

PHYSICIAN PRACTICE OPTIONS™

A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Whistle-Blower Suits Present High Risk

Most physicians are unaware that their greatest risk of a government audit for Medicare fraud or billing errors may come from a current or former employee. Qui tam, or whistle-blower, lawsuits, are brought by anyone who has an insider's knowledge of possibly fraudulent billings. These plaintiffs file such suits against physicians on behalf of the government. Qui tam lawsuit (pronounced kwee tam) literally means "he who sues on behalf of the king."

Cases Pending

Qui tam actions pursued under the False Claims Act (revised in 1986) represent 60% to 80% of federal fraud recoveries in health care. Taxpayers Against Fraud, a nonprofit, public interest organization in Washington, D.C. (at www.taf.org), says civil fraud recoveries under the act totaled \$175 million in 1998 and \$1.2 billion in 2000, or about 1% of all Medicare expenditures. The number of criminal cases against physicians and other health care providers has climbed rapidly, from 343 in 1992 to 1,939 in 2000. The number of defendants criminally indicted has risen from 116 in 1992, to 668 in 2,000, according to federal reports.

The federal government estimates that it gets about \$8 back for every dollar invested in medical fraud actions. The federal Department of Health and Human Services uses the money to fund more investigations, audits, and prosecutions.

Whistle-blower lawsuits are done under seal. What's more, even before an investigation begins, the physicians and others involved may have no knowledge of the claim or the investigation. The insider funnels information to federal investigators, and the government has the option of taking over the suit or the plaintiff (also called a relator) may pursue the case independently. When the government pursues these cases in court, it wins 97% of the time. In either case, relators keep as much as 30% of the money recovered.

Physicians who believe that they are not at risk for a qui tam lawsuit are absolutely wrong, says Marc Raspanti, a lawyer in Philadelphia who is an expert in such cases. "Physicians need to know that the threat from within is more dangerous than the threat from without," he warns. "Physicians have a much greater risk of being brought down by someone in their own midst."

Insider Help

One of the best ways for the government to investigate fraud is with the help of an insider, Raspanti explains. An insider can be a billing manager, a former partner, a patient, or anyone who works for the practice or did so in the past.

Under revisions to the False Claims Act, whistle-blowers have specific and complete protection from retaliatory action, regardless of whether the case is valid. A physician or other

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Complexity Threatens the U.S. Health System

Technology is changing how physicians practice medicine. Today, diagnosing a patient's illness, treating it, dictating details of the encounter, creating the medical record, providing patient education material, and billing the payer with the proper payment codes—all before the patient leaves the office—have become known as point-of-care medicine.

But the systems that allow physicians to provide point of care medicine also require that doctors become technology proficient, which more physicians are willing to do. At the same time, however, they are mindful that their primary task is to treat sick patients.

Even as physicians are caring for the nation's sick patients and trying to do so with increased efficiency, the overall health care system needs to be overhauled, according to J. D. Kleinke, an author and health systems expert. Kleinke notes in his new book, *Oxymorons: The Myth of a U.S. Health System* (Jossey-Bass, San Francisco, 2001), that the U.S. health care system is too complex. The system is a huge labyrinth of process, paperwork, and hassles, which has so far failed to make people healthier, reduce costs, improve quality, or make physicians more efficient. Kleinke argues that we have added complexity that has not led to any improvement. "We just have more process," he concludes.

Some experts have said the answer to many of the problems in health care can be found in collecting more data on the outcomes of care. In fact, the answer cannot be found in collecting and reporting more data, Kleinke says. "Data cannot solve all problems," he comments. "This is one thing that we have all learned the hard way during the past decade of managed care. Medicine and health care are characterized by unpredictability. Little events on our radar screen that aren't in our spreadsheet or in our business plan tend to have the greatest influence over what really unfolds."

Instead, we need to reform the tax code to allow all Americans—not just businesses that pay for health insurance—to deduct the costs of care, Kleinke says. We need to simplify health insurance regulations nationally and in each state, and we need to develop a uniform benefits standard, providing one plan of coverage for all citizens, he adds.

"Right now, we have thousands and thousands of variations on the same themes—a health insurance Tower of Babel—and trying to manage this tower is consuming billions of dollars that ought to be spent on medical care, not administrative bungling," Kleinke says. Physicians would welcome the opportunity to spend more on patient care and less time on administrative bungling.



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Spanish Gains in Popularity

It has been eight years since the American Public Health Association, in Washington, D.C., published a groundbreaking report revealing that language barriers make it harder for Spanish-speaking patients to explain their symptoms fully, ask questions, and follow through with filling prescriptions. When patients use family or friends as translators, they may fail to disclose information or cause inaccuracies, violate confidentiality, and make it difficult to establish a rapport with physicians, according to the report, *Latino Health in the United States: A Growing Challenge*.

In a new ruling, the federal government is seeking to require physicians to provide translation services for patients with limited English proficiency. The ruling applies only to doctors who accept Medicaid and Medicare Part A reimbursements. Failure to comply could mean disenrollment from the programs, though sanctions may not be imposed until the U.S. Department of Health and Human Services notifies physicians of violations and requests voluntary compliance.

Doctors' Orders

The new ruling stems from reinterpretations of Title VI of the Civil Rights Act of 1964, and of an executive order signed by President Clinton before he left office, an order supported by the Bush administration. Last year, Congressman Bob Stump (R-Ariz.) introduced a bill (HR-969) that would repeal the executive order, but no action on it has yet been taken. Despite opposition from the AMA and all 50 state medical societies, the order stands.

"It is extremely inequitable to require physicians to fund written and oral interpretation services. The

cost of hiring an interpreter...can greatly vary between \$30 and \$400 per office visit," wrote Robert W. Gilmore, MD, the AMA's deputy executive vice president in a letter to the administrator of the federal Office of Management and Budget in December. The AMA believes the order will have the opposite effect than intended, as some physicians will opt out of Medicare and Medicaid for financial reasons. "The costs...will reduce, not improve, access to health care services," Gilmore wrote.

MD, president of the National Hispanic Medical Association, in Washington, D.C. That means doctors will learn Spanish themselves rather than hire translators, she says.

Improving Rapport

Some doctors anticipated the need to learn Spanish well before the Civil Rights Act was reinterpreted, studying the language out of the desire to communicate more effectively with their Hispanic patients. James Autin, MD, age 49, an otolaryngologist in Port St. Lucie, Fla., is one of them.

"I perceive that Hispanic patients would prefer that doctors use broken Spanish than no Spanish at all. A better relationship develops."

—James Autin, MD

Though the order applies to all non-English speakers, it is Hispanics—America's non-English-speaking majority—who may see their access to care reduced most. The Institute of Medicine, which receives government funding for studies, supports the use of translation services but suggests that the funding come from payers, according to IOM's book, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (National Academy Press, Washington, D.C., 2002).

While some doctors whose practices do not fully depend on Medicare and Medicaid payments will disenroll from these programs, doctors who rely on federal reimbursements for a substantial amount of their practice income may have no choice but to hire a Hispanic nurse or a translator, or learn Spanish themselves.

"Doctors are going to try to do the less costly things," says Elena Rios,

When Autin landed a position with a group practice in Port St. Lucie in 1984, a two-hour drive from Miami where many Hispanics live, there were few Spanish-speaking residents living in his area. Over time, however, more Spanish-speaking Americans moved out of Miami and settled in the Port St. Lucie area. Now, at least a half dozen patients whose first language is Spanish come to Autin's practice each week.

Seeking to relate more closely to his new patient population, Autin began listening to Spanish instruction tapes. Once he got used to hearing the language, he joined two volunteer medical missions to Bolivia and furthered his Spanish language ability.

To become bilingual, Autin took daily classes last summer in Costa Rica, a country where he was forced to speak the language. Returning to practice, he found he had tremendous rapport with Spanish-speaking

(Continued on page 4)

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patients, even though he felt he butchered the language. "I perceive that Hispanic patients would prefer that doctors use broken Spanish than no Spanish at all," he says. "A better relationship develops."

John Fisher, MD, an oncologist in Sacramento, also was frustrated about his inability to communicate directly with Spanish-speaking patients. When he saw Hispanic patients, members of their family served as interpreters, and Fisher was concerned about whether they could correctly convey medical terms and the adverse possible affects of medications. He felt particularly vulnerable on hospital rounds when patient's relatives were not always available to translate.

Fisher, at age 59, researched Spanish immersion programs on the Internet. Then, he ventured to Mexico one year and to Costa Rica during another. Each trip, for three weeks, six hours a day he studied Spanish at private language academies and lived with host families who spoke no English. Now, at 64, he watches patients' faces light up as he says, "Hablo Espanol!"

Latin Influence

Spanish is the second most spoken language in the United States, according to the U.S. Census Bureau, and the number of Spanish speakers is increasing. In 1990, 17.3 million people over age 5 spoke Spanish at home. By 2000, the number jumped to 26.7 million, about half of whom spoke English "less than very well." Also in 2000, non-Hispanic whites became a minority in California, the country's most populous state. At mid-century, projected demographic trends indicate 96 mil-

lion Hispanics will represent one quarter of the U.S. population.

As a result of the burgeoning Latin influence, doctors who speak Spanish are in demand, according to some of the country's largest physician placement agencies. "Five years ago, there were maybe one or two requests for Spanish-speaking doctors," says Don DeCamp, chief operating officer at CompHealth, a recruiter in Salt Lake City. "Currently, we have requests for 200 Spanish-speaking physicians."

Phillip Miller, of Merritt Hawkins & Associates, in Dallas, another physician placement agency, says, "Now, it's not uncommon to receive requests for bilingual doctors, and generally it's a condition for the job."

Often, hospitals and physician groups will not pay extra salary for bilingual physicians, but Spanish-speaking doctors have an advantage over non-Spanish-speaking physicians, says DeCamp. "Clients frequently choose a bilingual candidate over a doctor who speaks only English," he adds.

Requests for bilingual doctors come not only from states with large Hispanic populations (such as Arizona, California, Florida, and Texas), but from other states as well. For example, even in Minnesota, doctors are finding a need to learn Spanish.

David Dvorak, MD, age 37, is an emergency physician in Minneapolis, who went to Costa Rica two years ago for an immersion language program because his state has a burgeoning Spanish-speaking population of migrant farm workers. "In a single shift, it is not uncommon to have at

least one patient who speaks Spanish only," Dvorak says. "I introduce myself and say in Spanish, 'I speak enough Spanish to be dangerous.' It breaks the ice."

Some physicians are seeking Spanish courses to enhance their resumes. Between residency and employment, Linell King, MD, age 31, a hospitalist in Tappahonock, Va., took a month off to participate in an immersion program in Costa Rica because he was planning to work in South Florida. He wound up working in central Virginia, where he says there isn't much call for Spanish. However, he is confident that he acquired a skill that will serve him well in the future.

Medical Spanish

So great is the need for Spanish-speaking physicians that medical Spanish may become a required course in some medical schools. At least one school that offers the class as an elective, the University of Texas Medical School at San Antonio, is considering making it mandatory. Other schools offering the elective include Vanderbilt University School of Medicine, Indiana University School of Medicine, the School of Medicine of the University of California at San Diego, Robert Wood Johnson Medical School, Emory School of Medicine, and Chicago Medical School.

For doctors eager to accelerate the learning curve, the choices are many. "There are hundreds of language schools throughout Mexico, and Central and South America that teach Spanish," says Juli Goff, direc-

"Five years ago, there were maybe one or two requests for Spanish-speaking doctors. Now, it's not uncommon to receive requests for bilingual doctors, and generally it's a condition for the job."

—Phillip Miller, Merritt Hawkins & Associates

“Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact in a timely manner during all hours of operation.”

—U.S. Department of Health and Human Services

tor of SeHablaLaPaz, a Mexican language school that focuses on medical Spanish.

Costs for immersion programs vary from about \$800 to \$3,700 (without airfare) for a suggested one month of study. Husband and wife forensic pathologists George Thomas, MD, and Jill Gould, MD, of Jacksonville, Ore., paid only \$650 each for private lessons, room, and board when they underwent an immersion program in Antigua, Guatemala, in 2000. Gould described it as “a fantastic experience,” adding, “I love to be able to express myself in Spanish so that families understand what my investigation has found.”

Fees depend on several factors, one of which is whether a home stay with a local family is included versus staying in a hotel. Though privacy is sacrificed, a home stay is less expensive. Sacramento ophthalmologist Neil Kelly, MD, age 60, tried it both ways in Costa Rica, staying with a family one year and renting a hotel room the next. “You learn more when you stay with a family,” Kelly says, explaining that he was forced to speak the language in a natural environment. In a hotel, however, there are still opportunities to speak with housekeepers, waiters, and clerks.

Today, Kelly greets his Hispanic patients in Spanish and tells them he wants to practice his Spanish. “I go through the entire history and treatment recommendations in Spanish,” he says. “Most of the time, patients tell me they understand everything just fine.”

To physicians who say they cannot

leave their practices for the month that many programs suggest, Kelly protests that they can if they want to. In his case, his partners covered for him. “If you are solo, it’s harder because you lose income,” he says. “But you can do it. It’s a matter of desire.”

Learning the Dialect

When seeking a language program, it is important to select a country in which the Spanish is similar to the Spanish spoken in the area where the physician practices. Accent and word use can vary greatly. For example, doctors who go to Spain to learn Spanish spend needless time and effort learning the formal plural form of “you” or “vosotros,” a form that is superfluous among major U.S. Hispanic groups that use the more familiar “ustedes.”

The quality of the school’s teaching staff is important. Potential students should inquire about teaching credentials and the number of daily hours of instruction. Too few hours can leave physicians wanting; too many, exhausted. For example, Fisher came home to his host family after six hours of daily instruction and collapsed.

Also, physicians should ask about which method is used to teach. Some schools make learning fun by asking students to play games like “Simon Says” to learn body parts, and students study the verses of popular songs to understand idioms. Class size is important too. The smaller the class size, the more the teacher can focus conversation on vocational needs. The school Kelly and Fisher attended in Costa Rica, Centro Linguistico Conversa, guaranteed no

more than four in a class, and often there were only two or three students, allowing opportunities to learn words used in a medical office. Some companies specialize in helping physicians find schools that teach medical Spanish, such as Amerispan Unlimited (at www.amerispan.com) in Philadelphia.

Language schools do not guarantee fluency after one month, but students return to their practices with the basics to converse in precise, simple sentences. “Immersed” physicians stress the importance of continuing to study by visiting Spanish restaurants, watching Spanish television, or taking vacations in Spanish-speaking countries. “Because you learned so much in such a short period, it doesn’t get implanted in your mind as deeply as if you had taken over a longer time,” says King.

Physicians who make the effort to become bilingual are good for the health of Hispanic patients. One fifth of Spanish-speaking Latinos in fast-growing Hispanic communities say they do not seek medical treatment because of language barriers, according to a report released in December by the Robert Wood Johnson Foundation, in Princeton, N.J. The foundation offers grants of as much as \$1 million to physician groups and other health professionals willing to provide translators to patients through its program, *Hablamos Juntos*, or *We Speak Together*.

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

As Complexity Rises, Income Falls

By John W. McDaniel

Physicians today are facing an increasing number of challenges that make it difficult for them to deliver optimal patient care. At the same time, they are confronting different challenges that make it hard for them simply to run their businesses.

While many of the challenges physicians confront today may seem to be occurring at a dizzying pace, there are five major trends that physicians need to be aware of in order to be successful. First is that payers are focusing on reducing reimbursement in outpatient medicine; second, evaluation and management (E&M) coding is receiving increased scrutiny by all payers; third, physicians are opting out of the Medicare and Medicaid programs; fourth, more physicians will seek information technology solutions; and fifth, physicians will begin to view their employees as being capable of enhancing revenue.

Reimbursement Woes

Among physicians, one of the most important issues today is the declining rate of reimbursement for outpatient services. Over the last decade, payers have been successful in shifting the majority of health care services to the outpatient setting. Last year, hospital revenue totaled \$430.3 billion and ambulatory care revenue amounted to \$443 billion. Physician offices accounted for the biggest

share of ambulatory care revenue at \$215.2 billion.

Given the growth rate of outpatient medicine, payers are continually looking for new ways to control costs. Interestingly, the best tools to control costs and to improve quality have been developed in an area that is becoming less important: inpatient health care.

The federal Centers for Medicare and Medicaid Services, for example, is decreasing Medicare payments to physicians this year by 5.4%; at the same time, however, CMS is raising hospital reimbursement for outpa-

to charges, collections, and adjustments. At the same time, practices must analyze the effect of changes in the Medicare fee schedule because specific procedure codes will vary with respect to Medicare reimbursement.

Coding Compliance

Coding is important in the second trend as well—because E&M coding is receiving increased scrutiny by all payers. In its work plan for this year, the Office of Inspector General (OIG) of the federal Department of Health and Human Services has

As reimbursement declines and other costs—such as professional liability insurance expenses—increase, making a profit will be a significant challenge for medical practices.

tient Medicare services by 2.3%. The growth in the number of Medicare recipients due to the aging population has created a problem for CMS: It wants to control Medicare expenditures but it does not know how to control volume. Indeed, the Medicare program faces a difficult challenge with respect to balancing higher costs with rising utilization, and the likely target for cost reduction will be outpatient medicine, specifically physician services.

The actions of CMS cause a domino effect on various managed care contracts, particularly those that use a Medicare fee schedule as the basis for physician payments. A complex formula exists with respect to physician payments, and in order to determine appropriate reimbursement rates from each of their major payers, medical practices must continually review their top 25 CPT-4 codes with respect

made E&M coding a top priority.

Through its ongoing audits, the OIG is trying to determine whether physicians are coding correctly for E&M services and are using documentation guidelines effectively. While physicians still have the option of using either the 1995 or 1997 guidelines, it is generally believed that physicians tend to overcode for the services they document and undercode for the services they provide. Overcoding can lead to an audit and fines, and undercoding results in physicians failing to get full reimbursement for the work they have done.

Furthermore, the OIG said in its work plan that it will closely examine coding for consultative services. In particular, federal officials will look for the appropriate utilization and documentation of consultations from referring physicians.

The increased scrutiny by the OIG

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has resulted from the audits involving codes 99214 (evaluation and management during an office visit that include a detailed history, examination, or decisionmaking of moderate complexity), and 99233 (evaluation and management related to a hospitalized patient). Government auditors have found that about 75% of these codes were downcoded by at least one level of service due to insufficient documentation. Furthermore, E&M services represent 11 of the top 25 most frequently billed services to Medicare.

For example, code 99213 (evaluation and management during an office or other outpatient visit of an established patient that require an expanded-problem-focused history or examination, or decisionmaking) was billed 91.2 million times last year, accounting for 12.3% of total Medicare services. Interestingly, 97110 (therapeutic exercise) increased by 34% since 1999, the single largest increase in terms of the number of claims of any other CPT code, including 99213.

Steps to Take

Since the federal government is continuing to monitor the use of procedural codes, medical practices should develop and implement an effective coding compliance program. This program should involve at least the following three steps:

- An analysis of the use of all E&M codes by physicians to ensure compliance with CMS standards;
- A chart audit for each physician to ensure that each physician is using the codes correctly and documenting appropriately; and
- Educational sessions with physicians to review the outcome of the assessment.

Given declining reimbursements and the complexity of Medicare and Medicaid compliance procedures, it is no surprise that many physicians are choosing not to serve the beneficiaries of these federal and state programs. As Medicare reimbursement

declines and operating expenses rise, the average medical practice cannot continue to survive financially without making drastic changes. The states also are reviewing Medicaid reimbursement and looking to cut

In effect, physicians should be able to calculate the return on investment that each employee either produces or indirectly assists in producing. If a nursing assistant can help a physician see just one additional patient per

While most medical practices tend to view their employees from a labor expense standpoint, employees can also be seen as human resource investments.

fees, most of which come at the expense of physician income.

As Medicare and Medicaid reimbursement continues to decline or fails to keep pace with expense increases, such as those for professional liability insurance and the cost of regulatory compliance, many medical practices may find that making a profit in the future will be a significant challenge.

Seeking to do more with less, physicians are fostering the fourth trend by turning to information technology for solutions. Physicians will use computers to increase patient throughput and enhance the patient visit experience while decreasing operating expenses, particularly administrative costs.

More practices will consider the costs and benefits of electronic medical records and various hand-held personal digital assistants (PDAs) for coding, charge capturing, and prescription writing, among other tasks.

Since the market has put so much pressure on physicians, they will foster the fifth trend by beginning to view employees as being capable of improving revenue. In virtually every area of health care, staff members are either directly providing patient care or giving immediate assistance to caregivers. While most medical practices view employees as a labor expense, employees should be viewed as investments in human resources.

day, the assistant's contribution would be worth about \$15,000 annually, in addition to the contribution he or she is already making to the practice.

Boosting Revenue

Similarly, if front office personnel are highly trained, motivated, and appropriately compensated, they may be in an ideal position to improve over-the-counter collections of copayments, collections on deductibles for noncovered services, and collections on outstanding patient accounts.

The front office employees have the first opportunity to provide outstanding customer service. Also, as they become more efficient at insurance verification, eligibility, and the gathering of demographic information, this work can lead to fewer denials and rejections of insurance claims, thereby increasing cash flow.

Indeed, viewing employees as human resource investments means physicians must care for and nurture them with appropriate compensation, ongoing in-service training, continuing education, and performance evaluations that can provide the basis for base-pay and incentive compensation plans.

While the environment certainly is challenging for any physician practice, there are steps physicians can take to confront these challenges while also improving efficiency and boosting revenue. ■

Risk Plans Offer Benefits, Says Expert

Capitated provider organizations will continue to be viable despite the predictions of some experts, says Michael Alper, president of Meridian Health Care Management, a managed care management services organization in Woodland Hills, Calif.

"There continues to be much debate about whether managed care risk contracting in the form of capitated-delegated contracting actually works and whether it will survive in the future," Alper says. Initially, the capitation model was designed to control rising costs, especially those related to hospitalizations and referrals to specialists. Nonetheless, health care expenses continue to rise.

Rising Numbers

Last year, after absorbing the biggest health care benefit cost increase in a decade, employers are expecting even bigger increases this year, according to William M. Mercer, Inc., consultants in New York. The average increase predicted for 2002 is 12.7%, and many employers (15% of those surveyed) expect costs to rise by 20% or more, Mercer says. For the 16th annual Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, Mercer surveyed more than 2,800 employers. The results showed that the average cost of health care benefits for active employees rose 11.2% in 2001. This increase—in a year when general inflation was just 1.6%—follows an 8.1% increase in 2000, Mercer says.

"Many physician groups and provider organizations, especially in California, are going bankrupt or clos-

ing due to financial problems," says Alper. "Many claim that capitation rates are insufficient to cover the cost of care and are driving provider groups out of business. But these failing organizations also lack the management expertise, technology, administrative infrastructure, aligned interests, and effective compensation and incentive programs necessary to succeed." Alper, who is responsible for overseeing all components of Meridian Health Care Management's operations, also works directly with clients on organizational development, managed care operations, and strategic planning. He offered his comments at a meeting of the Medical Group Management Association Conference of San Diego County chapters.

Although anecdotal evidence seems to suggest that health plans and provider groups are stepping away from capitation, some form of the model will survive, Alper predicts. "As a result, physician groups and provider organizations must continue to analyze their business operations, restructure their processes, and develop strategies for improved performance under risk contracting," he says.

Costs and Quality

Several studies have shown that managed care has resulted in both lower costs and better health care quality, Alper says. For example, a recent study by the Integrated Healthcare Association, "Delivering Managed Care Through Physician Groups: The California Delegated Model Is Working But Needs to Evolve," addresses risk contracting. According to the IHA study, the delegated

model has been successful in lowering costs and improving quality, but it is at a critical juncture in which drastic analysis and change must occur. IHA is a policy development coalition of health plans in Walnut Creek, Calif.

The study makes six key points:

- The delegated model is working and has achieved significant results in lowering costs and improving quality.
- The financial situation for physician groups is improving.
- Physician group success requires sound management.
- Business relationships between health plans and delegated physician groups remain poor.
- Physician groups need to consolidate in order to survive.
- Paying for performance will help all parties.

Commenting on the study, Alper says, "The delegated risk model puts decisionmaking in the hands of physicians, which leads to better care. But more cooperation, clearly defined roles, and significant provider rewards for quality must still be achieved. The study anticipates that there will still be stormy weather ahead for capitation. Higher performing provider groups will survive, but the poorly run groups will continue to be weeded out or consolidated into stronger organizations."

Certainly, a good number of medical groups have failed in recent years. These group failures have been highlighted by the media, especially in California. But when groups fail, the management of the individual groups is most likely to blame—not the entire capitation system, Alper believes.

"While some physician groups and
(Continued on page 9)

One observer says capitation is here to stay and physicians need information systems to help them succeed with it.

“More than regulation, physicians need technology that can reduce costs, improve efficiencies, and provide business intelligence.”

—Michael Alper, Meridian Health Care Management

(Continued from page 8)

provider organizations have gone bankrupt, other groups in the same markets are doing well,” Alper explains. Poor group performance may result from undercapitalization of the group; inadequate alignment of interests in a financial incentive plan, which should give providers a financial stake in improving care and outcomes; lack of business management expertise; and underuse of technological solutions that can enhance financial analysis and performance.

Statistics on group failures may lead some observers to conclude that capitation is at fault. An article, “Downstream Without a Paddle: State Legislatures That Tackle Medical Group Insolvencies Have Come Up With Strategies That Sometimes Shift Accountability to HMOs,” in *Managed Care* (December 2000), reports that in the previous five years, 150 medical groups had gone bankrupt or closed for financial reasons. In California, where many state residents are in managed care plans, 132 medical groups have failed since 1987, and some industry experts have cited such statistics as proof that capitation as a model is failing, Alper says.

Such conclusions are debatable, and the situation may not be as precarious as the numbers suggest, Alper comments. “Claims of ‘weekly closures’ and ‘hundreds of bankruptcies’ occurring are highly exaggerated,” he adds.

Of the 361 medical groups and IPAs accepting capitation payments in California, just 32 groups have filed for bankruptcy or closed due to financial problems since January 1998, according to the California Association of Health Plans in Sacramento. “This resulted in an annual closure rate of approximately 1%,” Alper notes.

“This failure rate is not out of line with what would be expected in other industries or businesses.”

Solvency Issues

To help prevent medical group failures, new solvency requirements are being reviewed and passed into legislation. “Each state is handling solvency requirements differently,” Alper says. “For instance, in California, state regulators have developed statutes for financial solvency, driving improvements in other areas as well.”

But state regulations are a modest step toward solving the underlying problems of capitation, Alper continues. “More than regulation, provider groups need solutions and technology that can reduce costs, improve efficiencies, and provide business intelligence,” he says. “Information technology systems are a central tool to use in improving business decisionmaking. They track where money is going and improve a group’s ability to operate within a budget; these factors can contribute to turning around the performance of a borderline provider group. But such solutions are often overlooked.” Despite the misconception that capitation rates are universally too low and that the capitated model encourages doctors to restrict care, capitated contracting continues to survive, making such group management solutions even more important, he adds.

Capitated Management

Information systems that allow physicians to track revenue and spending may take on increased importance if capitated systems become more widespread. Surveys have shown either an increase in the volume of capitated

business or in the number of physicians paid under this system. For example, a survey in 1999 indicated that 44% of office-based physicians received capitation payments in 1998, compared with 40% in 1996, and that the share of gross income these doctors derived from capitation jumped from 15% to 20%, Alper says.

More recently, a survey by National Health Information, a company in Atlanta that publishes newsletters, found that 75% of responding primary care groups reported they were either seeking more capitation or keeping their current level of risk contracts. Similarly, Evergreen Re, a reinsurance brokerage and health care consulting firm in Stuart, Fla., found that 74% of physician groups in markets with HMO penetration of about 30% accepted capitation in 1999, an increase of 9 percentage points over the 65% of groups in such markets that accepted capitation in 1998.

InterStudy, a company in St. Paul, Minn., that collects data on HMOs, reports that from 1998 to 1999, the number of HMO patients in capitated plans jumped from 37.5 million to 43.2 million. “These studies show that capitated contracting is here to stay, and that we must continue to identify strategies to succeed under this model,” Alper concluded.

To date, managed care has faced much criticism from consumers, physicians, and other providers. “But any program with the goal of controlling health care costs would need a system to sustain the availability of health care services and the ability to change the way physicians practice in order to increase cost-consciousness and verify the necessity of certain tests and procedures,” Alper asserts.

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health care provider cannot discharge, suspend, demote, threaten, harass, or discriminate against a whistle-blower. If a physician does so, the U.S. Justice Department will apply penalties rigorously. An employee unfairly demoted must be reinstated; paid double the salary lost, plus interest; and be compensated for special damages, including attorney's fees.

Experts advise physicians to make it easy for staff to report billing errors and other discrepancies, and physicians should investigate such problems vigorously and take remedial action. Physicians should locate their reporting systems and compliance officer near where care is rendered, and they should use the information they learn from staff, says Stephanie Fletcher, RN, a nurse who filed a successful qui tam lawsuit against her former employer, a large health system. Fletcher received \$630,000, plus \$180,000 for attorney's fees as part of a multimillion settlement against the health system. Today, Fletcher works as a consultant in Marina Del Ray, Calif., helping whistle-blowers to pursue suits and advising physicians on how to reduce risk. She also has a Web site (at www.justwhisper.com) that provides information on qui tam actions.

Familiar with physicians' risks, Fletcher advises, "Don't disregard or shoot the messenger. The federal and state government agents and attorneys are listening to more and more people. Doctors are being taken into court on criminal and civil issues."

Often, a physician group can make good on billing errors and other discrepancies without the need for a federal or state investigation. But if an

employee makes a complaint about fraud or billing errors, physicians should investigate and inform the employee about progress on the investigation, Fletcher says. Also, the physicians should be thorough in their investigation and document the corrective actions taken, says Fletcher. "Keep the case file confidential, and let the employee know you are listening and taking action," she says.

Warning Signs

If an insider files a qui tam suit, the government has no obligation to inform the physicians while it investigates. Nevertheless, there may be signs a case is pending, says Raspanti. Such signs include, for example, a government request for a routine review of some patient charges or payers making requests for repayment.

A case could begin with questions from a worker. Fletcher illustrates: "You've got a nurse or billing clerk who starts questioning you, saying, 'I'm not finding the records for this patient,' or 'There is a question of proof of medical services being rendered.' If you start isolating or retaliating against this worker, suddenly this worker may file a suit."

Typically, physicians lack education on how to bill correctly, which makes them vulnerable to legal action, Fletcher adds.

Egregious Wrongdoing

Another whistle-blower, Thomas Poulton MD, agrees that physicians need to be careful when billing. "One thing physicians need to be aware of is that they never know when one of their employees will become a relator,"

he cautions. "If an employee brings a billing compliance issue to your attention, you would be wise to take the concern—and the employee—very seriously. Try to stay within the lines."

A lieutenant commander in the U.S. Naval Reserve, Poulton is an anesthesiologist and pediatric critical care physician with University Medical Associates at the University of Nebraska, in Omaha. He brought a successful qui tam case against his former employer, a university medical school in another state.

"When I became chairman of the department of anesthesiology at the university," he explains, "I also became aware of likely improper billings, and I reported this situation to my superior. I was told to ignore it. Then, threats were made against my future prospects in medicine both at the university and elsewhere if I were to pursue my concerns."

At that point, Poulton began working closely with federal investigators from the office of the U.S. Attorney and from the FBI. He filed a qui tam suit and won.

"The university paid several million dollars in a settlement to the federal government and a modest amount to me," Poulton says.

The reactions among Poulton's peers to his qui tam suit were mixed. "Some think I was nuts, and some applaud my toughness and integrity," Poulton says. "It certainly hasn't hurt my employability."

A Question of Fairness

Poulton contends that the federal enforcement effort is not excessive or unjust. "Most of the suits and

"Physicians need to know that the threat from within is more dangerous than the threat from without. Physicians have a much greater risk of being brought down by someone in their own midst."

—Mark Raspanti, lawyer

Lawyer Offers Steps for Qui Tam Protection

Physicians should establish an anonymous system for staff to report billing errors or potential fraud, advises Marc Raspanti, a lawyer in Philadelphia who is an expert in qui tam cases. "If you're in a small practice, you can use an outside firm and give all the employees the number of the hotline, so they can call 24 hours a day, seven days a week with no fear of anyone recognizing their voice," he says.

Once a complaint is lodged, the physician, group administrator, or compliance officer should follow up promptly and investigate fully, he says.

Physicians should educate all staff and managers on how to find and resolve problems, how to use the hotline, and how to report any problems, Raspanti adds.

The group also should insist that any employee who reports a problem should have no fear of reprisal. "Develop a no-retaliation policy, and make sure everyone in the organization knows this policy extremely well," he says.

Finally, physicians should let the staff who report potential fraud or billing errors know that the physicians are addressing the problem. —DK

investigations that result in penalties are against those truly guilty of obvious or egregious wrongdoing," he says. I have not seen abuses of discretionary power."

By believing that the federal compliance effort is unfair, some physicians have become their own worst enemies, Raspanti says. "Doctors aren't getting the message because they think it's wrong," he says of the federal compliance effort that has targeted physicians and other providers. "They think the whole government health care fraud initiative is wrong, the whistle-blower is wrong, or the government is wrong."

Compounding the problem is the fact that physicians have received little or no education on compliance, says Raspanti. "Doctors come out of medical school with absolutely no training on fraud and abuse issues," he adds. "Then they mentor with someone with no experience or knowledge of fraud and abuse laws."

The lack of understanding of the issues leads some physicians to react incorrectly if there is a complaint filed against them, Raspanti says. "Their instincts get them into trouble," he explains. "Often, doctors targeted for investigation will wait far too long before engaging competent counsel. They engage in self-help, following well-meaning but dangerous advice

from their peers. They start backdating records, clarifying files, destroying records, and doing other things that look bad to an FBI agent."

A Compliance Program

The best defense against any billing problem is to have a compliance program, experts say. "When it comes to compliance, if you don't solve your own problems, it's fairly well documented that someone else will solve them for you," Raspanti says. "Doctors need to understand that the stack of whistle-blower lawsuits on the desk of the Department of Justice is very high. Thousands have been filed in the last couple of years, and the flow is not subsiding. Physicians need to be aware that without compliance insurance, all costs for defense and penalties come out of their pockets. Legal costs alone can exceed \$300,000, not including any settlement they reach."

Simply having a compliance program can be an effective legal shield, says Jim Bickett, assistant U.S. Attorney with the Justice Department in Akron, Ohio. Internal guidelines from the Justice Department direct investigators to consider the existence of a compliance program as a mitigating factor in how aggressively the investigator proceeds with an investigation.

"When you can show that you

have an operational compliance program in place, you have significant protection," Bickett says. "It's harder for the government to win a case because you can show an effort to comply with the guidelines. Juries understand this, and tend to rule in the physician's favor, plus the problems are fewer. Essentially, with problems minimized, we have little enforcement incentive left. You can say, 'We have acted in good faith,' and that's a shield."

Amy Woodhall, a health law attorney with Walter & Haverfield in Cleveland, agrees. "There's no legal duty to have a compliance program in place, only a duty to comply with the law," she says. "But having a compliance program is a good risk management tool."

Physicians seeking to develop a system to reduce the potential for fraud can follow the guidelines for physician practices from the Office of Inspector General of the federal Department of Health and Human Services. The guidelines, *OIG Compliance Program for Individual and Small Group Physician Practices*, are available on the Web (at <http://oig.hhs.gov/authorities/docs/physician.pdf>).

—Reported and written by David Kettlewell, in Akron, Ohio. More information on physician practice strategies is available on our Web site (see page 16).

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Today, even HMOs—the most restrictive type of insurance plan—are beginning to relax restrictions. According to the American Association of Health Plans, an organization in Washington, D.C., that represents plans with about 170 million members, hospital admissions that required preapproval from HMOs fell from 42% to 35% between 1996 and 1999.

“There’s no question that managed care is evolving,” Alper observes. “But even as HMOs loosen some restrictions, managed care organizations will still be under pressure from employers to keep costs down and to improve the quality of patient care. Physician groups and provider organizations will be caught in the middle of conflicting interests: consumers wanting more care and health plans wanting to increase control over utilization and costs. Under these conditions, it’s no wonder that provider groups have challenges in managing their risks and capital.”

Limiting Choices

Although many health care organizations may be ready to abandon capitation with all its challenges and difficulties, there are not many other options available, Alper says. “For instance, many in the industry claim that the PPO model with its choice of providers and flexibility is superior, but it also has its negative attributes, including high premiums, high deductibles, and a lack of oversight,” he explains.

In a study conducted by *Consumer Reports*, in Yonkers, N.Y., 83,000 readers of the magazine were surveyed about their experiences with health plans. The survey’s researchers found that HMO members were just as satisfied as the members in PPOs, even when they were asked about their choice of doctors and the quality of care from doctors.

“HMOs are undergoing significant changes that may help to improve managed care contracting in the

future,” Alper continues. “Many benefits are being redesigned, allowing enrollees to have more choice and flexibility in their plans.”

But choice comes at a price. “For instance, several managed care companies are introducing a surcharge on consumers who choose to visit more expensive hospitals,” Alper says. “If consumers want increased freedom of choice under their managed care programs, they will have to be willing to shoulder some of the expense.”

In addition, HMOs are also loosening the controls over delivery of care, allowing physicians more freedom to practice medicine, Alper notes. “Reducing the number and types of services that require preauthorization or automating authorizations is going a long way toward improving provider satisfaction,” he says.

HMOs are trying to improve consumer satisfaction as well. “HMOs are providing consumers with more choice and flexibility, and simultaneously shifting associated expenses to them,” Alper observes. “Patients will feel the financial pinch and have a different outlook on managed care restrictions as a trade-off for

the system will be fine tuned to foster cooperation between health plans and providers and to more clearly define the roles of the two parties.”

Group Survival

Such cooperation will be necessary as health care costs continue to rise, fueled by increased utilization as the population ages. “Consumers have played a significant role in increased health care spending, actively opposing many of the hallmarks of managed care, including restrictive networks, utilization management, and prior authorizations to see specialists,” Alper says. “After a decade of competing, the health plans that are left standing must now raise premiums to more sustainable levels. In light of premium increases, employers will place a lot of pressure on managed care organizations to control costs. Meeting these expectations will require provider groups and health plans to share information to hold down expenses.”

In addition, physicians groups and provider organizations are increasingly investing in the technology to track costs, negotiate better rates,

“To abandon capitation at this time would be to turn our backs on a model that is just beginning to show promise,” Alper says.

decreased health care expenses.”

As managed care evolves, so too will, capitation, which is still a relatively new model, Alper concludes. “Weaker groups have now been weeded out, and stronger groups endure—better equipped and experienced to handle capitation in the future,” he says. “As these groups increase their enrollment, they will achieve more desirable economies of scale. As a result, to abandon capitation at this time would be to turn our backs on a model that is just beginning to show promise. With more modifications,

and handle administrative tasks more efficiently, Alper adds.

“Despite apocalyptic claims that a record number of groups are closing down, many provider organizations are holding their businesses together in the face of increased costs and utilization,” Alper concludes. “Many provider groups are committed to fixing what’s wrong under the current system, keeping quality care as the focal point to improve.”

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

Author Criticizes Health System for Focus on Process Over Results



J. D. Kleinke is the founder and president of Health Strategies Network, a health care software development company in Denver (at www.hs-net.com). A

*medical economist and health information technology expert, Kleinke is the author of *Oxymorons: The Myth of a U.S. Health System* (Jossey-Bass, San Francisco, 2001); *Bleeding Edge: The Business of Health Care in the New Century* (Aspen Publishers, Gaithersburg, Md., 1998); and other books. In this interview, he discusses *Oxymorons* with Richard L. Reece, MD, editor in chief.*

Q: Since I interviewed you several years ago about your book, *Bleeding Edge*, it seems you have made a remarkable turnaround in your philosophy. Then, you espoused managed care and integrated physician-hospital networks; now, you believe in another solution. Tell us about the difference.

A: The latest book reflects a natural evolution based on some of the hard realities presented in *Bleeding Edge*. The main thrust of *Bleeding Edge* was that managed care as commercially practiced by insurance companies would eventually force providers to act more like businesses and less like uncoordinated,

fragmented entities, thereby inspiring a market-based process to force health care to grow up.

That vision did not come fully to fruition. Many providers have gotten the message that they must be more aggressive, more rational, more businesslike, and more data driven than they were before managed care. But the full realization of the process I described in the book fell short.

Over the past several years of helping physicians and other providers implement the frameworks presented in the book, I discovered that the marketplace that often should—and in other industries does—inspire greater efficiency and greater customer responsiveness often fails in health care.

My goal in writing *Oxymorons* was to help providers get past this market failure and to progress toward a better business model. I remain a staunch believer in market forces in health care, consumer choice, consumer rights, and the ability of providers and consumers ultimately to pursue their own economic interests in a way that improves the system for everyone. But the obstacles to this type of market are out of the control of any of the individual actors—the hospital, the doctor, the consumer, even the insurance company. Regulatory reform and consumer-driven health care purchasing will

achieve improvements in a way that the current private health care market has been unable to.

Q: The tone of *Oxymorons* is passionate and full of outrage. Why is that?

A: My indignation is not directed toward any one constituency or any one set of economic objectives, but rather toward a legacy of faulty accidental regulation and lack of planning, lack of coordination, and lack of real insight into the broader, deeper problems of health care. No one is at fault. Most people in the health care system are trying to cope with an incredibly complex, dysfunctional system. In the book, I used a strenuous tone about certain features of the system so that I could clearly make my case for how to fix those features.

We have created this huge labyrinth of process—full of paperwork and hassles—yet what do we get as a result? If this complexity made people healthier, reduced costs, didn't hurt doctors too much, and led to better quality, then fine. But all this complexity has not led to improvement, just more process. Doctors will always do what doctors do. Patients will always demand what patients demand. Medical progress will cost money. Managed care can't fix any of those realities. That is the central point of the book: We cannot

(Continued on page 14)

“Doctors will always do what doctors do. Patients will always demand what patients demand. Medical progress will cost money. And managed care can't fix any of those realities. That is the central point of the book: We cannot engineer our way out of certain features of medicine.”

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engineer our way out of certain features of medical practice.

Q: You present an anecdote in *Oxymorons* involving two doctors discussing a complex patient and reams of data. When they present the case to another doctor, she said, "Let me see the patient." This anecdote shows how physicians, based on their experience, can simplify complicated problems.

A: This scenario, which I observed in a physician's lounge in a busy hospital, was an eye opener for me after years of believing that computers, data, and statistical analyses could be fully and effectively mobilized. They are effective and useful, but we have probably oversold their effectiveness and their useful-

ness for a long time. The intuitive, nonverbal aspects of medicine cannot be supplanted by quantitative methodologies, computers, and remote rule-sets; at best, they can be augmented by them.

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ness for a long time. The intuitive, nonverbal aspects of medicine cannot be supplanted by quantitative methodologies, computers, and remote rule-sets; at best, they can be augmented by them.

Data cannot solve all problems, which is one thing we have all learned the hard way during the past decade of managed care. Medicine and health care are characterized by unpredictability. Little events on our radar screen that aren't in our spreadsheet or in our business plan tend to have the greatest influence over what really unfolds.

Q: What are some of the solutions that you propose?

A: First and foremost, we need to correct the tax code. People should be able to purchase their own scope and type of health coverage—and direct medical care not included in that coverage—with their own pretax money. They should have the

same tax advantages that their employers now have when buying coverage and direct care. This strategy will put true consumerism into a health care marketplace completely distorted by the presence of employers—a third party with very different motives and needs than the employee-consumers for whom they are purchasing coverage and care.

Second, we need to simplify health insurance regulations, across state lines and nationwide. Doing so will allow big insurers to act like big insurance companies, gaining the economies of scale in claims processing, administration, and marketing that the consolidation of the 1990s was supposed to bring but that the

spend increasingly more of the 85 cents on administration of claims on the other side of the fence. It's complete madness.

Consumers are dying for clarity, providers are dying for less paperwork, and health plans are dying for efficiency. A uniform benefits plan that is published, marketed to millions of people, and administered by hundreds of plans would greatly simplify health care.

These three solutions are substantively and politically interrelated, and would be particularly powerful if implemented concurrently.

Q: Why do you think employers should not be a factor in the health care system?

A: If we truly want to simplify the system, we need to get the employers out of the way. There is no good reason that people running factories, service companies, software companies, or banks should be deciding how other people should be dealing with their health care. That is not an appropriate role for employers. Unfortunately, they were forced into that role by an accident of history decades ago, and they have been stuck there ever since.

Most people would agree that a functional market requires the person consuming the goods to be the purchaser of those goods, so that person can make the appropriate decisions. Some consumers love the convenience and impersonality of Kaiser; others want to spend more time deciding on the best providers in the market and will pay for that privilege. I do not think it is up to the employers to make that choice for them.

Q: What about a model like the Federal Employees Health Benefits Plan?

A: Something like the FEHBP should be implemented for the rest of the country. The program covers a huge block of consumers that basically have a voucher to buy whatever mix of insurance and

direct, out-of-pocket care they want. In effect, they are fully liberated health care consumers. They can pick virtually any insurer they want.

On a pretax basis, my employer can hand me \$4,000 worth of health insurance vouchers. I can choose to give Kaiser Health Plan the whole \$4,000 in exchange for full coverage, or I can just buy catastrophic coverage for \$1,500 and put the other \$2,500 in the bank to use to pay for physician visits, pharmaceuticals, and other routine health expenses. That should be my choice. That's exactly what the FEHBP offers. Ironically, the federal government has come up with a model that makes sense for the entire private sector, a program that allows people to make their own health care choices with their own dollars. Furthermore, the free market mechanism would allow people to discipline their health insurers the same way they discipline their retailers when they are not happy with the service they are getting.

That \$4,000 is given to me as health insurance purchasing power, not as real cash. But it's still my compensation. Employers think about insurance as part of compensation. It does not matter to them if it is paid as \$4,000 in gross, pretax income to the employee or as \$4,000 to a health insurer as a business expense. The effect on the employer's income statement is virtually identical.

It is not fair to me, as an employee, to have you, an employer, siphon off \$4,000 of my gross compensation and decide what you will buy for me with it. It is paternalistic, intrusive, and inefficient—three factors that perfectly define an employer-based health insurance system. It's the equivalent of allowing my employer to set aside my grocery money from my paycheck and then make me go to Safeway instead of Food Lion with a prepaid grocery card. It is a moronic system, but a system that we take it for granted because

“There is no good reason that people running factories, service companies, software companies, or banks should be deciding how other people should be dealing with their health care.”

that is how it has always been.

Q: *What will be the outcome of the prescription drug debate?*

A: More effective pharmaceuticals—even at a higher price—have economic benefits elsewhere in the health care system. Especially if you consider that a pharmaceutical is like a computer; that is, a technology that makes people more productive. Similarly, the more effective a drug therapy is on a patient with a chronic disease, the less likely that patient is to need hospitalization and surgery. Pharmaceutical development represents a natural evolution of the health care system away from services, hospital care, and surgery and toward the use of technology to keep people healthier. That's a good thing.

After much hysteria about rising pharmacy costs, people are starting to recognize that there is a huge benefit associated with those added costs. The best example is psychiatric care. Twenty years ago people who suffered from depression or schizophrenia were in the hospital for weeks, poorly medicated, observed helplessly, often physically restrained. Now they are on effective antidepressant or antipsychotic medications, and often they are productive and functioning members of society. This is wonderful news, the very embodiment of our great progress as a society. It is expensive, and it is worth it.

Q: *In Oxymorons, you write: “Consistent with American consumer culture in general, as patients we want everything, are willing to pay for*

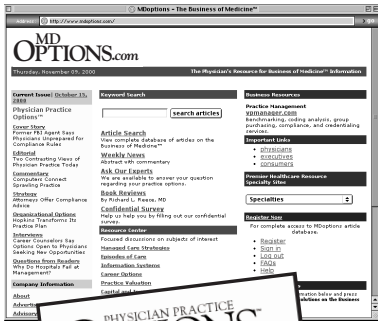
everything (except alternative medicine, of all things), and resort to litigation when the worse consequences of our own behavior result in bad medical reimbursement outcomes.” What does this statement imply about human nature?

A: It is human nature to want something for nothing. That's why we have lottery tickets and game shows. Unfortunately, generations of us have been trained to act as though health care were the same thing: free, like a prepaid, all-you-can-eat buffet. We think, “Hey, it's free, there are no economic consequences to that decision.” And the less people have to pay for something, the more they are going to demand of it. One reason we have such an outsized medical infrastructure is that it is perceived by the consumer to be free, and any economist will tell you that this circumstance will generate an artificially high level of demand, in contrast to how demand is related to price for all other commodities.

People are not responsive to price in health care because it's not their money being spent. If we could change this perception and its perverse economic consequences, then we will have made great strides in reforming our health care system. Liberating people with their own pretax dollars to buy health coverage and direct medical care would be a huge step in that direction.

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

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