SUNDAY

YOUR COMPLETE NEWSPAPER

□

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CROWNING GLORY

Lakewood boys and St. John Vianney girls are champions.

SPORTS/H1

How one HMO works

Payments to doctors from the Garden State Health Plan vary according to the patient's age, gender and Medicaid eligibility. But the figures below (accurate for a 55-year-old, blind woman residing in Middlesex County) are taken directly from the plan's documents and show how doctors can boost profits by cutting care. All payments to doctors are automatic.

Primary care: $128 every six months

- Includes office visits and basic services.
- The fee doesn't change, no matter how much or little care the doctor renders.

Specialty care: $493 every six months

- Includes medical referrals, tests and other services.
- Doctor keeps entire fee if not spent.

Hospital care: $617 every six months

- Doctor can keep up to half of unspent funds, depending on a complex formula.
- The state also can keep up to half of any savings.

The bottom line: $1,238 every six months

- If no specialty of hospital care is provided to the patient, the doctor can pocket up to $929 every six months. Of that amount, $801 depends on the physician's ability to limit medical care.

Asbury Park Press graphic
Source: Garden State Health Plan

The dark side of HMO plans

□ *EDITOR'S NOTE: This is the first in a periodic series on medical conflicts of interest that can pit a doctor's wealth against a patient's health.*

By MARK LAGERKVIST
PRESS STAFF WRITER

ONE MILLION New Jersey patients may not realize it, but they depend on health care plans that resemble Dr. Jekyll and Mr. Hyde.

Like the good doctor, health maintenance organizations, or HMOs as they are known, profess the best of intentions. HMOs are insurance plans that offer comprehensive medical services for a single fee. They promise quality care that avoids unnecessary costs and procedures.

But like Hyde, HMOs also have a dark side — an alter ego of perverse economic incentives that can tempt doctors to withhold services from their patients.

PROFITS vs Patients

In some HMOs, if a physician authorizes hospital care, referrals to specialists or other costly services, he may pay $12,000 or more from his own pocket. Or the doctor can profit by doing nothing.

An Asbury Park Press examination found that each of the state's 19 HMOs offers its physicians financial incentives to restrict or minimize the cost of health care. Patients are seldom informed of those arrangements.

The result is hidden conflicts of in-

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HMO

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terest that can compromise a physician's medical judgment. The amounts, types and combinations of incentives vary greatly among HMOs.

The Press found:

■ Fourteen HMOs pay doctors by "capitation" — a single fee, usually paid monthly, to provide medical care for each patient-member. If the care costs less, the physicians can keep the difference. If it costs more, they can lose the entire fee.

■ In eight HMO systems, "holdbacks" or "withholds" are used to motivate doctors. A portion of the fees — usually 10 percent to 20 percent — are withheld from doctors. To get that money, the physicians must meet cost-containment goals set by the HMO.

■ Three HMOs pay doctors bonuses based on the firm's overall financial performance, including their collective ability to limit the cost of medical services.

■ No law requires HMOs or doctors to disclose those deals to their patients.

"Patients should be very concerned," said Dr. Arnold S. Relman, editor of the New England Journal of Medicine. "I don't see how they can be expected to trust their physician's advice if they can't trust his motives."

HMO officials acknowledge the conflicts but say they are able to control unethical or inappropriate behavior by their doctors.

"There can be some concern that there might be an incentive to withhold care," said Roger W. Birnbaum, president of HIP/Rutgers Health Plan. "We don't want that economic consequence to be severe enough so that it will adversely influence a physician's decision.

"HMOs basically put physicians at risk," Birnbaum said. "We're trying to come up with some middle ground that gets the physician's attention so that the physician will stop and think, 'Gee, what are the economic consequences of what I do?' "

"That's the whole concept of HMO — transfer the risk from the insurer to the providers of care and give them a stake in what's going on," said Edwin Kelleher, a state health official who has regulated HMOs for 15 years.

HMOs offer an opposite approach to medicine's traditional fee-for-service structure. Under fee-for-service, medical providers are paid for each visit, test and procedure. The more services a doctor renders, the higher his income.

"Fee-for-service clearly has a perverse incentive to provide services that may not be necessary," said Dr. Michael Stocker, executive vice president of U.S. Healthcare Inc., owner of New Jersey's largest HMO. "Most data show that 20 percent of medical services provided are unnecessary."

Instead, HMOs reward doctors who can limit or minimize services to patients. That creates a motive that can cause physicians to cut corners or refuse to provide appropriate care.

"I think that incentives that reward the doctor for doing less are just as bad as incentives that reward a doctor for doing more," said Relman, a critic of abuses in both systems during his 14-year tenure at the world's largest medical journal.

"It would be reasonable to have concerns about all kinds of reimbursement systems," Stocker said. "You realize that all reimbursement systems are a compromise. And then you need to monitor it."

The ABCs of HMOs

Any discussion of HMOs involves terms specific to the topic. Here are a few:

■ **Bonus:** An incentive payment to a physician. It is usually based on the financial performance of the HMO.

■ **Capitation:** A method of payment in which a doctor or other provider is paid a fixed amount to provide care for each patient, regardless of the cost or number of services provided. The capitation is usually paid monthly.

■ **Fee-for-service:** The traditional method of reimbursement that pays a physician or other provider a fee for each medical service provided.

■ **Gatekeeper:** Also known as the primary care physician, case manager or family doctor. The gatekeeper is the HMO physician in charge of approving a patient's medical care.

■ **Health maintenance organization:** An insurance company or other organization that offers a comprehensive range of medical services for a single, fixed charge per patient.

■ **Withhold:** Also known as a holdback. It is a percentage of a fee or payment fee that is literally withheld from a doctor. To earn the withhold, the physician must meet the HMO's goals for controlling medical expenses.

Asbury Park Press Graphic

No state inspections

The New Jersey Department of Health has not conducted an HMO inspection since mid-1989.

Because of departmental cutbacks and reassignments, Edwin Kelleher is the sole survivor of a seven-member staff that once averaged four visits a year at each HMO.

Kelleher would not comment on how the cuts have affected the state's regulatory effort. However, he said that the health department is considering a proposal to increase its HMO staff.

The state Department of Insurance also regulates HMOs. But that agency watches the fiscal health of the plans, not the medical care they provide.

As a result, New Jersey HMOs are substantially on an honor system.

State law requires HMOs to monitor the quantity and quality of care rendered by their own physicians. In addition, they must conduct patient satisfaction surveys and maintain a grievance procedure.

HMO representatives say those internal systems adequately protect patients.

"As long as there is a good quality assurance program in place, I think it provides a reasonable safeguard," Birnbaum said.

Yet, HMO employees in charge of the reviews may have their own conflicts of interest. The medical directors, for example, may receive bonuses based on the HMO's ability to save money by restricting services.

"I really couldn't say it's typical, but it happens," Kelleher said.

The state receives complaints from HMO patients and attempts to resolve any problems, he said.

Those records were not available to the Press. The health department regards the complaints as confidential and exempt from public disclosure.

Kelleher said the state does not keep any totals on the number of complaints. But he did offer an opinion on the overall performance of HMOs.

"The level of quality in HMOs seems to be quite adequate, and the patient satisfaction levels seem to be quite high," Kelleher said.

Problems have occurred elsewhere. Thousands of patients complained about poor services and unpaid bills by Florida's largest HMO, formerly called International Medical Centers. In numerous cases, patients were denied medical services in emergencies and life-threatening situations.

The IMC controversy triggered congressional investigations — and a federal law intended to limit the risk incentives offered to doctors by HMOs. That law takes effect in April. When it does, regulators will try to decide how much risk is appropriate.

Reports by the General Accounting Office of Congress have warned that HMO risk-incentives could lead doctors to provide poorer care to Medicare and Medicaid patients.

In New Jersey, the state Board of Medical Examiners is considering a proposed rule that could prohibit HMO risk-incentives already in common use. HMO representatives say the wording of the would-be rule is unclear and confusing.

"We may have bitten off more than we intended," said Joan D. Gelber, a deputy attorney general assigned to the board. "The intent is to eliminate the economic disincentives, but not to try to change the entire HMO industry."

The effect of HMO incentives on quality of care defies scientific study. It is difficult to accurately measure how the fiscal pressures affect the medical judgments and private thoughts of doctors.

"Use your own common sense," advised Relman of the medical journal. "Do you think doctors are different kinds of human beings (who are) totally impervious to economic incentives?

"Obviously, the incentives are there because HMOs believe the doctors will be influenced," Relman said.

New Jersey's largest HMO

Individual doctors can lose up to $12,000 on a single patient in the state's largest HMO, the Health Maintenance Organization of New Jersey.

With nearly 400,000 patient-members — including 23,000 in Monmouth County and 14,000 in Ocean County — HMO/NJ is more than double the size of its closest competitor.

"You want to know why we're the largest?" asked Michael Stocker, HMO/NJ president. "Because people like us, and we give good care."

Each patient selects one of its 1,000 primary care physicians as a family doctor. Those physicians are actually independent contractors who are paid a capitation fee by the HMO to provide and manage medical care for each patient.

The average fee paid to primary care physicians in 1989 was roughly $25 per patient — or $300 a year — according to HMO/NJ records. The average physician is assigned to manage the care of roughly 400 patients.

In exchange for the fee, the doctor renders his own services. He also must approve and pay for many other medical expenses. No matter how much — or little — care is provided, the fee remains the same. By keeping costs to a minimum, the doctor can profit.

But if the patient requires specialty care or hospitalization, the doctor must pay for those services from his own pocket — up to a maximum of $12,000 a year per patient. The HMO pays any excess — plus all costs for laboratory tests, radiology, mental health and substance abuse services.

Facing that risk, doctors may be tempted to delay or deny medical services needed by patients.

"The doctor should not be put in a position where his or her judgment is going to be influenced directly by the consequences to his or her income," Relman said. "Any arrangement that puts him at risk for prescribing or recommending procedures and tests is wrong."

HMO/NJ officials say they have a complex system of additional financial incentives to ensure doctors provide patients with appropriate medical care. In fact, the same system is employed by the entire six-state, 1 million-member chain of HMOs owned by U.S. Healthcare Inc.

"It makes a lot of sense to us, but it's hard to explain," Stocker said. "People get confused."

HMO/NJ typically does not pay the entire capitation fees to its primary care physicians. Instead, it rates those doctors individually on the quality and quantity of care provided to patients.

Depending on their ratings, the physicians are paid anywhere from 60 percent to 100 percent of the capitation. It is essentially a "withhold" or "holdback," but HMO/NJ doesn't like those terms.

"We try to get away from the word 'withhold' because it has such a negative connotation," Stocker said.

According to Stocker, half of the rating reflects the quality of care provided by the doctors. The measurements include patient surveys, grievances, audits of medical records and the number of patients who quit their HMO doctor.

The other half is based on measurements of the quantity of hospitalization and specialty care approved by doctors. Those numbers are compared to the averages of other physicians and the expectations of the HMO.

There is another incentive — a bonus based solely on HMO/NJ's criteria for measuring quality of care, not cost.

HMO's goal for controlling medical expenses.

The group approach

Instead of individual doctors, Aetna Health Plans and PruCare of New Jersey contract with large groups of physicians known as IPAs — independent practice associations.

In exchange for capitation payments, the IPAs assume responsibility for a major portion of each patient's medical care.

The IPAs typically withhold 15 percent of the money from their physicians. Those funds are placed in a "risk pool." Based on their success in controling medical expenses, any surpluses in the risk pool are later paid to the group's doctors.

Although the physicians are still at risk, they collectively share the burden with fellow doctors.

"Group values can take hold," Relman said. "It's much less likely that a group of reputable physicians will be collectively swayed by economic incentives than individual doctors will."

PruCare will soon switch from IPAs to contracts with individual physicians, said Raymond C. Allen, PruCare vice president. The HMO has roughly 45,000 patient-members, including 2,000 in Ocean County and 400 in Monmouth County.

Aetna has about 135,000 patient-members, including 8,000 in Monmouth County and 4,000 in Ocean County.

One plan — CoMed HMO — contracts with both individual primary care physicians and IPAs.

Another HMO called Oxford Health Plan pays primary care physicians on a traditional fee-for-service basis. The only difference is that Oxford withholds 15 to 20 percent of those fees. To get the balance, physicians must control costs.

Three New Jersey HMOs use a combination of salaries and bonuses as economic incentives for physicians.

Rutgers Community Health Plan and HIP of New Jersey are technically separate HMOs awaiting merger. Meanwhile, they are being marketed as the HIP/Rutgers Health Plan.

To serve its 170,000 patient-members — including 2,000 in Monmouth County and 1,000 in Ocean County — HIP/Rutgers maintains 13 health centers. Those centers are staffed by physicians from two large professional groups that contract with HIP/Rutgers.

The doctors are paid by salary — no capitation, withholds or holdbacks. The physicians can collectively earn a bonus ranging from zero to 10 percent — depending on the HMO's annual financial progress.

"Everybody has an interest in the total economic performance of the whole program," said Roger Birnbaum, HIP/Rutgers president. "It's the only element of risk-sharing in our program.

Another exception to the rule is the state's first HMO, which is now known as the Health Center Division of BCBSNJ's Medigroup Central. Most of the Trenton-based plan's members are state employees.

Similar to HIP/Rutgers, salaried doctors treat patients in a facility owned by the HMO. The difference is the physicians are actually employees of the HMO, not independent contractors or a corporation formed by doctors.

Based on the HMO's overall finances, the employee-physicians are also paid bonuses.

"I don't want to publish the amount, but it's nothing they would compromise their practices or professional futures for," said chief operating officer Sharon Hayman. "Certainly, they don't live and die by these bonuses."

"There's no way I could put a number on it, but it's much less than the capitation," Stocker said.

Through its maze of incentives, HMO/NJ tries to guide the decisions of its doctors.

"You want that magic element called judgment," Stocker said. "And judgment means doing the right thing at the right time — not too much and not too little."

The 'gatekeepers'

None of New Jersey's 19 HMOs are identical. Their structures, operations, finances and physician incentives can differ widely.

"If you've seen one, you've seen one," quipped Leo Carey, general manager of Cigna of Southern New Jersey.

Some HMOs retain hundreds of individual doctors as independent contractors. Others negotiate deals with a few large professional associations or groups of physicians. One HMO employs a full-time medical staff.

A few HMOs run their own medical centers. Most HMOs rely on physicians to provide care in private offices.

In the medical marketplace, vying HMOs tout the merits, coverages and advantages of their systems — and point to shortcomings of their competitors.

Overall, the entire HMO industry is constantly changing and evolving. State health officials say the 18 existing HMOs will be merged into 12 health plans in the near future.

However, there is one key similarity. All HMOs have "gatekeepers."

In an HMO, every patient-member is assigned to a gatekeeper. The name is descriptive: The gatekeeper often de-

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Gatekeeper

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cides who gets in the door to specialists and hospitals — and who doesn't.

Because of the connotations, HMOs prefer to call them primary care physicians, case managers or family doctors.

"It's a gatekeeper system, although nobody likes to use that word anymore," said Betty Kimmel, head of operations for CoMed HMO and Cigna of Northern New Jersey.

To control medical costs, HMOs usually reward or penalize gatekeepers according to the expense of the medical care they provide or approve for patients. There are three basic types of incentives: Capitation, withholds and bonuses.

Fourteen HMOs pay their primary physicians by capitation, a fixed fee per patient-member. Of that number, 11 HMOs contract with individual doctors, two HMOs have agreements with large groups of physicians and one HMO does both.

"Capitation means you're forcing a doctor to act as a mini-insurance company," said Steven Wiggins, president of Oxford Health Plan. "He's taking the risk."

The amount of risk assumed by those physicians ranges widely. At one extreme is HMO/NJ, which requires doctors to pay up to $12,000 per patient.

The incentives also are strong in the Garden State Health Plan, a Medicaid HMO run by the state government. Under that plan, Medicaid pays the physician-case manager extra for not approving specialty or hospital care. Those incentives allow doctors to pocket several hundred dollars a year for each patient not referred.

"The basic flaw in the system is that it gives the physician an incentive not to refer you for specialist care or hospital care," said Leighton Holness, senior attorney for Legal Services of New Jersey.

RELMAN

At the other end of the spectrum are five HMOs owned by Medigroup Inc., a subsidiary of Blue Cross and Blue Shield of New Jersey. Medigroup has a total membership of 70,000 patients, including 9,000 in Ocean County and 6,000 in Monmouth County.

In the Medigroup system, the primary care physicians are only at risk for their own services and office procedures. The expenses of specialists and hospitalization are fully covered by the HMO — not the doctor.

"We've definitely minimized the risk," said Charles R. Mooney, Medigroup director of operations. "We certainly think our approach is the fairest to the physician and provides the least disincentive."

A similar approach also was recently adopted by both Cigna of New Jersey and Cigna of Southern New Jersey — two HMOs owned by the same insurance firm.

"The concern always is that the patient won't receive the service they need because the physician is so cost conscious," said Betty Kimmel, Cigna of New Jersey.

Four HMOs — CoMed HMO, Sanus of New Jersey, MetLife HealthCare Network and Travelers Health Network — withhold 10 to 20 percent of their capitation payments to individual primary care physicians. To get that money, the doctors must meet the

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Asbury Park Press

IMPACT

WEEK IN REVIEW
FEATURING EARTHWEEK — PAGE 4

Critics doubt HMO's more-for-less approach

By MARK LAGERKVIST
PRESS STAFF WRITER

The Garden State Health Plan seems too good to be true.

The poor will receive better medical care, their doctors will be paid more — and yet it will cost taxpayers less, state officials predict. The goal is to place New Jersey's 500,000 Medicaid recipients in the state-run HMO, a health maintenance organization.

But hidden conflicts of interest may turn that dream into a nightmare. The plan directly pays a doctor more money for providing less services to each Medicaid patient.

Under the plan, the patient's family doctor loses income by approving diagnostic tests or referrals to specialists. If a patient is hospitalized, the doctor earns less.

HMOs offer comprehensive medical services on a budget. To differing degrees, all HMOs try to control costs by offering various financial incentives to physicians.

Compared to most HMOs, the Garden State Health Plan uses extreme incentives to motivate doctors — including direct penalties for medical services provided to each patient.

"The basic flaw in the system is that it gives the physician an incentive not to refer you for specialist care or hospital care."

Leighton Holness
LEGAL SERVICES OF NEW JERSEY

"It's a terrible arrangement," said Dr. Arnold S. Relman, editor of the New England Journal of Medicine. "I can promise you there will be abuses — that patients will not be happy and doctors will not be happy."

"The basic flaw in the system is that it gives the physician an incentive not to refer you for specialist or hospital care," said Leighton Holness, senior attorney for Legal Services of New Jersey.

"Because there is an incentive for physicians to restrain services, we're just concerned that Medicaid patients will suffer a reduction in the quality of care they get," said John Jacobi, assistant deputy for the state Public Advocate.

In contrast, state officials contend the plan will result in better care and more preventive medicine for those patients.

"The physician's motivation is to keep the patient as healthy as possible — because the less referrals that are made, the higher the reimbursement," said Thomas M. Russo, Garden State's chief executive officer.

The push for the HMO is coming from the very top of New Jersey government. It is an effort to control the state's $1.2 billion annual budget for Medicaid, the public health care program for the poor.

Gov. Florio alluded to the plan in his budget message in January, when he pledged changes that would "probably provide better health care to our people, and we will control

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Medicaid costs."

The state believes it could cut costs by 30 percent, or $360 million a year, if all Medicaid recipients belonged to the plan. However, that estimate is based on an actuarial study, not the actual experience of the HMO.

"Garden State Health Plan enrollment of Medicaid clients should be expanded using every means possible," stated last year's report by the Governor's Commission on Health Care Costs.

Currently, the HMO only has 4,200 patient-members — less than 1 percent of the state's Medicaid population — and contracts with 130 doctors. The plan operates in 10 counties — Middlesex, Mercer, Burlington, Atlantic, Camden, Sussex, Essex, Passaic, Union and Morris.

State leaders want rapid growth. The official goal is an increase of 125,000 patients — 25,000 in each of the next five years. In the process, the HMO will expand to the rest of New Jersey, including Monmouth and Ocean counties.

"If all the goals are met, all Medicaid-eligible persons would be offered the opportunity to participate in the plan," said Russo. "It could be 500,000 then."

One way to view the system is through Gardenia, a 55-year-old blind woman who lives in Middlesex County and belongs to the Garden State Health Plan.

All of Gardenia's medical care is either provided or approved by her HMO family doctor, called a physician case manager. In exchange, Medicaid pays the doctor in three different ways:

- For providing Gardenia with primary care, including office visits and basic services, Medicaid pays the doctor $128 every six months. No matter how much or how little care he renders, the fee remains the same.
- Medicaid pays an additional $493 every six months to cover the cost of medical referrals, tests and other specialty services. If the care is provided and the money is spent, the physician case manager gets nothing. But if Gardenia does not receive any of those services, the doctor keeps the entire $493.
- Another $617 is earmarked for Gardenia's hospital care every six months. If she is hospitalized and the money is exhausted, the physician case manager gets nothing. If any money is leftover, the doctor can keep up to 50 percent, depending on a complex formula. The state can also keep up to 50 percent of any savings.

The bottom line is simple: If no specialty or hospital care is provided to Gardenia, the physician case manager can pocket up to $800 in extra income every six months.

Gardenia is a fictitious person, but the figures are taken straight from Garden State Health Plan documents. The amounts of the payments vary according to age, gender, county of residence and type of Medicaid eligibility.

"It's a built-in conflict of interest," said Holness of legal services. "The fundamental thing is that it gives financial incentives to give less care. And it's not clear to me that there are any significant safeguards against it."

Garden State Health Plan monitors its physician case managers through a quality assurance program. Officials say there has not been a significant volume of complaints.

According to Russo, the plan reviews medical files, analyzes computerized payment records and maintains a toll-free telephone number that patients can use to register complaints.

The New Jersey Medicaid program has a conflict of interest of its own. It is responsible for ensuring that patients get adequate care. Yet it also benefits by reduced care — particularly any savings on hospital expenses.

"I think that is absolutely correct," said Jacobi, state Public Advocate's office. "That creates a real dilemma."

Some HMO industry experts are skeptical of the state's ability to operate a successful health care plan.

"I hope governmental officials can efficiently run a health care system — and if they can, it will be a first," said Steven Wiggins, president of Oxford Health Plan. "I've never met a government regulator I would turn my HMO over to."

Overall, the state-run HMO is an innovative attempt to solve serious flaws in the existing Medicaid system.

The poor often find it difficult to get medical care. Many doctors refuse to see Medicaid patients because the state pays an average of $15 per office visit. Instead, those patients frequently end up receiving expensive care at their last resort, the hospital emergency room.

In turn, those costs contribute to the rising cost of Medicaid and the burden on taxpayers. Including the federal contribution to the program, New Jersey Medicaid costs more than $2 billion a year.

"The Garden State Health Plan is an attempt to move in the right direction," said Jacobi. "I agree there are tremendous risks and pitfalls. If those pitfalls can be modified before it expands very much, I think the consumers would be much better off."

"It may be seen as a fiscal necessity by the state," added Relman. "But it's a sad

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TOP DOLLAR

Bank CEOs, like Midlantic's Robert Van Buren (left), are earning less, but don't pass the hat yet.

BUSINESS/B1

Profit motive faulted in physicians' referrals

"It (self-referral) provides incentives for a physician to do things for — if not to — their patients that may not be absolutely necessary. It clouds the judgment of the physician."

Dr. Arnold S. Relman
EDITOR,
NEW ENGLAND JOURNAL OF MEDICINE

By MARK LAGERKVIST
PRESS STAFF WRITER

THE DOCTORS were warned the deal might run afoul of fee-splitting laws. Even if legal, the arrangement could be viewed as a professional conflict of interest.

Yet that prognosis did not stop more than 30 area physicians from buying partnerships in a Brick Township imaging and therapy enterprise. Nor does it prevent them from sending patients there for medical services.

Projected annual returns exceeding 100 percent — with no extra work or medical duties — attracted physicians to invest in New Jersey Diagnostic Associates Limited Partnership, which leases offices at 455 Jack Martin Blvd. The venture is detailed in confidential documents provided to prospective investors.

The physician-investors were told to expect a return of $141,209 on a $30,000 limited partnership in less than 4½ years. A $15,000 investment would yield an estimated $69,712.

PROFITS vs. Patients

The actual profits depend, in part, on referrals from the investing physicians. The more patients they send for imaging and therapy, the greater their income.

Thousands of physicians own or invest in a variety of health care services where they refer their patients. Nationally, one out of eight doctors engages in that type of "self-referral," according to one federal survey.

Studies indicate that physician-owners prescribe more services than other doctors. Critics say self-referral is an unethical practice that results in excessive health care costs.

"It provides incentives for a physician to do things for — if not to — their patients that may not be absolutely necessary," said Dr. Arnold S. Relman, editor of the New England Journal of Medicine. "It clouds the judgment of the physician."

■ The Senate may ban physicians from sending their patients to a health care service in which they have a certain amount of financial interest. Story, A21.

But physician-investors say the financial incentives do not compromise their ethics or tempt them to order unneeded tests and procedures.

"I don't know of any physician that

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Referrals

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would do such a thing," said Dr. Philip L. Infantolino, who invested $30,000 as a limited partner in New Jersey Diagnostic. "I feel it is an unconscionable thing to do, and I find it offensive to discuss."

However, the Brielle cardiologist admits a doctor's business interests influence where patients are referred. "He (a physician) is more likely to refer to a center he has a share in," Infantolino said.

"I'm still forming my own opinion of what's right and what's wrong in this whole debate," said Om P. Soni, a general partner in the Brick venture. Soni — a Long Island entrepreneur and not a physician — also heads the firm that provides management services to the partnership.

Soni acknowledges that prospective investors were informed the deal could possibly violate the federal anti-kickback statute. The law forbids fee-splitting or other payments to physicians made in exchange for referrals for medical services under Medicare or Medicaid. The maximum penalty for the felony is five years in prison and a $25,000 fine.

However, the law does not specifically address payments to partnerships in which the referring physicians are investors. The doctors are not individually paid for each referral — which the law prohibits — but collectively through the business's profits, which rely on referrals. To date, no physician has been convicted for taking part in such a partnership arrangement.

"You can read the kickback and abuse statute either way," Soni said. "If the interpretation is on the stricter side, you could be in for a lot of trouble."

The limited partners include at least 30 physicians in Monmouth and Ocean counties, Infantolino said. As limited partners, they share in the profits but have no role in management. The enterprise is controlled by two general partners — Soni and Rajiv Saxena, also of Long Island.

Soni said he could not recall the number of limited partners or how many of them were physicians, but the executive promised to check the records after he returns from a current trip. Saxena could not be reached for comment.

According to Soni, the partnership does not know how much of its business is generated by referrals from its physician-partners.

"We don't keep records like this," Soni said. "There is no requirement on the part of the physician to refer."

New Jersey Diagnostic owns high-tech equipment — including magnetic resonance imaging (MRI), CAT scan, linear accelerator, ultrasound and X-ray — which it leases to a radiology practice also located at 455 Jack Martin Blvd. The partnership's income is based on how frequently the gear is used by the radiologists.

Example: For an MRI test, the patient is charged about $800. Of that, the partnership receives $600, and the radiologists keep $200 for their professional services.

The partnership predicted gross revenues of more than $26 million — and a net income exceeding $11 million — from August 1987 through December 1991. To reach that goal, more than 187,000 various services would be provided to patients during that period, according to projections.

The enterprise fell far short of its financial projections.

"Unfortunately, it didn't come close — or I would have retired," Soni said. "If you look at it from my standpoint, I'm not very happy with it."

Soni said the operation opened 16 months behind schedule and spent $1.5 million more than budgeted for equipment. However, the venture turned its first profit in 1990 and now returns 15 percent a year on its investment, according to Soni.

Investors say they performed a public service by bringing new medical technology to northern Ocean County. Previously, the nearest MRI centers were eight miles south in Toms River or 15 miles north in Ocean Township.

"It was done as a business venture," Infantolino said. "But it was also done because there was a need for the services."

A national phenomenon

Across the country, self-referral has become a common medical practice.

> **"The (self-referrals) I've seen are so outlandish and so obscene in the sense that they are . . . kickback schemes."**
>
> **Rep. Fortney "Pete" Stark**
> D-CALIF.

Roughly 12 percent of Medicare physicians send patient tests to laboratories in which they have an interest, according to a study by the U.S. Department of Health and Human Services. American Medical Association surveys report that 6 percent of doctors say they refer patients to facilities where they have a financial stake.

Two years ago, a congressional subcommittee reviewed evidence gathered on hundreds of self-referral arrangements.

"The ones I've seen are so outlandish and so obscene in the sense that they are nothing more than kickback schemes . . . dreamed up to allow physicians to charge referral fees under the guise of calling them joint ventures or partnerships," said Rep. Fortney "Pete" Stark, D-Calif., who chaired the hearings.

"They (entrepreneurs) don't generally offer these arrangements to doctors who aren't going to refer patients," said Relman, the medical journal editor.

"Most of the doctors who invest are the doctors who are going to refer patients," continued Relman. "Doctors know the more patients they refer, the more money they're going to make. It's as simple as that."

Physicians invest in laboratories, home health care agencies, durable medical equipment sales and leasing firms — plus centers that offer physical therapy, cardiac rehabilitation, renal dialysis, ambulatory surgery, sports medicine, radiation treatment and other specialty services.

Those same doctors can then generate business for their ventures through their prescriptions and recommendations to patients.

The medical profession is sharply divided on whether the deals are ethical.

"Physician ownership interest in a commercial venture with the potential for abuse is not in itself unethical," states the AMA's written policy.

"The practice of self-referral of patients for a diagnostic or therapeutic medical procedure may not be in the best interest of the patient," countered the American College of Radiology. "Accordingly, referring physicians should not have a direct or indirect financial interest in diagnostic or therapeutic facilities to which they refer patients . . ."

The issue is also being debated in New Jersey.

"It drives up the cost of health care and does nothing to increase the quality of health care," said Sen. Richard J. Codey, D-Essex, who has sponsored legislation that would eventually eliminate physician self-referrals.

The New Jersey Medical Society opposes restrictions — and the idea that doctors allow their personal economic interests to affect their professional judgments.

"The physician says, 'I'd really like to take my wife to the Bahamas, so let me send this poor schlemiel to my cardiac rehab service.' My reaction is: I doubt it. I don't think it's the case," said Clark W. Martin, medical society lobbyist.

"Does it matter to a patient whether the physician has a financial investment? It doesn't matter at all; it's not an issue," concluded Martin.

Yet there is strong evidence that physician ownership plays a significant role in how a doctor practices medicine.

Patients of self-referring Medicare physicians received 45 percent more clinical laboratory services than the average Medicare patient, according to a 1989 Health and Human Services study.

Similarly, a 1984 investigation by Blue Cross-Blue Shield of Michigan concluded that clinical laboratory costs per patient were 43 percent higher in facilities owned by referring physicians compared with other laboratories.

"The evidence is very clear," said Relman. "When physicians have economic interests in laboratories, they refer their patients for more tests."

Secret deals, few disclosures

No one really knows how many physician-owners refer patients to their own health care businesses. The deals are often secretive and complex. Few disclosures are required by state or federal laws.

In New Jersey, doctors are seldom required to license or register their clinics, laboratories and other health facilities with the state Department of Health. As part of the physician's "private practice," the enterprise is exempt from many of the regulations and requirements governing other owners of health care services.

Physician-owners are required by state law to disclose those interests to their individual patients, but governmental agencies currently do not collect that information. As a result, authorities do not know the extent of self-referrals — or whether doctors are complying with the disclosure statute.

"There is no way of knowing," Codey said.

Five years ago, a statewide survey identified 250 physical therapy centers owned by referring physicians — primarily orthopedic surgeons, according to Bonnie Teschendorf, director of the American Physical Therapy Association's New Jersey chapter.

"We now think that's doubled or even tripled," Ms. Teschendorf said. "It's become increasingly prevalent."

Under current law, physical therapy requires a doctor's prescription. Ms.

Teschendorf said many physicians only refer patients to the centers they own or therapists they employ. Independent physical therapists claim it is unfair competition.

"I think physicians should be earning their income by practicing their own profession — not by owning my profession," Ms. Teschendorf said.

Self-referral is also under attack from a former ally. Health Images Inc. of Atlanta is trying to buy back the limited partnerships it once sold to physicians.

Health Images controls a national chain of 28 centers that feature magnetic resonance imaging — a state-of-art diagnostic test known as MRI. Referring physicians are still partners in six of those operations.

"Unfortunately, too many imaging centers are little more than abusive self-referral schemes operating with dubious business and professional ethics," wrote Health Images president Robert D. Carl III earlier this month in a letter to the remaining physician-partners.

"Physicians are frequently offered investment units for little or no cash, and these 'investments' are but thinly disguised incentives for patient referrals," continued Carl. "We have decided to support legislation and regulations which most likely will seek to limit or eliminate physician ownership interests in imaging centers."

Doctors oppose reforms

Physician-owners have strongly opposed proposed governmental restrictions. They contend their investments often focus on a community's need rather than a doctor's greed.

"In the case of a physician, it's just as possible that he or she wanted to see a service offered locally instead of some great distance away," said lobbyist Clark Martin, New Jersey Medical Society.

"It's just as possible that (a physician) wanted to see a service offered locally instead of some distance away."

Clark Martin
MEDICAL SOCIETY LOBBYIST

"It's just as possible that they would be willing to break even on that facility as long as they could offer that service to their patients," Martin said. "It may be more likely that physicians would invest in a service that would give them a marginal profit or break even than other types of investors."

"There are more MRI units, laboratories and facilities being built now than we really need," said Relman of the New England Journal of Medicine. "And in order to make them economically successful, obviously the doctors who invest in them have to refer a lot of patients.

"It jacks up the cost; it exposes patients to the risk of unnecessary testing," Relman said. "In the vast majority of cases, doctor ownership offers no advantages to anyone — except the doctors and the owners."

Physician-owners say their investments put them in a hands-on position to assure their patients of quality services. Relman says that argument does not apply to limited partnership arrangements.

"Limited partners have no responsibility for either professional or business administration," Relman said. "By law, they cannot have any responsibility — and they don't."

The most complex argument centers on the conflict of interest inherent in traditional fee-for-service medicine. When any doctor recommends services that he or she can provide, that physician is in a position to profit from the advice.

So self-referring physicians compare their situation to that of a doctor who asks a patient to schedule a follow-up office visit.

"We think it is no different than saying doctors should only see their patients once," Martin said.

"To allow self-referral is to make that conflict of interest worse," answered Relman. "You're strictly making money as an entrepreneur and not a professional — that's the difference. You're using the patient as a commodity; you're trading in on the trust the patient has in you."

"If it happened in any other field or profession, it would be stopped," observed Ms. Teschendorf, physical therapy association. "This is part of the pedestal we've created for physicians ... We assume they have our best interests at heart.

"In fact, not all of them always have our best interests at heart," she concluded. "We have not noticed that they have become entrepreneurs."

Bill would limit self-referrals

By MARK LAGERKVIST
PRESS STAFF WRITER

THE DAYS may be numbered for New Jersey doctors who profit from their own patient referrals. However, those days could turn into decades.

The state Senate is considering a bill that would ban physicians from sending their patients to a health care service in which they have financial interest exceeding 5 percent or $5,000 in value.

"When they (doctors) refer for a test, you should feel certain that they're doing it for your physical health and not their financial health," said Sen. Richard J. Codey, D-Essex, sponsor of S-3251.

However, the measure contains a "grandfather" clause that would allow existing self-referral situations to continue through the end of the physician's medical career.

"By grandfathering them, we will not cure this problem for 50 years," said Bonnie Teschendorf, director of the American Physical Therapy Association's state chapter. "If it's wrong, stop it. If it's not wrong, then let everybody do it."

Codey says an immediate and absolute ban would not survive opposition from New Jersey's powerful medical lobby. Even with a grandfather clause, he estimates the bill's prospects for passage is "about 50-50."

If successful, it will be the second self-referral compromise by Codey to become law. The first is a 1988 statute that requires doctors to inform their patients of financial interests of more than $5,000 or 5 percent in clinics, laboratories and other medical services where the patients are referred.

"What we were trying to do is create a compromise between the ban and doing nothing at all," Codey said.

"When they (doctors) refer for a test, you should feel certain that they're doing it for your physical health, not their financial health."

Sen. Richard J. Codey
BILL'S SPONSOR

Under that law, doctors are supposed to give patients a written disclosure prior to referral. They must also post a copy of the disclosure in the waiting room or other public areas in their offices.

State officials say no doctor has ever been charged with violating the statute — nor have authorities checked on whether physicians are complying with the law. The state Board of Medical Examiners has yet to adopt rules to implement the disclosure law.

"It's very hard to enforce such a statute, and there's much reason to believe that such rules are ignored," said Dr. Arnold S. Relman, editor of the New England Journal of Medicine. "Even if patients are informed, they are not likely to do anything about it because it involves directly challenging the doctor's integrity or judgment."

Elsewhere, reforms are currently being debated in the legislatures of other states, including New York and California. So far, Michigan is the only state that has an outright prohibition of self-referral practices.

New federal laws may soon be on the horizon. In June, self-referral will be the focus of hearings by a congressional subcommittee chaired by Rep. Fortney "Pete" Stark, D-Calif.

Two years ago, the Stark subcommittee sparked a statute that bans physicians from referring their Medicare and Medicaid patients to clinical laboratories where they are owners or investors. The resulting law will take effect in 1992.

This time, the hearings will focus on physician ownership of imaging centers. As part of the evidence, the congressman plans to use the results of a yet unreleased Florida study.

"It's going to be a mind-boggler when it is released," Stark said. "I'm led to believe it's going to show tremendous involvement of physicians in diagnostic and imaging centers."

Stark said the legislation is needed to close apparent loopholes in the federal anti-kickback law. That statute prohibits payments to physicians in exchange for referrals for services charged to Medicare or Medicaid.

Neither the law nor existing regulations address the profits or payments received by partnerships in which referring physicians are investors.

"There's a law on the books that says kickbacks and referral fees are illegal," Stark said. "But there are an awful lot of creative business advisers and lawyers who have dreamed up a lot of ways to get around that."

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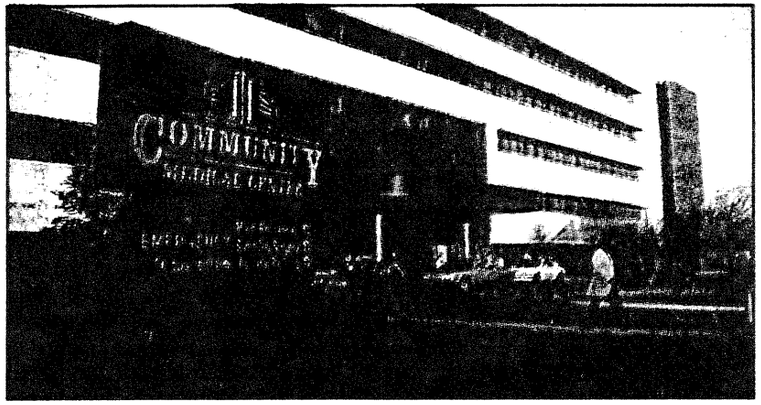
TV Moms

Lucy tops our TV writer's list of tube moms and mom wanna-bes.

ARTS & LEISURE/E1

Health-care ventures profit hospitals, doctors



Asbury Park Press

Community Medical Center, Toms River, encourages self-referrals.

By MARK LAGERKVIST
PRESS STAFF WRITER

ONE OF four doctors at Community Medical Center refers patients to health care businesses where the physician is an investor.

The Toms River hospital not only encourages the practice, its parent company shares in the profits. That firm's subsidiaries are partners with 83 referring doctors in five different ventures — an imaging center, dialysis facility, urology office, X-ray clinic and medical supply firm.

"Self-referral" poses a professional conflict of interest for physicians. In some instances, doctors invest even after being warned the deals could run afoul of kickback or fee-splitting laws.

Hospital officials say the ventures make medical services more readily available to patients. Critics say the financial incentives tempt doctors to profit by prescribing unnecessary tests and procedures to patients.

"It's reprehensible," said Dr. Arnold S. Relman, editor of the New England Journal of Medicine. "I think the hospitals are wrong in setting up those arrangements — and I think the doctors are wrong to participate."

"To the extent that it raises the (ethical) question, it concerns us," said

PROFITS vs. Patients

William N. Phillips, Community Medical Center vice president of corporate finance. "To the extent that there is the appearance there could possibly be a conflict of interest, we don't like that."

Yet, such concerns have not stopped the owners of Community Medical Center and other hospitals from continuing for-profit ventures that rely on self-referrals.

In Monmouth and Ocean counties, six health service businesses are partnerships among hospital owners and a total of 102 referring physicians, an Asbury Park Press survey disclosed.

One enterprise is a for-profit cardiac rehabilitation unit located in Riverview Medical Center, Red Bank. The business is owned by the hospital, a management firm from Texas and 19 physicians who are cardiologists or internists.

Riverview officials refused to re-

Please see **Ventures**, page **A16**

Ventures

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lease further information, including the identities of the doctors.

"I can't get anybody who wants to talk," said hospital spokesman Peter J. Lyden.

The other five joint ventures involve for-profit firms owned by Community Memorial Hospital Health Services Corp., the parent company of Community Medical Center:

■ Whiting X-ray — a radiology center at 65-G Lacey Road, Manchester Township — is half-owned by 35 referring physicians. The other half is owned by CSMC Urgicenter Management Inc., a corporate affiliate of the hospital.

■ Uro-Care — a urology business at 67 Route 37, Toms River — is half-owned by six urologists and half-owned by another hospital affiliate, CSMC Urological Corp.

■ Center State Renal Dialysis Center — located at Lakehurst Road and Route 37, Dover Township — is a half-owned by six nephrologists and half-owned by a third hospital affiliate, CSMC Renal Corp.

■ Toms River Infusion Service — an enterprise that rents equipment and sells supplies for home use by kidney patients — is a business one-third owned by nephrologists, one-third by CSMC Renal and one-third by a Pennsylvania sales firm.

■ Toms River Imaging Associates Limited Partnership is a venture comprising 35 physicians, a California firm and CSMC Imaging Corp., a fourth hospital affiliate. The partnership leases high-tech equipment — including magnetic resonance imaging, diology practice at 21 Stockton Drive, Dover Township.

The four hospital affiliates are wholly owned subsidiaries of the for-profit Center State Health Services Corp. — which, in turn, is a wholly owned subsidiary of Community Memorial Hospital Health Services, the hospital's non-profit parent corporation.

"We only do projects that are consistent with the mission of the medical center," said Phillips, a corporate officer of the for-profit hospital affiliates. "They bring needed services to the community."

They can also bring profits to the physicians who become partners.

Projected annual returns of 40 percent attracted 35 Community Medical Center physicians to invest in Toms River Imaging Associates. The doctors were told to expect a $20,552 return over five years on a $10,000 maximum investment, according to a confidential document provided to prospective investors.

The limited partnerships were only sold to active physicians on the hospital medical staff who practice in Monmouth, Ocean or Burlington counties. According to the partnership agreement, doctors must sell their shares if they retire or move from the area.

The agreement does not require the physicians to refer patients to the imaging center. However, the partnership's profits depend on how many tests are performed there. And the more tests — MRIs, CAT scans, ultrasounds, X-rays and mammograms — the greater the income.

The physician-investors were informed the deal could possibly violate kickback or fee-splitting laws.

"The body of law . . . as to whether the financial arrangement . . . constitutes illegal physician fee-splitting is uncertain," stated a memo to partnership's business comes from referrals by physician-investors. He said the limited partners include a dentist and pathologist "who never refer anyone. Yet, there are guys who have big orthopedic practices and send a lot of patients."

The executive declined to name the physician-investors. "I doubt whether they'd want to be called," Phillips said.

Collectively, the 35 doctors own 25 percent of the partnership. They invested $250,000 — 100 shares at $2,500 each. On average, each physician-investor holds three shares.

The hospital's for-profit affiliate, CSMC Imaging Corp., owns 37.5 percent of the enterprise as the corporate general partner. The remaining 37.5 percent is controlled by the managing general partner, American Health Services Inc. of Newport Beach, Calif.

Phillips said the enterprise is not just profitable; it brought the first MRI facility to Ocean County. Before the imaging business opened in December 1987, the closest MRI was located in Monmouth County's Ocean Township, about 20 miles away.

"Four years ago, there was no service — and it wouldn't have been available to anyone in Ocean County if it weren't for that joint venture," Phillips said. Currently, there are three MRI facilities in the county.

Relman, editor of the New England Journal of Medicine, believes hospital owners should not offer those deals to referring physicians.

"They (hospitals) can open up MRIs, but not bind the doctors with golden handcuffs — so the doctors are going to be using that facility because they're going to make money," Relman said. "I think the businesses they go in should not seduce the physician — (and) should not erode the professionalism of the doctor."

Ten miles west of Toms River, are partners who profit from self-referrals to Whiting X-Ray. The radiology office is next door to a "walk-in" clinic operated by the hospital affiliate in western Ocean County.

"More than 50 percent of the (X-ray) referrals come from investors," Phillips said. "They (doctors) needed a place to send patients who needed X-rays."

Phillips said the investing doctors consist of "about all of the physicians on our medical staff who practice in that area of the county." He declined to identify individual physician-investors.

Two other for-profit enterprises in Dover Township — Uro-Care and Center State Renal Dialysis Center — receive almost all of their business from referrals by investing physicians, according to Phillips.

Uro-Care is a urology clinic that uses ultrasound to detect tumors in the prostate. Phillips said the venture is a partnership between a hospital affiliate and seven staff urologists: Dr. Franklin Thelmo, Dr. Martin Schor, Dr. Charles Binder, Dr. Richard Dias, Dr. Paul Low, Dr. Parvez Mahmood and Dr. William Zurich.

Center State Renal Dialysis offers out-patient dialysis to kidney patients. Phillips said the business is a joint venture between a hospital affiliate and six staff nephrologists: Dr. Michael DiBella, Dr. Luzminda Anama, Dr. Robert Arnold, Dr. John DePalma, Dr. Stephen Ellis and Dr. Jin S. Park.

"It's just an expansion of the medical center service in a nicer location," Phillips said. "And it happens to have the physicians as investors, which is good.

"I think they bring an element of concern about the clinical expertise that's offered," continued Phillips. "I don't think in this particular situation that anybody would ever be referred

"To the extent that it raises the (ethical) question, it concerns us. To the extent that there is the appearance there could possibly be a conflict of interest, we don't like that."

William N. Phillips
VICE PRESIDENT OF CORPORATE FINANCE, COMMUNITY MEDICAL CENTER

erring kidney patients to Toms River Infusion Service, a Cherry Hill Township enterprise that leases equipment and sells supplies for home use.

One-third of Toms River Infusion Service is owned by the nephrologists; one-third is owned by the hospital affiliate, CSMC Renal; and the remaining one-third is owned by the Pentech Infusion Inc., a supply firm located in Media, Pa.

"Doctors should not make money from referring patients to facilities and services they don't personally provide or supervise — period," Relman said. "That's a basic concept of professional ethics that seems to have been forgotten lately."

Instead, self-referral has become a common practice for thousands of physicians. American Medical Association surveys found that 6 percent of doctors say they refer patients to medical businesses where they have a financial stake.

Other studies indicate that estimate may be low. About 12 percent of Medicare physicians send patient tests to laboratories where they have a financial interest, according to a 1989 report by the U.S. Department of Health and Human Services.

Those doctors ordered 45 percent

"The evidence is very clear," Relman said. "When physicians have economic interests in laboratories, they refer their patients for more tests."

As a result, state and federal lawmakers are proposing new reforms.

Under current New Jersey law, self-referral is legal if the physician discloses that financial interest to patients. The doctor is required to give written notice to each patient and post a copy of the disclosure in the waiting room.

State officials say no doctor has ever been charged with violating the statute — nor have authorities checked on whether physicians are complying with the 1988 law.

The state Legislature is currently considering a bill that would ban physicians from referring patients to health care services where they are owners or investors. However, the measure has a "grandfather" clause that would allow existing self-referral enterprises to continue.

The federal anti-kickback statute forbids payments to doctors in exchange for patient referrals for services covered by Medicare or Medicaid. However, neither the law nor current regulations specifically address whether or not doctors can legally earn profits as investors in the enterprises where they send patients.

To close one of the apparent loopholes, Congress passed a statute that will prohibit self-referrals of Medicare and Medicaid patients to clinical laboratories. That law will take effect in 1992.

Next month, a congressional hearing will focus on other physician self-referrals, particularly imaging centers, said Rep. Fortney "Pete" Stark, D-Calif.

"It's something we ought to put an end to," Stark said. "Everybody suffers — the doctor's reputation suffers, the federal government pays more

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BIRDS OF OLD

Vintage World War II planes will highlight the two-day Spirit of America air show next week.

GENERAL NEWS/A6

Bad loans had hospital in trouble

■ Despite losses exceeding $7 million in 1988 and 1989, Kimball Medical Center managed to recover without a state bailout.

By MARK LAGERKVIST
PRESS STAFF WRITER

KIMBALL MEDICAL Center was teetering on the brink of bankruptcy.

The Lakewood hospital had lost $6.8 million in 1988 and another $580,000 in 1989. Last year, its officials asked state authorities for help.

"I will tell you that with that $7 million loss, we are trying to pay off clambering vendors who are like barbarians at the gate and almost over the wall," Kimball President Joseph Sherber told the Hospital Rate Setting Commission last December.

The losses were partially caused by loans to corporate affiliates owned by Kimball's parent company. Several million dollars were borrowed from the hospital — beyond the rule or regulation of state health officials.

Many of the state's 84 other acute-care hospitals also risk their assets on outside business ventures. The non-profit institutions have advanced — or pledged collateral for — millions of dollars in loans to their corporate affiliates.

In Kimball's case, the hospital was unable to retrieve its money when the ventures turned sour. According to its financial records:

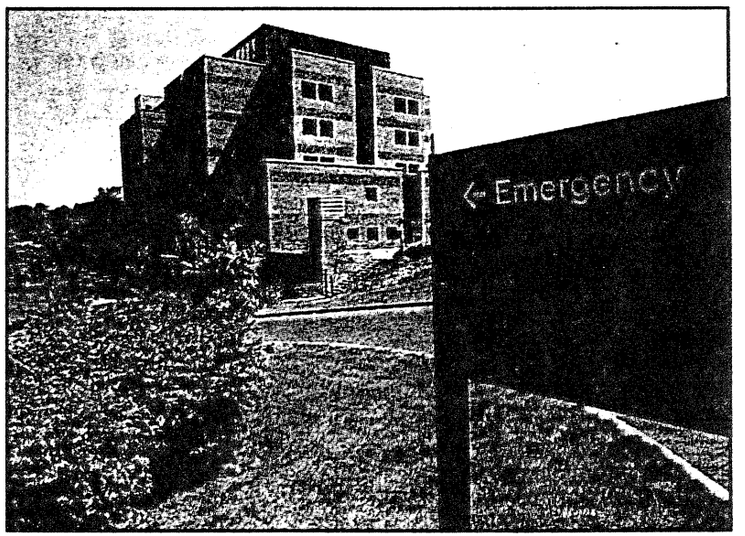
■ The hospital lost nearly $2.2 million in bad loans to Kimball-Manchester Ambulatory Care Center Inc. — a non-profit affiliate that opened a health facility in Manchester Township.

■ In exchange for another $1.3 million in uncollectable loans to KMACC, the hospital acquired the assets of the center. In the process, Kimball also assumed responsibility for a $1.8 million mortgage on the building.

Please see **Hospital,** page **A8**

PROFITS vs. Patients

■ Kimball Medical Center President Joseph Sherber turns red ink to black, A12.



STEVE SCHOLFIELD/Asbury Park Press

Kimball Medical Center, Lakewood, posted a $2.3 million gain for 1990.

Hospital

From page A1

■ Kimball loaned $1.6 million to a for-profit venture that built a medical office building in Lakewood. Instead of repayment in cash, the hospital now receives office space in the structure.

The 354-bed hospital was plagued with other dilemmas — particularly its inability to control costs in treating patients. "There were so many problems," Sherber said.

Kimball managed to recover from its fiscal ills without requiring a bailout by New Jersey authorities. Led by Sherber, a new hospital administration prompted a series of operational efficiencies, a refinancing of long-term debt and some timely cooperation from state regulators.

"You have to quote Shakespeare on this: 'All's well that ends well,' " Sherber said.

However, high-risk loans to corporate affiliates could jeopardize the financial health of other New Jersey hospitals.

"Perhaps there should be a change in legislation which would limit the degree to which hospitals can get involved in risky sideline ventures," said Geoffrey D. Liss, executive secretary of the rate-setting commission. "There should be some limits placed on the extent to which they can pledge assets or make loans that could put the hospital in jeopardy."

Currently, it is a one-sided risk. If a hospital cannot save itself, it usually can count on rescue by state government. Liss said he can recall five hospitals that received bailouts from the commission.

Some losses are absorbed by ratepayers — the patients and insurance companies that pay for hospital services.

"It's really been the ratepayers who have been at risk if it turns out to be a bad decision or judgment," said Lila Steele, assistant deputy to the state public advocate. "If you're going to let the hospitals have the ability to spend or invest the money where they wish, there has to be some method of holding them accountable."

"The hospital ultimately gets bailed out," said Edward Peloquin, senior consultant to the Central Jersey Health Planning Council. "Hospitals are not allowed to fail economically because of their public purpose."

"There's a certain amount of comfort in being regulated," said Ron Czajkowski, spokesman for the New Jersey Hospital Association. "I don't think you'd find a hospital executive in the state who wouldn't admit that."

On the other hand, hospitals defend their deals with corporate affiliates as the last bastion of free enterprise in a tightly-regulated industry.

"We're so regulated right now by the state, we're just short of turning over the keys to the Department of Health," Czajkowski said. "If you tossed over the for-profit and affiliated corporations to state regulation, you just might as well give them the keys and let them run the hospitals."

Hospitals contend their business ventures through corporate affiliates can provide additional sources of revenue. "Many hospitals are depending on that return to cushion their bottom line," Czajkowski said.

"These financial ventures of hospitals into non-hospital enterprises are by no means always moneymakers providing funds to hospitals," countered Ms. Steele. "In many instances, loans to affiliated companies have not been repaid to hospitals — and some have been written off as bad debts."

At Kimball, the bad debts and unpaid loans contributed to the hospital's near-bankruptcy.

"One of the biggest problems we had in 1987 and 1988 was the Kimball Ambulatory Care Center," Kimball Vice President James Bowden told the rate-setting commission in April 1990. "There was a large outflow of support — the hospital supporting KMACC — and we just stopped the bleeding there."

In 1988, a write-off of $1,362,914 in bad loans to KMACC contributed to the hospital's loss of $6,806,685, according to Kimball's financial reports.

The hospital would have posted a surplus for 1989 except for a write-off of $795,707 in bad loans to KMACC. As a result, Kimball reported a $580,876 loss instead of a $214,831 gain for the year.

Overall, the hospital loaned $3,503,488 to KMACC, but none of the cash was repaid. Instead, Kimball eventually assumed the assets of the facility, valued at $1,345,047. But as part of the deal, the hospital also assumed KMACC's mortgage — a long-term debt of $1,832,786.

Kimball President Sherber said the losses stopped after the hospital took control of KMACC in August 1989. As part of an agreement to save KMACC, the state Department of Health gave the center approval to charge rates identical to the hospital's rates for services.

"It (KMACC) was taking a bath," Sherber said. "The mistake was accepting a rate which was significantly lower than a hospital rate."

With higher rates, KMACC's fortunes improved. Sherber said the facility has now reached the break-even point. More importantly, the hospital's revenues are bolstered by the patients KMACC refers to Kimball.

Other deals have crimped Kimball's cash flow. While the hospital was asking state officials for financial relief last December, its books showed $2,306,775 in loans due from corporate affiliates.

Of that total, $1,630,129 was owed by Kimball Health Care Affiliates Inc., a for-profit firm. The hospital affiliate — in a joint venture with physicians — built the Kimball Professional Center, an office building across the street from the Lakewood hospital.

Unfortunately, occupants were scarce when the building opened in 1987. According to Sherber, the planners "made some serious mistakes about the need for office space in the area and the rental value." The venture also was hurt by the slump in the real estate market.

As repayment, Kimball is now leasing space in the building, according to hospital documents. Sherber said Kimball expects to be reimbursed either in cash or office space for the entire amount of the loan.

At the end of 1990, $756,825 was due the hospital from three other nonprofit corporate affiliates. Kimball Health Care Corp., the hospital's parent company, owed $602,499. Kare Med Inc., an agency that provides in-home health care and private duty nurses, owed $115,208. Kimball Medical Center Foundation, the hospital's fund-raising arm, owed $39,118.

Despite Kimball's past difficulties, Sherber says he favors the involvement of hospitals in non-hospital health care ventures.

"You have to ask yourself the question, 'What are these businesses being run for?' " Sherber said. "If they, in fact, supplement and complement the hospital operation, I don't see a damn thing wrong with it."

"What's happening here is that dollars are still being spent on patient care," said Czajkowski, New Jersey Hospital Association spokesman. "It's accountable, it's legal and dollars are being spent on patient care."

"It can't continue to be a one-way street where they (hospitals) make the decisions and the ratepayers pay," said Ms. Steele, assistant deputy, state public advocate. "The current system where they decided where to spend the money, and if they get in trouble the ratepayers bail them out — that's not acceptable. It can't go on that way."

"Whether hospitals are making bad loans, good loans or whatever, there's no way of knowing to what degree that's occurring," said Liss, of the Hospital Rate Setting Commission. "We don't have any legislative authority to look at it."

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Stuck in the '70s

Disco, Watergate, platform shoes, and more are back in a '70s revival.

PANORAMA/D1

N.J. hospitals' code red: $16 million in bad loans

By MARK LAGERKVIST
PRESS STAFF WRITER

TWO-THIRDS of New Jersey hospitals risked at least $200 million in funds and assets last year on loans to outside business ventures of their corporate affiliates — separate companies controlled by hospital owners.

The money for the loans to affiliates typically comes from surpluses earned by the non-profit hospitals for providing services to patients. Some loans to affiliates are interest-free or unsecured by collateral, or both.

In addition, hospitals commonly use their assets to guarantee repayment of debts their affiliates borrow through banks, revenue bonds and other sources.

If its affiliates default on loans, the hospital itself may be jeopardized. Rate-payers — patients and insurance companies — may ultimately pay higher rates from a state bailout. Yet New Jersey authorities rarely review the deals between hospitals and affiliates.

PROFITS VS. patients

■ Eight hospitals in Monmouth, Ocean counties have $31 million in loans out. Story, A12

The Asbury Park Press examined the 1990 financial statements submitted by 83 acute care hospitals to the state Department of Health. The study found:

■ Affiliates owed 51 hospitals nearly $84 million in loans, advances and other debts at year's end. Only 14 hospitals reported that affiliates were charged interest. Three hospitals said loans were secured by collateral.

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Loans

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■ Some deals turned sour. Nine hospitals were forced to write off losses of roughly $16 million from bad loans and investments with affiliates during 1988 through 1990.

■ An additional $103 million in debts of affiliates were guaranteed by the assets of 15 hospitals at the close of 1990. While hospitals declared no losses from guarantees last year, they reported no financial gains from the deals.

■ Overall, at least 55 of New Jersey's 85 acute-care hospitals had either outstanding loans or loan guarantees to affiliates at the close of last year. Two hospitals have yet to file reports for 1990.

The loans went to a wide variety of for-profit and non-profit activities by affiliates — including fitness clubs, office buildings, medical clinics, nursing homes, parking garages, child care centers, charitable foundations and expenses of hospital parent companies.

However, most hospitals did not disclose the specific purposes of the loans in their financial statements.

State officials said they were not aware of the extent of loans or guarantees hospitals made for affiliates.

"The magnitude of the loans is really surprising to me," said Lila Steele, assistant deputy to the New Jersey Public Advocate. "We suspected this was a problem around the state, but I'm surprised at the magnitude of what you found."

"Whether hospitals are out there making bad loans, good loans or whatever, there's no way of knowing to what degree that's occurring," said Geoffrey D. Liss, executive secretary of the state Hospital Rate Setting Commission. "We've never been apprised of any concern that there's an extensive amount of money (involved)."

According to the New Jersey Hospital Association, the amounts of loans and bad debts are not significant.

"Those are small numbers — in terms of a $7 billion industry generating some legitimate side activities that may eventually bring money back to the acute care facility," said Ron Czajkowski, spokesman for the hospital association.

Czajkowski said the loans make it possible for hospital owners to provide new health-care services outside the walls of the hospital — and beyond the control of state regulators. He said the ventures can provide hospitals with additional sources of revenue.

"Many hospitals are depending on that return to cushion their bottom line," said Czajkowski.

Instead, some deals have threatened the financial health of hospitals.

Bad loans to affiliates totaling $5.7 million caused most of a $7.9 million loss last year at Muhlenberg Regional Medical Center in Plainfield.

"During 1990, the medical center determined that the recoverability of certain advances made to two affiliates was not assured," stated the hospital's financial report.

Muhlenberg's affiliates still owed the Union County hospital an additional $4.9 million — not including a $700,000 bank loan guarantee — at the end of last year.

Two Ocean County hospitals — Community Medical Center in Toms River and Kimball Medical Center in Lakewood — also were recently hurt by bad loans to affiliates.

Last December, Community agreed to forgive $700,000 of a $1.04 million loan to CSMC-Urgicenter Inc., a for-profit affiliate that runs a medical clinic in Manchester Township.

Community also accepted 20 percent ownership of the clinic in exchange for $200,000 of the debt. The remaining $140,000 is to be repaid by CSMC without interest over a five-year period.

Kimball's uncollectable loans to its Kimball-Manchester Ambulatory Care Center totaled more than $2.1 million for 1988 and 1989. The losses contributed to $7.4 million in deficits by the hospital for those two years.

The deficits prompted Kimball president Joseph Sherber to declare the hospital was "on the brink of bankruptcy."

"I will tell you that with that $7 million loss, we are trying to pay off clambering vendors who are like barbarians at the gate and almost over the wall," Sherber told state officials last December.

That crisis has passed, but four other Kimball affiliates still owe the hospital nearly $2.4 million. Despite Kimball's past losses, Sherber defends the practice of using hospital funds to support health-care ventures outside the hospital.

"You have to ask yourself the question, 'What are these businesses being run for?' " said Sherber. "If they, in fact, supplement and complement the hospital operation, I don't see a damn thing wrong with it."

The other hospitals that reported affiliate-related losses in 1989 and 1990 are: Somerset Medical Center, Somerville, $2.8 million; Robert Wood Johnson University Hospital, New Brunswick, $1.8 million; Irvington General Hospital, $1.1 million; St. Francis Medical Center, Trenton, $1 million; Hospital Center at Orange, $300,000; and Helene Fuld Medical Center, Trenton, $300,000.

"Even if rate-payers are not asked to make that up, there still is an effect because the money is no longer available for improvements and things that need to be done within the hospital," said Ms. Steele of the public advocate's office.

The money that goes to affiliates could also be used by hospitals to reduce fees for patient care, according to Ms. Steele.

Community Medical Center reported more interest-free loans to related corporations than any other hospital in New Jersey.

The Toms River hospital disclosed its affiliates owed it more than $2.9 million in non-interest bearing advances as of Dec. 31, 1990. The balance does not include the $700,000 in loans the hospital forgave its CSMC-Urgicenter affiliate last year.

In its annual financial report to the state, Community did not indicate the purpose of the outstanding loans, which of the hospital's 10 affiliates received the funds, or whether the debts were secured by collateral.

"Ask any other business person if they'd give a loan without interest," said Ms. Steele. "You and I know better than to loan money out with no security and no interest — unless it's your mother."

By far, the leader in all loans to corporate affiliates is John F. Kennedy Medical Center in Edison Township.

The hospital had nearly $16 million in debts due from its parent company, JFK Health Systems Inc., at the end of last year. The medical center has guaranteed an additional $18.5 million in loans, mortgages and revenue bonds on behalf of several affiliates.

The Middlesex County hospital did not post any losses from those ventures. But it did not report whether or not any interest, earnings or other revenue were gained from them.

Most hospitals were similarly vague in their disclosures of loans to corporate affiliates.

Nearly 95 percent — 48 of the 51 hospitals owed money by affiliates — did not disclose whether or not the loans were secured by collateral. Only two hospitals stated the loans were secured. One hospital listed two debts that were backed by collateral and one that was not.

A majority — 32 hospitals — did not report whether the affiliates were charged interest. Twelve hospitals charged interest; five hospitals charged no interest. Two hospitals assessed interest on some affiliate loans, but not others.

Complete information on loans to hospital affiliates has not been systematically gathered nor analyzed by either the state Department of Health nor the Hospital Rate Setting Commission — the two agencies that regulate New Jersey's non-profit hospitals.

"To my knowledge, they have not been collecting it in an organized way," said Ms. Steele.

However, hospitals may soon be required to provide more details on loans to corporate affiliates. Ms. Steele said the rate commission staff has promised to request that information as part of the routine disclosures required when hospital rates are set each year.

SUNDAY

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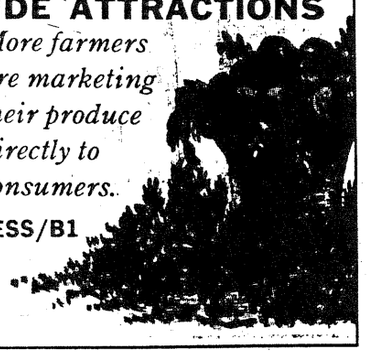

JULY 21, 1991 SINCE 1879 PRICE $1.25

Hospital facing money squeeze

■ Community Medical Center seeks higher fees for services so it can refinance long-term debt and save $8 million in interest payments.

By MARK LAGERKVIST
PRESS STAFF WRITER

COMMUNITY MEDICAL Center is in danger of default next year on $38 million in revenue bonds — a predicament partially caused by the hospital's loans to its corporate affiliates for non-hospital ventures.

The Toms River hospital is not insolvent nor delinquent in payments to bondholders. But it is caught in a complex financial squeeze that could be costly to patients and their insurance companies.

A default would cost ratepayers $8 million in interest expense, according to the hospital's financial projections.

Repayment of $2.4 million in interest-free loans owed by the affiliates is not expected in the near future. As a result, Community estimates it will fall just short of a key asset requirement that secures the revenue bonds.

The shortfall would cause default and prevent the hospital from refinancing $38 million of its long-term debt at a lower interest rate.

To avoid default, Community is asking the state Hospital Rate Setting Commission to approve an immediate increase in its fees for services. The measure would increase in-patient charges by 11 percent, hospital officials said.

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Hospital

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"It looks like they (Community) gave to related organizations, and now they're saying they don't have the cash," state health official Ronald Hibbs told the commission last month.

"There's no regulation saying we can't do these loans (to affiliates) as we've done them," replied John A. Forsman, the hospital's chief financial officer. "Maybe there should be some stipulation about that sometime in the future ... but the reality is we've done nothing wrong."

The rate commission deadlocked last month on Community's request to increase its cash flow through higher fees. The issue is likely to be reconsidered in August, according to the commission staff.

"If we don't get the cash flow relief, we would be at substantial risk that we could be in default," Forsman said.

No New Jersey hospital has ever defaulted on revenue bonds issued through the state, according to the Health Care Facilities Financing Authority. Such a failure would affect more than just the hospital.

"The ratepayers would be the big losers," said Stephen M. Fillebrown, the authority's director of research and development. In addition, a default could raise doubts about all state-issued bonds.

The Community Medical Center "Series C" revenue bonds were issued in 1988. It was an intricate refinancing plan intended to cut the interest expense of the hospital's existing long-term debt.

Through the sale of the Series C bonds, the hospital borrowed $38 million at 7¾ percent annual interest. The money is currently earning interest in an escrow account.

On July 1, 1992 — known as the "crossover" date — Community is scheduled to use the funds to pay off Series B, a previous bond issue that costs the hospital 11 percent a year in interest.

The difference in interest rates would save Community and its ratepayers $8 million, according to hospital officials. Currently, the bonds have identical ratings of A by Moody's and A-minus by Standard & Poor's.

However, there is a catch. The crossover cannot occur unless the hospital meets all of the conditions in the bond covenants. One requirement is for Community to have a current asset-to-liability ratio of at least 1.20 to 1.

"The covenants have to be met when the crossover is to occur — or the deal's off," said Karen Baker-Mosner, the financing authority's project manager.

The ratio will be only 1.17 to 1 on the crossover date, according to hospital projections. Community will have an estimated $34.7 million in current assets and $29.7 million in current liabilities on July 1, 1992.

The estimated ratio would have been an acceptable 1.25 to 1 if the hospital had not advanced $2.4 million to its affiliates in "non-current" loans — debts not expected to be repaid within a year.

"The fact of the matter is, the loans are there, so I can't put them back in the equation ... so it's irrelevant to the issue," Community's Forsman told the rate commission.

If Community fails to comply with the bond covenants next July, the money in the escrow fund would be returned to the purchasers of the Series C bonds. And the hospital would continue to pay 11 percent interest on Series B bonds until the year 2014.

To avoid default, Community is depending on the rate commission to grant its request for $14 million in cash flow relief. That's how much the non-profit institution claims it will be underpaid during 1991 at the present rates.

If the relief is granted, the hospital predicts it would have a current asset ratio of 1.64 to 1 on the crossover date.

"We're only talking about giving the hospital the cash it's entitled to," Forsman said. "We're not looking for one extra dime of revenue."

Under the state's complex hospital reimbursement system, Community would eventually receive its approved total revenue for this year. Any shortages or excess in collections would be later reconciled. The hospital claims it needs the money now to avoid a default.

However, the Department of Health generally opposes mid-year rate increases by hospitals.

"Some hospitals that project they are undercollecting end up overcollecting," said Kathleen Brennan, acting director of hospital reimbursement.

"A principle that the department is trying very hard to uphold is that hospitals — like insurance companies — set their rates once a year," Ms. Brennan said. "Insurance companies can't change their premiums every month."

While some aspects of hospital finances are tightly regulated, state authorities have not limited the non-profit institutions from using their funds and assets to support unregulated corporate affiliates.

Two-thirds of New Jersey's hospitals risked at least $200 million last year on loans and guarantees on behalf of their affiliates, according to an Asbury Park Press study published earlier this month.

Nine hospitals lost roughly $16 million in bad loans to affiliates during 1988 through 1990. One of the losers was Community Medical Center, which last year wrote off a $700,000 uncollectable loan to a for-profit subsidiary of its parent company.

At the end of 1990, Community was owed another $2.9 million by its corporate affiliates, according to the hospital's annual financial statement.

About $900,000 was classified as current loans, debts that could be repaid within a year. The remaining $2 million was categorized as non-current loans.

Community's more recent disclosures to state authorities involved only non-current loans. In April, three affiliates owed the hospital $2.2 million. The money went to a nursing home, a psychiatric hospital and an early childhood center.

The hospital projects the non-current loans to those affiliates will grow to $2.4 million by the end of June 1992.

"We're addressing the complete health care needs of the area," Vice President Forsman told the rate commission. "You have to put up a few million dollars to get it done ... that's a cheap way of doing it."

But if those ventures fail — or if hospitals default on their debts — the burden is likely to fall on patients and their insurance companies.

"It's really been the ratepayers who have been at risk if it turns out to be a bad decision or judgment," said Lila Steele, assistant deputy to the state public advocate.

"If you're going to let the hospitals have the ability to spend the money where they wish, there has to be some method of holding them accountable," Ms. Steele said.

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Haskell hopeful

Hansel is the heavy favorite in today's Haskell. **D1**

SPORTS PLUS

Self-referral practice by doctors gets limits

■ **Federal and state limits are to take effect next week, but will not eliminate the practice for decades.**

By MARK LAGERKVIST
PRESS STAFF WRITER

THE PRACTICE of physician "self-referral" will get a double dose of reform next week when new federal rules and a state statute take effect.

The measures will limit doctors in referring patients to medical services where those physicians are an owner or investor. But in many situations, self-referrals will remain legal.

Thousands of physicians have financial interests in businesses where they send patients for tests, X-rays, magnetic resonance imaging and other outpatient procedures. By increasing referrals, the doctors can gain income.

Critics claim self-referral is an unethical practice that results in excessive costs and unnecessary care. A 1989 federal study found that physicians with financial interests in medical laboratories prescribed 45 percent more services than other doctors.

Effective Monday, physicians may risk prosecution if they refer Medicare or Medicaid patients to businesses where they have financial interests, according to a regulation issued by the Department of Health and Human Services.

However, the rules exempt health care businesses where referring doctors and hospitals have an ownership interest of 40 percent or less — and 40 percent or less of the revenues are from patients referred by investors.

In addition, the restrictions apply only to self-referrals for services that are billed to the Medicare or Medicaid programs. It does not cover services

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paid by a patient or private insurance company.

The reforms may hit home especially hard at Community Medical Center in Toms River. One-fourth of the medical staff — 83 physicians — and corporate affiliates of the hospital are partners in five joint ventures that engage in self-referrals.

Earlier this year, hospital officials said Whiting X-ray, one of the joint ventures, received more than 50 percent of its business in referrals from physician-investors. If true, it would run afoul of the new regulation.

"Until we have a chance to review the rules in full, I can't give you a conclusion on that," said Community vice president David A. Mebane. "We intend to comply with the rules."

The purpose of the regulation is to clarify the existing federal anti-kickback law. Violators may be prosecuted under the law, which carries penalties of up to five years in prison and a $25,000 fine.

"We know that the overwhelming number of health care providers want to operate legally, and will restructure their arrangements in compliance with these rules," said HHS Secretary Louis W. Sullivan.

New Jersey's attempt at reform will take effect Wednesday — but decades will pass before the statute eliminates physician self-referral.

While the law prohibits the practice, it also contains a grandfather clause that exempts all doctors who currently refer patients to services where they have financial interests.

"In the long term, medical costs to our residents will decrease because of the ban," said Sen. Richard J. Codey, D-Essex, the law's co-sponsor. "In the short term, there's not much effect because of the grandfather."

"The Legislature is saying nobody else can do this (self-referral) because it's unethical, but these doctors can do it because they're already doing it," said Bonnie Teschendorf, director of the state association of physical therapists. "We're talking about 25 to 30 years before we will be rid of this problem in New Jersey."

Statewide, about 550 physicians refer patients to physical therapy practices they own, Ms. Teschendorf said. That number does not include the various types of other medical ventures where self-referral is a common practice.

New Jersey physicians who continue to self-refer under the grandfather clause will be required to inform patients of financial interests exceeding either $5,000 or 5 percent ownership. Violations of the disclosure or self-referral sections of the law are punishable by fines of up to $2,500.

Neither federal nor state agencies have an accurate count of how many medical enterprises are owned by referring physicians. Two years ago, a federal study estimated one in eight doctors referred patients to laboratories where the physicians were owners or investors.

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DECEMBER 22, 1991 SINCE 1879 PRICE $1.25

WET AND WILD

Redefining wetlands could threaten N.J. wildlife habitats.

IMPACT/C1

vs. Patients

Ventures targeted by IRS

■ **For-profit deals between doctors and non-profit hospitals raise questions.**

By **MARK LAGERKVIST**
PRESS STAFF WRITER

FOR-PROFIT DEALS between physicians and non-profit hospitals have prompted the Internal Revenue Service to intervene.

The IRS is targeting "self-referral" ventures between hospitals and doctors. Those arrangements enable a physician to profit by referring patients to certain medical services in which the doctor has an investment interest.

Ultimately, what's at stake is the tax-exempt status of hundreds of hospitals — including Community Medical Center, Toms River, and Riverview Medical Center, Red Bank — that have joint ventures with their medical staffs. The federal tax code does not permit private individuals to share in the revenues of a non-profit corporation.

"For New Jersey hospitals, tax-exempt status is sacred," said Ron Czajkowski, spokesman for the state hospital association.

Without exemption as a charitable institution, a hospital would be required to pay corporate income taxes and municipal property taxes. Tax-exempt bonds could not be sold to raise money for capital improvements. And contributions to the hospital would not be tax deductible.

IRS attorneys are urging the agency to revoke the exemptions of three unidentified hospitals at which physicians

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Ties that bind

One hospital in Monmouth County and another in Ocean have a total of six "self-referral" business ventures involving 102 physicians, according to an Asbury Park Press survey earlier this year. Those for-profit health care businesses are:

- **The cardiac rehabilitation unit at Riverview Medical Center, Red Bank.** Owned by 19 physicians, the hospital and a Texas corporation.
- **Uro-Care — a urology clinic at 67 Route 37, Toms River.** Owned by seven urologists and the non-profit parent company of Community Medical Center, Toms River. Nearly all of Uro-Care's business comes from referrals by physician-owners.
- **Center State Renal Dialysis Center — Lakehurst Road and Route 37, Dover Township.** Owned by six nephrologists and Community's parent company. Almost all business is from referrals by physician-owners.
- **Toms River Infusion Service** — a Cherry Hill Township enterprise that rents equipment and sells supplies to kidney patients. Owned by the same six nephrologists, a Pennsylvania medical supply firm and Community's parent company. Most patients referred by physician-owners or hospital.
- **Whiting X-Ray, 65-G Lacey Road, Manchester Township.** Owned by 35 physicians and Community's parent company. More than half of its patients referred by physician-owners.
- **Toms River Imaging Associates Limited Partnership** leases magnetic resonance imaging (MRI) and other equipment to a radiology practice at 21 Stockton Drive, Dover Township. The lease fees are solely based on the number of tests performed on patients. Owned by 35 physicians, Community's parent company and a California management company.

Asbury Park Press graphic

Ventures

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profit by referral of patients to services jointly owned by those doctors and hospitals. Some of the arguments encompass business practices that exist at many other non-profit hospitals.

"One might wonder whether there is any real harm in giving physicians a financial incentive to refer or admit patients . . . or why the Internal Revenue Service should care," wrote an IRS associate chief counsel in a 38-page opinion.

"Physicians may be tempted to refer patients for unnecessary services or for necessary services provided in an unnecessarily costly setting. . . . The patient's right to freedom of choice is compromised by the physician's incentive to steer the patient. . . . Where physicians receive hidden or disguised payments for referrals, honest competition among health care providers based on quality or price is undercut.

"These potential harmful effects are fundamentally inconsistent with the community-benefit standard on which a hospital's exemption is based," concluded the IRS attorney.

The IRS memo is being studied by hospital executives and their tax experts.

"Hospitals will be scrutinizing both their existing joint ventures with physicians as well as any future arrangements much more closely," said Rob Holmes, chief counsel to the New Jersey Hospital Association.

"We take our tax-exempt status very seriously," said David A. Mebane, vice president of Community Medical Center. "We do not believe the IRS ruling is going to create a problem for us, but it will be closely reviewed. . . . If we need to act, we'll act."

Through its corporate affiliates, the Toms River hospital is engaged in five for-profit ventures with 83 physicians.

They include a urology clinic, a radiology office, a renal dialysis center, a supply firm that caters to kidney patients and an enterprise that owns equipment at an imaging center.

The physician-investors are in position to profit by referring patients to those services. Yet hospital officials do not "believe any of our joint ventures constitutes private inurement by the medical center to our physicians," Mebane said.

Some of Community's for-profit ventures have received financing backed by the hospital's tax-exempt assets, according to financial disclosures.

Riverview Medical Center has one joint venture — a for-profit cardiac rehabilitation unit located in the Red Bank hospital. The enterprise is jointly owned by Riverview, 19 physicians who are cardiologists or internists, and a management firm based in Texas.

Hospital spokesman Peter Lyden III said Riverview officials had not reviewed the IRS memo and were not able to comment.

"Without seeing it, we couldn't say whether it applies to anything here," Lyden said.

Both hospitals are secretive about their joint ventures with physicians.

"We have a policy at the medical center of not commenting on specific issues relating to physician ownership in ventures," said Mebane of Community. "Ownership and referral patterns are not publicly discussed. And we don't think it's appropriate to publicly discuss them."

Because the deals are often kept private, no one knows how many of New Jersey's 115 non-profit acute-care and specialty hospitals have joint ventures. Two of the nine acute-care hospitals in Monmouth and Ocean counties are involved in for-profit ventures with referring physicians, according to an Asbury Park Press survey conducted earlier this year.

Hospital industry observers say joint ventures are common.

"I would expect that almost all New Jersey hospitals have some joint venture arrangements with physicians on their medical staff," said Rob Holmes, of the hospital association. "I would also expect — given the diversity of hospitals in New Jersey — that those relationships with physicians are extremely diverse."

According to Holmes, many joint ventures benefit patients by providing additional health-care services to the area served by the hospital. The arrangements may also help the hospital increase its corporate revenues and retain the loyalty of its medical staff.

However, those factors may not be enough to protect a non-profit hospital's tax-exempt status.

"The presence of a single non-charitable purpose, if substantial in nature, will destroy exemption regardless of the number or importance of charitable purposes," states the IRS opinion.

The memo is not legally binding, but it does set the stage for a federal crackdown on hospitals that may be abusing tax-exempt status.

"I think it's significant," said Holmes. "It does give us an idea of the closer scrutiny which the IRS will be placing (on non-profit hospitals) in the future."