director of the Tufts Managed Care Institute, in Boston. "Sorting out is a natural phenomena, a natural part of the evolution of the market," says Phillips.

Reinhardt suspects that any movement by physicians away from HMOs will not lead to a mass rejection of managed care plans. "In every city you have doctors who will never accept any insurance," he explains. "Their numbers are growing but you may never know by how much because these doctors don't fill out questionnaires. My own hunch is those doctors will remain a relative minority because there is a population to support them. But their numbers will never be that large."

#### A Measure of Freedom

Before Ezrick disenrolled from Aetna U.S. Healthcare, his only capitated health plan, the bimonthly check had given him a measure of freedom and security. If he wanted to spend a few days skiing, some of his private, solo practice expenses were covered.

Ezrick's accounting records demonstrated that since his panel was small and Aetna patients didn't visit often, he was earning a respectable average of \$80 per patient visit. After a time, however, his established patients who were on indemnity and other plans, saw Ezrick's name in Aetna's provider directory and switched, often because it enabled them to pay lower premiums. But what was good for patients was not good for Ezrick. The number of Aetna patients seeking appointments doubled and his average revenue per-patient from Aetna plummeted.

For more than a year, Ezrick, was troubled about what to do. He was losing

**"I am much happier now because I don't have the ethical conflicts."**

**—Edward Ezrick, MD**

money on the Aetna plan, yet he felt a professional obligation to Aetna patients to whom he promised care. He wondered if his practice could sustain the loss of Aetna income. "There was some fear about leaving Aetna because I was also getting off Prudential," he says. He decided his time was more valuable than he was being paid for. He gave 60 days' notice.

In Goldberg's case, his private group practice signed up for all plans in his area at first, thus making it easy to accept patients from referring doctors. But reimbursement of billings went from 95% in 1983 with no HMOs when he started in practice to 37% when half of his revenue came from HMOs. Now partners are presented with financial data at monthly group practice meetings for the purpose of deciding which HMOs to dump. The decisions are not easy.

"I am not afraid because I have a two-income family," Goldberg says. "But some of the other doctors who come from one-income families, and the younger guys, are concerned. Personally, I'd rather lose revenue than work for what some HMOs offer us. And, on some plans, we can't even write a script without HMO approval."

When both physicians dropped HMOs, they felt as if they were abandoning patients. "I lost patients I've been taking care of for 17 years," Goldberg laments. "I told them, 'I can't survive on what your HMO pays us, and they hassle us too much.'"

#### Emphasizing Efficiency

If good physicians will be leaving HMOs, consumers may want to know who will staff the panels of lower-paying HMOs. While some experts believe insurers may have to improve reimbursement to fill panels, others think locating willing providers will not be a problem. "You will always find physicians who can make a living by re-engineering their practices to be more efficient, such as by adding a nurse practitioner or physician assistant,"

says Phillips. "That doesn't mean low quality care."

Princeton's Reinhardt agrees. "It might be that younger doctors who have to take lower fees just to get on plans so they can pay back medical school loans possess cutting-edge knowledge," he says. "These younger doctors might be better at extracting information from the Internet."

Moreover, working for a capitated plan means financial success can depend on a random level of sickness in a particular physician's population, says Randy Killian, executive vice president of the National Association of Managed Care Physicians, in Glen Allen, Va. "Some doctors can make it on a low reimbursement plan if they have a low cost structure," he says. "If patients are sicker, they won't."

Patients whose employers offer one low-budget HMO might be presumed to be at a disadvantage because experienced doctors who do not need high patient flow may not be in the plan. More than one in three American working families are offered a single health plan by their employers, and nearly 60% of the time, it is an HMO, according to a study, "Who Has A Choice of Health Plans?," released in February by the Center for Studying Health System Change, in Washington, D.C.

"Limit of choice might or might not impact quality," Reinhardt says. "There may be no correlation between fees and clinical outcome. Doctors who are expensive will have 'gee whiz' toys and nice carpeting. But whether their human capital is better, no research would back this up."

In the future, Reinhardt predicts, access to a wide range of physicians and plans will occur in a different way. "A lot of employers are going to get out of the insurance-picking business," he explains. "They'll give employees a voucher that they can use to buy into tightly managed

(Continued on page 9)

(Continued from page 8)

HMOs, PPOs, or indemnity plans.”

In the meantime, physician discontent continues to rise. Declining fees, which in some cases do not pay physician's expenses, may be the catalyst for disenrolling from HMOs. But physicians have other reasons too. For years, doctors have found themselves at odds with HMOs about what constitutes appropriate patient care. There is also continuing disenchantment with HMO restrictions, increasing paperwork, formulary frustrations, condition-specific maximum hospital stays, and the need to seek authorization for a wide array of expensive tests and treatments. In addition to these hassles are nagging ethical concerns about working for for-profit health plans.

“Getting off Aetna wasn't purely financial,” Ezrick says, adding that he always felt uncomfortable about the built-in disincentives in the capitated plan. He received a sliding monthly bonus that rose if he kept referrals down and admitted no hospital patients. He was uncomfortable having to choose between his income and admitting a patient who needed acute-care treatment.

“I felt trapped trying to provide comprehensive care for such a low reimbursement,” Ezrick explains. “Obviously the HMOs could afford to pay for my services; so I was subsidizing the insurance companies. I felt like I was being taken advantage of. I am much happier now because I don't have the ethical conflicts.”

Other business reasons exist for dismissing HMOs. With fewer HMO contracts, overhead falls because additional salaried staffers are not required to handle HMO referrals and precertification.

#### Tiered Health Care

The result of the shakeout is that health care is becoming more stratified. “What we are seeing is a tiered system,” explains Reinhardt. “Tightly managed HMOs for the lower classes, PPOs for the middle classes, and indemnity plans for the top 10% to 15% of income distribution.”

Tiers may affect levels of care. Before a physician examines a patient, he or she reviews a fact sheet attached to a chart that lists the name of the patient and the patient's plan. In that moment, some

**“I am not afraid because I have a two-income family. But some of the other doctors who come from one-income families, and the younger guys, are concerned.”**

**—Harris Goldberg, MD**

physicians determine how much time to spend in the exam room. It is all too familiar to John Russell, president of the Academy of Managed Care Physicians, in Long Beach, Calif., who uses the phrase, “treatment planning by benefit plan rather than need.”

Three times as many patients say their doctor gives them worse service because of the type of HMO they are in than say their doctors give them better service because of the HMO they are in, according to a study in 1997 by PacifiCare Health Systems, a large managed care organization in Cypress, Calif.

“Some of us will be getting a different level of service than others primarily because of our insurance or our ability to buy around the system,” says medical ethicist, Mark Yarborough, PhD, director Health Care Ethics, Humanities and Law at the University of Colorado Health Science Center.

Doctors who would speak on the subject would only do so if their names were not used. One physician says his patients don't know they are in capitated plans or what capitation means. “They don't realize why they are getting a cold shoulder,” the physician says. “If I receive \$10 per month for a cap patient or \$120 per year, after one visit, they've used up a year's worth of payments. If they call again, I'll try to handle their problem by phone, if possible.”

Killian takes issue with this contention. “Does the financial incentive to do less actually diminish the quality of care?” he asks. “We're not seeing it discussed among physician groups but my guess is that 98% of physicians will do what's best for patients because they practice good, legal medicine.”

Regarding income dictating health plan selection, Russell says, “There are plenty of highly paid professionals who

will belong to low-budget HMOs and hope that they don't need health care. Cost is a factor for everyone.” Typically, patients who can afford traditional indemnity plans have few complaints about access to care. Yarborough finds this troubling. “If you have substantial resources, you will be able to access the highest levels of care,” he says.

These trends, however, are predictable, explains Reinhardt. “This country views itself as classless,” he says. “But it is extremely class conscious defined by income. People with money don't want to sit in waiting rooms. On the other end, Medicaid has always been a welfare system in which half of all physicians won't participate because of the low fees.”

Where physicians practice may have much to do with whether they survive financially after disenrolling from an HMO. Ezrick and Goldberg's practices thrived when they relinquished some HMO contracts because they practice in regions populated by middle- and upper-middle class Americans. They might see more openings in their appointment books if they practiced in areas where there are lower-income patients. In these areas, patients may be able to afford only inexpensive HMOs if they have any insurance at all.

“HMOs will survive because the lower classes need them,” Reinhardt says. “These people wouldn't have insurance if not for tightly managed health plans.”

Physicians who rushed to sign HMO contracts are beginning to see that patients are on their side. If they can afford to, they would rather switch insurers than switch doctors.

—Reported and written by Maureen Glabman, in Miami. More information on physician practice strategies is available on our Web site (see page 16).

# Unorthodox Faculty Group Aims High

By Thomas M. Gorey, JD

Although the University of Colorado School of Medicine is the only medical school in the state, its medical faculty has been forced to take aggressive steps to survive in the highly competitive Denver market.

In June 1982, the Board of Regents of the University of Colorado approved the establishment of the University of Colorado Medical Services Foundation, a freestanding, nonprofit corporation that does business as University Physicians Inc. (UPI). As the centralized practice plan for the faculty of the University of Colorado School of Medicine, UPI is authorized to bill, collect, and disburse all patient and other revenue earned by the faculty and to enter into contracts for the benefit of the university.

Market dynamics throughout the 1980s and 1990s created an urgent need for UPI to move aggressively in securing contracts and in developing a strategic plan to define its goals and determine its course for the future. As the market began moving to a competitive, managed care environment in the mid-1980s, UPI negotiated its first managed care contracts with Kaiser Permanente and others.

Today, Denver is considered one of the most competitive and advanced managed care markets in the country. With these changes, physician, hospital, and payer groups have undergone rapid consolidation and reorganization. As a result, some of UPI's long-term affiliates have grown

closer while others have moved into different, competing relationships. A recent study by Policy Planning Associates for the AMA and other organizations explores the variety of forces that are affecting faculty practice plans and describes the initiatives being implemented to reposition them. The report is based on case studies of the faculty practice plans at seven leading academic medical centers, including the University of Colorado School of Medicine.

## Contracting Strategies

Extending its traditional marketing initiatives beyond routine payer contracting, UPI has developed comprehensive payer networks that support populations served under its managed care contracts. To administer contracts effectively that

the dominant health care provider. For the past seven years, UPI has been responsible for providing care to 15,000 to 20,000 patients from the University of Colorado system.

UPI and University Hospital then got together with Denver Health, Children's Hospital, and a consortium of 47 federally qualified community health centers and formed a Medicaid HMO, Colorado Access. UPI now provides specialty care for approximately 40,000 covered lives through Colorado Access, a capitated, voluntary, Medicaid managed care program. The impetus for this initiative was the state's intent to move at least 75% of its Medicaid patients into capitated plans. The Colorado Access partners had long been the safety net providers for this population and feared that if these

**The faculty practice plan needed to move aggressively to secure contracts and to define its goals for the future.**

have shifted from fee-for-service payments to tightly managed, risk-based arrangements, UPI has started a joint venture with the University Hospital to implement computerized scheduling and managed care applications.

UPI believes it is ahead of the curve on contracting because early on it adopted an aggressive managed care strategy. As Denver was moving rapidly to managed care, UPI explicitly rejected the strategy of developing an integrated delivery system. In addition to being capital poor, the practice plan did not believe that the future was in buying practices or in merging with a hospital. Instead, UPI decided to try to capture populations of patients so that it could decide where patients were sent for tertiary care. Recognizing that there were 20,000 faculty and staff employees on the four campuses of the University of Colorado, UPI began contracting with the university to become

patients were lost to commercial HMOs the result would be a negative effect on training programs and finances.

Another major step in the implementation of UPI's contracting strategy was bidding for and assuming health plan responsibilities for the 21,000 retirees and others who had been using Fitzsimmons Hospital, a major teaching hospital that was closing. This move resulted in a key contract, which gave UPI leverage to become part of the consortium that successfully bid for a government contract to replace the CHAMPUS program for U.S. military enrollees and their families in 16 Western states. The government awarded the contract to provide and manage care in Colorado to a limited partnership made up of the hospital, which owned 70%, and UPI, which owned 30% of the entity.

Another part of UPI's strategy was to establish what it called its "University

*Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development. More information on physicians' organizational options is available at our Web site (see page 16).*

**Editor's note:** The Case Study Analysis of Faculty Practice Plans can be obtained by contacting Kristin Sabec at the Michigan State Medical Society (517/336-5769). The report costs \$95.

Affiliates" program, which involves more than 400 Colorado clinicians who serve as volunteer faculty. In this program, each medical student would spend one-half day per week for three years in a primary care physician's office. The program helped to bolster the School of Medicine's primary care education program, and the participating PCPs began referring more patients to the University Hospital for tertiary care.

#### A Pediatrics Initiative

The University Affiliates is one example of how UPI has developed collaborative relationships with community physicians. Another example is the prominent role the university's department of pediatrics has played in the development of UPI. In 1990, pediatric services were moved from the University Hospital to Children's Hospital, approximately four miles west of the health sciences campus. In the late 1980s, the department of pediatrics began losing money, in large part because Children's Hospital had been recruiting pediatricians away from the university. It became clear that Colorado's relatively small population could not support two major pediatric hospital programs and maintain quality clinical care.

As the situation became untenable, University Hospital merged with Children's Hospital and moved all pediatric services, with the exception of the high-risk nursery, to Children's Hospital. Since pediatrics has moved, it has become the largest clinical revenue-producing department in the School of Medicine, and its research grants have surged from \$7 million to \$18 million.

A key feature of the practice plan that has allowed the department of pediatrics to thrive has been UPI's willingness to allow the department to contract as part of a local pediatric network named KidSmart for pediatric carve-out contracts. In pursuing such contracts, the department has worked collaboratively with community practitioners. KidSmart now has contracts with almost all third-party insurers in Denver and provides care to about 20,000 children under capitated reimbursement plans.

## To increase effectiveness, the practice plan and the hospital needed to collaborate more closely in contracting.

#### Challenges for the Future

A number of factors has contributed to UPI's success, including its centralized organizational structure and a good working relationship between the practice plan and the university hospital, which led to a shared strategic vision. This shared vision was instrumental in setting in motion Colorado Access, the University of Colorado health plan contracting, and the government contract, which accounts for a considerable portion of UPI's primary care patient flow.

As with all practice plans, however, challenges remain for the future. Among the key issues UPI faces are the following:

**Enhancing its competitive position in an unforgiving market.** UPI's aggressive contracting initiatives have demonstrated the practice plan's ability to compete effectively. Nevertheless, UPI needs to continue its efforts to increase the number of privately insured patients and to overcome a lingering perception that the University Hospital, as a public hospital, serves solely an indigent population.

**Maintaining the academic mission.** As at other academic institutions, changes in health care financing have had an adverse effect on funding the academic missions at the School of Medicine. Providing a solid rationale and reinforcement for continued involvement in academic medicine in the face of more lucrative private practice opportunities is likely to be an ongoing struggle.

**Continuing to provide appropriate recognition for clinicians.** UPI and the School of Medicine have taken steps to carve a niche for clinician-educators. In 1997, the School of Medicine changed its rules on promotion and tenure to move from a two-track system (a tenure track and a clinician-educator track) to a single track in which all faculty members begin as assistant professors. The

new system separates promotion decisions from tenure decisions, thereby removing some of the barriers to promotion for clinicians. Since the School of Medicine expects to hire more clinician-educators as faculty members, it will be important to continue to provide appropriate recognition for these clinician-educators and to provide opportunities for promotion.

**Developing a group culture.** In establishing a group culture that extends beyond centralized billing, UPI has reached a number of important milestones. It developed a single rate for cost allocation across all departments and specialties, an important first step. It adopted standards groupwide for clinical service and physician behavior, and it supported the recruitment of primary care physicians. Still, UPI faces the ongoing challenge of shifting from a departmental focus to an entitywide focus in which decisionmaking will be based on what is best for the organization as a whole.

**Developing more synergistic contracting efforts with the hospital.** Given its centralized administration, UPI is a formidable, organized force that the hospital must deal with, and it challenges traditional notions of hospital control. Currently, UPI has single-point contracting throughout the practice plan—a single signature can bind all UPI physicians in all specialties. In general, however, UPI and the University Hospital contract separately. To increase the overall effectiveness of the practice plan and the hospital, the two parties may need to collaborate more closely in contracting and other ventures.

**Redesigning business processes.** Redesigning business processes to remain effective and efficient in a managed care and regulatory enforcement environment will add considerably to administrative costs and complexity and will be a challenge for all health care providers. ■

# AAPS Director Calls for Changes in Medicare To Protect Physicians



**Jane Orient, MD** is an internist in Tucson, Ariz., who has served since 1989 as the executive director of the Association of American Physicians and Surgeons

in Tucson. Founded in 1943, the association works to preserve private medicine. Orient graduated from Columbia University College of Physicians and Surgeons in New York in 1974. She performed her residency at Parker Memorial Hospital in Dallas and the University of Arizona Affiliated Hospital in Tucson. Following her residency, she served as a member of the faculty of the University of Arizona College of Medicine from 1977 to 1980. She has authored two books, *Your Doctor Is Not In* (New York: Crown Publishers, 1994) and *Sapira's Art and Science of Bedside Diagnosis, 2nd Ed.* (Philadelphia: Lippincott Williams & Wilkins, 2000). Richard L. Reece, MD, editor-in-chief, conducted this interview.

**Q:** Tell us about the Association of American Physicians and Surgeons. How big is it, how old is it, and what is its primary mission?

**A:** The Association of American Physicians and Surgeons, or AAPS, currently has approximately 4,000 physicians nationwide, across all specialties. We were formed to preserve private medicine, which we define as the physician working on behalf of the patient in the tradition of Hippocrates, and to oppose government and other third-party intrusions into the patient-physician relationship.

**Q:** Can you tell us how you promote this mission?

**A:** We are probably best known for suing the government. For example, we brought suit against the Clinton Healthcare Task Force, which was violating federal laws by meeting in secret.

We wanted to have sanctions implemented against the government in this case because of the false affidavits that Ira Magaziner, the task force director, filed. The Department of Justice decided however, that prosecuting him for perjury was not warranted. Furthermore, the federal court that heard the case decided that there wasn't enough evidence to sanction the government, based on Magaziner's affidavit invoking the all-federal employee exemption from the Federal Advisory Committee Act, which states that task forces may meet in secret as long as 100% of the members are "insiders" in the government and thus presumably disinterested.

Through this lawsuit, however, we managed to publicize a number of documents the task force produced. These documents are now publicly available at the National Archives in College Park, Md. Unfortunately, the agenda outlined in these documents, such as "administrative simplification," is being implemented piecemeal, and the public is not paying too much attention.

Of course, we promote our mission in many other ways as well. For example, AAPS has a monthly newsletter, AAPS News, and a bi-monthly peer-reviewed journal, *The Medical Sentinel*. Journal arti-

cles frequently appears in the *Congressional Record*. Recently, we testified on proposed privacy legislation and the abuses of administrative law in pursuit of health care fraud.

Finally, AAPS holds an annual membership meeting to bring physicians together for mutual encouragement. At the meeting, we teach physicians about current events in health care and some strategies for fighting the battles to preserve private medicine in this country.

**Q:** AAPS surveyed physicians in 1999 on the effects of Medicare changes. What were the findings of the survey?

**A:** AAPS has been surveying its members about every two years. The purpose of the survey is to determine how members are responding to changes in Medicare regulations, and to gauge their attitudes toward private contracting with Medicare patients outside the Medicare system.

Our recent survey findings were disturbing. Nearly one-fourth (23%) of physicians do not accept new Medicare patients under any circumstances, and 9% do so only under special circumstances. Nearly three-fourths (71%) report making changes in their practice because of fear of prosecution, including deliberate undercoding and restriction of

**"Nearly three-fourths (71%) of physicians responding to the survey report making changes in their practice because of fear of prosecution."**

cles tend to focus on ethical and legal issues such as managed-care incentives, mandatory vaccines, the effects of the "public-private" partnership, privacy, and free-market solutions. We also offer fax alerts to our members on legislative issues.

AAPS submits a lot of comments to lawmakers on health care regulations. We testify in Congress, and our testimo-

ny frequently appears in the *Congressional Record*. Recently, we testified on proposed privacy legislation and the abuses of administrative law in pursuit of health care fraud.

The survey revealed that physicians are so intimidated by the Medicare bureaucracy that they are starting to make dra-

matic changes in their practice. Low Medicare fees are a relatively minor factor. Physician practice changes are primarily driven by fear that if they offer certain services they will become a high-profile target for Medicare audits to determine compliance with fraud and abuse regulations.

I can't blame physicians for this fear. Government prosecutors will claim that they think most doctors are honest and they would never ever go after someone who makes an honest mistake. But as one former prosecutor pointed out at a meeting of medical administrators, there isn't any incident in his experience that the government considered to be an honest mistake if the doctor made it. In an attempt to get huge settlements, so many doctors with small practices have been subjected to very intrusive audits to find errors in coding and the government has used tactics that would be called extortion if a member of the private sector performed them. For example, one typographical error in a form resulted in a \$2.80 difference in reimbursement, and the government demanded a \$40,000 punitive payment from the doctor. The doctor mortgaged her house to pay the damages, being unable to risk criminal prosecution, which was threatened if she did not settle immediately.

**Q:** *What options do physicians have in these cases besides simply refusing to treat Medicare patients?*

**A:** Well, one option is to quit. More and more physicians are retiring early. If they're too young to retire, many of them are looking for another occupation; they're going back to school to get a law degree or an MBA, or they are starting a business of some other type. Many physicians simply feel that the medical profession is being destroyed.

**Q:** *Do many physicians undercode, or code procedures with lower-than-appropriate reimbursement, in order to avoid Medicare fraud and abuse scrutiny?*

**A:** Yes, certainly some physicians resort to undercoding, and in doing so are forgoing reimbursement that they have rightfully earned. They feel that the hassle of trying to defend a higher code is not worth it, so they just put down the lowest code.

**“One former prosecutor said there isn't any incident that the government considered to be an honest mistake if the doctor made it.”**

**Q:** *You're in an active practice. How do you handle this issue personally?*

**A:** I always had my patients file their own claims with the itemized bill as an attachment, because I felt that it was their Medicare benefit, not mine, and that it was only right that the government should pay the patient the benefit, not me, and that if the patient was collecting the money, the patient should be the one to file the form.

Then, in 1990, Congress passed a law requiring physicians to file all Medicare claims. I suppose Congress decided that it was just too difficult for the patients to write their names and Social Security numbers on the forms and staple my itemized bill to it, sign it, and mail it, so they forced the doctors to file the forms. But with the requirement that physicians file the forms, the whole process immediately became vastly more complicated.

When that law was passed, I made the decision that I was not going to file Medicare claims, and therefore that I would not accept Medicare reimbursement. I didn't think that I could ever fill out a claim accurately enough to say, “I'm promising under penalty of perjury that I've done all this right”—because there are so many things about medical diagnosis that are subjective and are ever-changing. So I announced to my patients and put an ad in the paper that my services were no longer being reimbursed by Medicare and my patients were invited to transfer their records to other doctors if they wanted to, although I would still be glad to see them if they wanted to see me as private patients. Some of them left me and some of them stayed, and those who stayed paid just like other patients did, without filing Medicare claims.

**Q:** *AAPS has been involved in other Medicare issues, such as the right of Medicare patients to pay for care outside the system. What is the status of that issue?*

**A:** One of our past presidents, Lois Copeland, MD, together with her

patients filed a lawsuit in 1992, which was dismissed in federal court because the judge said the plaintiffs hadn't shown that the federal Health Care Financing Administration (HCFA) had any formal policy preventing patients from deciding on a case-by-case basis to pay their doctors privately without filing a form. HCFA has acknowledged that such private payment has occurred under certain circumstances, such as psychiatric patients or AIDS patients who have decided that they don't want HCFA to have access to their records, with a caveat that if the patient changes his mind and wants to file a claim the doctor has to file it.

Then, as part of the Balanced Budget Act of 1997, Congress passed a proviso that physicians could privately contract with patients and not be bound by the Medicare limiting charge if the physicians filed an affidavit and renounced all Medicare reimbursements for two years. United Seniors Association, a consumer group in Fairfax, Va., sued over this issue, based on their belief that they were going to be deprived of certain services if they couldn't find a doctor who had totally opted out of the Medicare system. That lawsuit was also dismissed on the grounds that patients can always receive a noncovered service by paying privately, and that such services could be received from a physician who had not opted out of the system.

The trick for patients is to know what is covered and what is not covered. HCFA stated that it would not sanction physicians who provide “unnecessary” covered services as long as they're not “unwarranted,” whatever that means. This was how the court stated its findings. It is confusing and probably uninterpretable other than in an arbitrary and capricious way.

I know a number of physicians who have taken advantage of the opportunity offered in the Balanced Budget Act to opt out, even though they are losing the abil-

*(Continued on page 14)*

**“We have uninsured young people who can’t afford insurance for themselves being forced to pay for the Medicare generation, many of whom could afford to pay for themselves.”**

*(Continued from page 13)*

ity to bill for Medicare patients. In an emergency, however, physicians are not allowed to contract privately, and may be forced to treat the patient, file a Medicare claim, and take the Medicare reimbursement for the emergency service. The question is, what is an emergency? HCFA doesn’t make that clear. One of the surgeons in our association said that if it’s a case of a patient going directly from the ER to the OR, it’s an emergency; in contrast, if the patient goes from the ER to ICU, it’s not an emergency. So even if a physician is the only neurosurgeon available and the patient later has to go to surgery, there’s a controversy about whether the physician will be forced to file a claim or whether it’s unlawful for the physician to file a claim. So HCFA still has a presence in every transaction that occurs, even if a physician opts out of the system.

**Q.** *Medicare patients are sometimes astonished that Medicare will not pay for preventive services. Do you feel that is an injustice?*

**A.** Medicare was never designed to pay for routine check-ups. After all, preventive care is by definition even more “unnecessary” than services that Medicare denies for sick people, even if it is desirable and sometimes staves off future problems. Most preventive services have always been excluded from reimbursement. In response, many doctors have put down a diagnosis and claim that the preventive service was really for the treatment of that condition, because screening examinations just aren’t covered. Basically, physicians have a choice of either lying about the real purpose of the service or having their patients furious with them because they’re having to pay out of pocket instead of getting the government to pay.

Still, physicians are never entirely sure if Medicare will cover these services or not, so they sometimes ask the patient to

sign an advance beneficiary note, which means the beneficiary agrees to pay if Medicare doesn’t. For example, sometimes colonoscopies are covered and sometimes they’re not. If the doctor could know in advance, he or she could tell the patient that the test will not be covered and that the patient has to decide whether to have it or not. Instead, there’s this uncertainty, and the doctor fears that he’s going to be sanctioned for doing something that’s unnecessary, even though he thinks it’s warranted.

**Q.** *What is your opinion of the discussion about Medicare fraud and abuse and how it must be stamped out because it consumes 10% of the health care budget?*

**A.** I think it’s pure politics. The government has made promises regarding Medicare coverage that it knows it cannot keep, but it will not admit it. Medicare cannot be saved because it’s a Ponzi scheme that’s going to collapse just by pure demographics, because of the aging of the baby boomers. So HCFA’s answer is, we’ll just step up fraud and abuse audits, and they are collecting these exorbitant fines from physicians for honest errors. It’s kind of an unlegislated tax, a very discriminatory tax against doctors who are out there just trying to do their job. And it’s causing covert rationing, because many doctors are not providing services to Medicare patients.

The Medicare system is really unjust, too, if you consider that 25 year-olds are being taxed much more heavily than the older generation was taxed to pay for benefits for the current older generation that are not going to be available when they themselves retire. On the other hand, many of the people who are receiving the benefits are quite affluent compared with the young people who are being forced to bear the burden of the taxes. So we have uninsured young people who can’t afford insurance for themselves being forced to pay for the Medicare generation, many of whom

could afford to pay for themselves, but they’ve been taught to believe it’s not their responsibility to pay and are very, very angry if anyone suggests that Medicare benefits be reduced. We have this required intergenerational transfer instead of making it possible for people to save for their own retirement.

**Q.** *It strikes me that quitting or retiring early or just not seeing Medicare patients is an act of desperation rather than a constructive solution. What do you see as a legitimate response to this deepening crisis?*

**A.** We need to make it possible for each generation to provide for itself by allowing income to build up tax free in a medical savings account that would carry over into retirement. That is the only long-term solution.

In the meantime, we need to open up the escape hatches. It makes no sense to increase the pressure on this system by refusing to let people who can afford to pay out-of-pocket go outside the Medicare system to do that. HCFA should stop persecuting people who want to provide for themselves—and their doctors.

In addition, if HCFA were really serious about getting rid of fraud, it should get rid of the incentives for fraud. The real burden of Medicare fraud comes not from individual doctors who are just trying to make an honest living, but from scam artists who do nothing but file claims for services of marginal value.

This fraud is possible because of the assignment of benefits. Assignment of benefits means that payments are going to the provider rather than to the beneficiary, so the beneficiary never knows what’s being paid.

The Medicare situation makes it increasingly difficult for patients to get personalized medical care from the doctor who cares about them.

—*Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).*

# Lenders Avoiding Health Investments

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

The generally poor performance of the health care services sector over the last five quarters has made lenders largely unwilling to lend money to companies in health care. In a recent assessment of lender preferences, Phoenix Management Services, a turnaround company in Philadelphia, revealed that 84% of its surveyed pool of lenders responded that they would not lend money to health care-related companies. Phoenix Management also reported that this latest survey marked the fourth consecutive quarter that health care has led the list of the least attractive industries from the lender's perspective. This trend is best illustrated by the downward trend of debt and equity offerings for publicly traded HMOs and health systems. After rising from \$441 million in 1997 to \$1,945 million in 1998, these offerings dropped to \$206 million last year.

The dilemma is made worse by the fact that there seems to be no sign of relief for the troubled industry. "There are very few signs of life among the varied sectors that make up the industry," said Phoenix President E. Talbot Briddell. Two sectors that have shown signs of life are the pharmaceutical and biotechnology sectors. In the survey, 41% of lenders ranked the pharmaceutical and biotechnology sectors among the most attractive sectors in health care, up from 35% in the previous quarter. Managed care companies and HMOs were ranked least attractive according to 55% of lenders, a 2% increase from the previous quarter.

Financial issues continue to top the list of concerns for small- and middle-market health care companies. In a recent survey

by Heller Financial, a financial services firm in Chicago, nearly half of the more than 800 decisionmakers at companies with revenue of \$5 million to \$250 million responded that they consider obtaining financing extremely important to their company's growth over the next year. Moreover, the largest number of respondents (42%) listed general financing issues, particularly cash flow and adequate capital, as one of the top three challenges their businesses face.

An interesting dynamic is that venture capital and private equity investing in start-up and early stage health care services companies has been rising from the standpoint of the amount of money invested. The sector has fallen off considerably, however, when one calculates the

percentage of total dollars invested. A report based on the *MoneyTree Survey* by PricewaterhouseCoopers, CPAs in New York, showed the health care services sector collected 4.5% of total dollars invested in 1999, down from 8.1% in 1998, and 9.2% in 1997 (table).

Despite the negative lending trends and the overall stagnation of the health care services industry, business owners and managers of small- and middle-market health care services companies remain optimistic. The Heller Financial report revealed that more than half of the survey respondents (53%) believe the industry, and the economy as a whole, will improve in the coming months, while 35% expect conditions to stay about the same. ■

## 1999 Venture Capital Investing By Sector

(in \$ millions)

	1997	1998	1999
<b>Biotechnology</b>	\$714.5	\$667.6	\$1,041.4
<b>Business services</b>	566.5	733.7	4,562.6
<b>Computers and peripherals</b>	429.9	447.2	761.1
<b>Consumer services</b>	197.0	307.7	1,126.7
<b>Electronics/instrumentation</b>	266.3	157.7	376.6
<b>Financial services</b>	213.6	551.9	1,607.5
<b>Health care services</b>	1,053.8	1,151.3	1,593.4
<b>Industrial</b>	538.6	468.9	551.9
<b>Medical devices</b>	599.4	734.7	1,090.0
<b>Networking and equipment</b>	986.7	1,486.8	3,619.2
<b>New media</b>	222.1	482.2	2,896.4
<b>Pharmaceuticals</b>	201.5	259.8	164.2
<b>Publishing/broadcasting</b>	239.5	226.6	274.4
<b>Retailing/distribution</b>	871.8	793.0	3,591.3
<b>Semiconductors/equipment</b>	293.1	359.7	519.2
<b>Software</b>	2,397.7	3,516.4	5,222.7
<b>Telecommunications</b>	1,690.2	1,888.2	5,222.7
<b>TOTAL</b>	\$11,482.2	\$14,233.4	\$35,591.9

Source: *MoneyTree Survey*, PricewaterhouseCoopers, New York, 2000.

*W.L. Douglas Townsend Jr. is managing director and CEO of Townsend Frew & Co., an investment banking firm in Durham, N.C., that specializes in health care transactions. Also, he is a member of the editorial Advisory Board of Practice Options. Jill S. Frew is managing director of Townsend Frew & Co.*

# MD OPTIONS.com



Our FREE online resource includes:

- ▶ A complete database searchable by keyword, subject, or issue
- ▶ Tools to develop and implement strategies to build your practice
- ▶ Interaction with experts on all aspects of the Business of Medicine™
- ▶ Links to business resources such as group purchasing, practice management, marketing, and CME
- ▶ E-mail updates on the latest developments in the Business of Medicine™

**vpmmanager.com** is an interactive site providing free "first line" consulting services to the small and medium-sized physician practice.

### E-MAIL UPDATES

Let **MDOPTIONS.com** come to you! **MDOPTIONS.com** can keep you up-to-date automatically on the latest developments in the Business of Medicine™. You can sign up at **MDOPTIONS.com** or fill in your name and e-mail address below and fax it to us at 973-316-5989.

Name: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

TOLL-FREE LINE **888-457-8800**

We are available to answer questions on the Business of Medicine™. This service is free to our readers.

# PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

July 15, 2000



Premier Healthcare Resource  
Suite 300, 99 Cherry Hill Road  
Parsippany, NJ 07054

BULK RATE  
U.S. POSTAGE  
PAID  
SMITHTOWN, N.Y.  
Permit No. 15