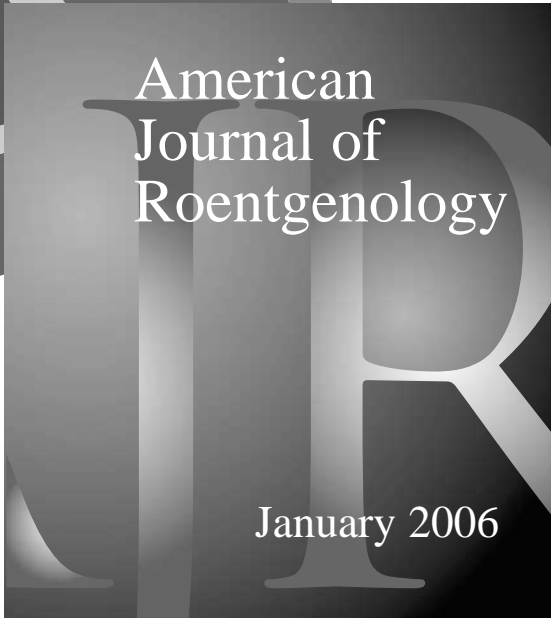


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MBA Education for Physicians: Cross Training Options



By Frank J. Lexa
Guest Editor
Health Policy

Introduction

In recent decades, there has been an explosion of interest in executive education for medical professionals. This appears to be driven domestically by an avalanche of changes in the organization of the U.S. health care system. This transformation has created the perception that there is a greater need for physicians to understand management and financial topics. In some cases, it is motivated by a desire for independence and entrepreneurship, particularly among younger physicians.

This phenomenon is also related to a truly global change in the relationship between technical and managerial disciplines. Worldwide, the traditional separation between managers and financial personnel on one side in opposition to scientific and technical experts on the other has been crumbling in many disciplines. This convergence is occurring in molecular biology, engineering, and telecommunications as well as to us in American medicine. There is a greater need than ever for us, as physicians, to have a broad appreciation of how management and medicine can be synergistic rather than antagonistic.

Take the example of opening a new center for your practice. There are many hurdles that you will face and business training and experience can help you succeed in overcoming them. Knowing how to write a business plan will help you anticipate and solve many problems before they become serious. Training in business negotiations can make the difference in winning or losing most of the key components of the venture. Marketing research will aid you in picking the right location and making sure that you will have enough referrals. Smart financial analysis will help you to make sure that the investment will meet your goals and to help you choose intelligently among competing choices such as another MR scanner vs. a PET/CT. Other business disciplines such as operations research and management can help you with day-to-day functions, human resource problems, etc. This article will focus on options for physicians who seek business education in order to enhance their medical careers.

MBA: Timing, Characteristics, and Options

If you want to pursue a business degree there are many options open to you. The

youngest readers of this article still have the simplest and usually cheapest choice of getting an MBA while pursuing their medical education. Currently in the U.S., there are almost 50 institutions that provide the option to pursue both an MD and MBA degree in some type of concurrent fashion¹. These continue to grow in popularity and new combined-degree offerings are launched regularly². These programs, when well executed, provide the best integration of education in both schools. Socially and financially, this is also an ideal time to accomplish these goals simultaneously while limiting the impact on your outside professional and personal interests. However, there are potential downsides as well. In particular, many of our students struggle with the problem of what to do immediately after graduation with both degrees. They often feel drawn in two disparate directions. Graduate medical education is not very compatible with the kinds of jobs that freshly minted MBAs are offered. Both early career paths usually require a high degree of commitment and long hours. The new graduate usually faces a stark either/or choice. This dilemma is worsened by the perception (usually at least partially justified) that whichever path they chose, the new graduates risk becoming rusty in the arena they sideline themselves from. Although both worlds seem to be becoming more flexible, it is still more difficult to return to start a residency as a PGY 1, several years after graduating from medical school than to go straight through. This is compounded if that time is spent in an entirely different job track in a very dissimilar milieu.

It is also possible to go back for an MBA after you have finished your training or been in practice. That feat can be accomplished in several ways, and the good news is that the demand has driven up the number of choices for those of us who are older and farther along in our careers. Each route has its own advantages and disadvantages. The most traditional way is to pursue a graduate MBA. These generally take just under two years going full time and the average age of the students is usually mid to late twenties. Many programs offer concentrations or majors, which can include health care or a closely related topic. Cost tends to be high particularly at the top schools—it is a shock to see that two years in an MBA may well cost you more than you spent for twice as much time in medical

school years ago. Keep in mind that going full time tends to be quite intense—particularly at the best-regarded schools. It is difficult or impossible to balance a full time graduate MBA with a typical 40-50 hour a week job, let alone the more demanding, committed kind that most of us have in medicine.

A cohort structure is typical. This means that the vast majority of students starts as unit, takes the basics together and graduates on the same date. This design creates group cohesion, encourages peer education, and bonds students in an impressive fashion. The style of education is interactive and is very different from the classroom experience many of us had in the first two years of medical school. At Wharton, we use a coproduction model to teach. The professors don't show up for a lecture with an hour's worth of slides and just lecture for the entire time slot. Instead, it is an active conversation with the students. This is not just calling on them to ask questions like the experience many American law students have in class. Instead, we are asking them to contribute to the class by bringing in their own work experiences to add to the prepared lecture material. This is one of the primary reasons why it is extraordinarily unusual for people to be admitted directly to business school from undergraduate programs. This work experience is critical on two fronts—first it brings the material alive for them and second it allows them to contribute to the education of their classmates (and sometimes their professors).

Executive programs are another option. They also generally take around two years, but differ substantially in structure from graduate MBA programs. Students generally attend primarily on weekends with some occasional additional days or weeks thrown in. Many are residential to accommodate students traveling from a distance (we routinely have had students attend by commuting from Europe or Asia). These students are older than the average graduate MBA, usually in their thirties, and they are usually still working at their pre-MBA job. Often they are sponsored by their employers as part of an agreement to return after completing the degree. The cost is often the same or greater than that of a graduate MBA at the same institution. Both executive and conventional programs often use a learning team approach. This means that you work within the same group of around five people

for all or most of your basic classes. Your performance including your grade depends upon the team as well as you individually.

This last item can be enormously frustrating at times for highly motivated, independent minded individuals such as specialist physicians. You can be dragged down if one or more of your team members turns out to be a slacker. However, that is one of the points of the design. If you are going to become a manager, you need to learn to manage people of all types—sometimes under difficult circumstances. Those sorts of events and what I learned from them have stuck with me long after I've forgotten the arcane details of advanced accounting.

There are also a wide range of part-time programs that are less structured, but which still allow you to cover the material and receive the degree. Some can be completed in an a la carte fashion over a fixed period and some offer additional scheduling options with classes during both day and evening. This flexibility is clearly attractive, particularly for

busy professionals. The downside is that there is a loss of both the learning team and cohort experiences. These can be the best choices for people who don't have the time or resources to devote to a two year, expensive program. In addition, there are distance-learning programs that minimize or eliminate most of the physical classroom experiences. These are offered on the Web and have the advantage of being even more convenient in time and space. The downsides relate to the loss of face-to-face contact with the faculty and fellow students.

A final set of choices revolves around the personal question whether or not you need the entire MBA offering. You should ask whether you really require another expensive piece of paper. When you count the costs, don't forget the extraordinary time value your medical training represents. In addition to paying for the degree, you are also losing the time value of your skills and the financial power they represent during a period of reduced earning. If you completely drop out you will also face

the potential of your abilities and skills getting rusty and stale.

There are many ways to get started without making the commitment to a formal program. It is beyond the scope of this article to explore all of them. However, many medical schools, business schools, and national organizations, such as the American College of Radiology have created shorter, more focused executive education programs that allow you to get started in cross training by starting just in one area such as finance or business planning. This will give you a taste for the material, gauge its relevance for you, and decide whether you are motivated enough to make a bigger commitment. ■

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In Practice

At Press Time...

Medicare Final Rule Slashes Physician Payments by 4.4%

Baltimore, MD—At press time, Medicare payments to physicians were set to be reduced by 4.4% beginning in January, but the American Medical Association (AMA) was encouraging Congress to stop the cuts and replace the “fatally flawed physician payment formula with one based on practice costs.”

The Centers for Medicare and Medicaid Services (CMS) issued its final rule on November 2. “In this rule, we continue to refine payment rates to reflect current medical practice, while doing all we can under current law to support physicians' efforts to provide greater quality and efficiency of care for Medicare beneficiaries,” said CMS Administrator Mark B. McClellan, MD, PhD.

The AMA argues that if the cut is imposed, average physician payment rates will be less in 2006 than they were in 2001. “Physicians cannot practice 21st century medicine with payment rates of the past,” said AMA Board Chair Duane M. Cady, MD. The AMA added that over the next six years Medicare physician payment cuts are scheduled to total 26%, while the cost of caring for patients will increase 15%. In a national AMA survey, 38%

of physicians say they will be forced to stop taking new Medicare patients if the first of the payment cuts occurs in 2006.

In addition to updating the Medicare physician fee schedule, the final rule addresses payments for certain diagnostic imaging procedures to reflect their “limited additional costs when they are performed on contiguous body parts in the same session with the patient.” CMS had proposed a reduction in fees for these types of procedures. The final rule phases in a payment reduction over two years, with the reduction in 2006 being 25% and the reduction in 2007 being 50%. The reduction does not apply to transvaginal ultrasound and ultrasound of the breasts, pending further study. The rule will apply the budget neutrality adjustment to the practice expense component of the services only.

CMS had also planned to include diagnostic and therapeutic nuclear medicine services and supplies as a designated health service (DHS), subject to the physician self-referral ban. The final rule delays the effective date for this regulatory change until January 2007 so facilities that would fall under this ban have time to restructure their financial arrangements.

Pay-for-Performance Project Shows Improved Quality of Care

Baltimore, MD—The quality of care has improved significantly in hospitals participating in Medicare's pay-for-performance demonstration project, the Centers for Medicare and Medicaid Services (CMS) reports.

Medicare has awarded \$8.85 million to hospitals that showed measurable improvements in care during the first year of the Premier Hospital Quality Incentive demonstration.

Quality of care improved in all of the five clinical areas for which quality was measured—from 87% to 91% for patients with acute myocardial infarction, from 65% to 74% in patients with heart failure, from 60% to 79% for patients with pneumonia, from 85% to 90% for patients with coronary artery bypass graft and from 85% to 90% to patients with hip and knee replacement.

Improvements in these evidence-based quality measures are expected to provide long-term savings because of their demonstrated relationship to improved patient health, fewer complications and fewer hospital readmissions, said CMS. “We are seeing that pay-for-performance works,” said CMS Administrator Mark B. McClellan, MD, PhD.

Hospitals in the top 10% for a given condition were given a 2% bonus on their Medicare payments for that condition. Hospitals in the second 10% were given a 1% bonus.

The demonstration began in October 2003, with more than 260 hospitals voluntarily participating and it is scheduled to end in September 2006.

Physician Voluntary Reporting Program Begins

Baltimore, MD—Phase one of the Physician Voluntary Reporting Program begins this month, enabling physicians to voluntarily report information to the Centers for Medicare and Medicaid Services (CMS) about the quality of care they provide to Medicare beneficiaries.

CMS is collecting adherence data on 36 evidence-based quality measures through the use of a dedicated set of Healthcare Common Procedure Coding System (HCPCS) codes, called G-codes. These data will supplement the claims data physicians currently submit to CMS. CMS has indicated it will provide feedback next summer to the physicians who submit the quality measures data.

The American Medical Association has expressed concern with the program, saying that “the excessive administrative requirements that this program will impose on physicians could doom this initiative and negate any intended quality improvements.”

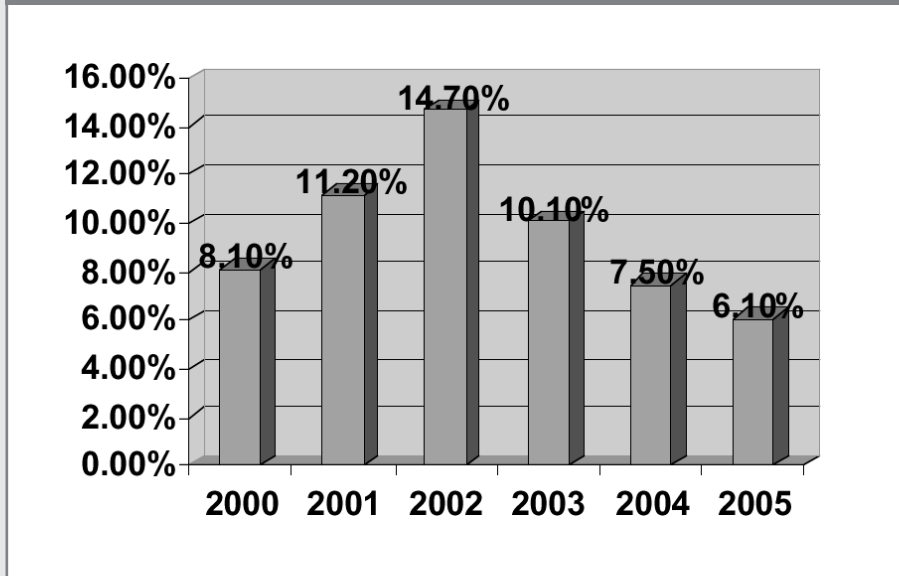
Improper Medicare Payments Cut in Half

Baltimore, MD—The number of improper fee-for-service Medicare claims payments has been cut in half, down from 10.1% in 2004 to 5.2% in 2005, according to the Centers for Medicare and Medicaid Services (CMS). The decrease in improper payments saved Medicare about \$9.5 billion in fiscal year 2005.

Much of the improvement can be attributed to a decrease in the number of errors due to non-responses to requests for medical records or insufficient documentation. CMS Administrator Mark B. McClellan, MD, PhD, noted that some of the errors resulted from fraud, but others were just innocent mistakes. Errors included payments for medically unnecessary services, incorrect billings submitted by providers and inadequate documentation to prove a service was necessary.

CMS pays more than one billion fee-for-service claims each year.

Fig. 1. Annual Change in Average Total Health Benefit Cost, All Employers



SOURCE: National Survey of Employer-Sponsored Health Plans, Mercer Health and Benefits LLC.

Employer Health Benefit Costs Increase Slightly

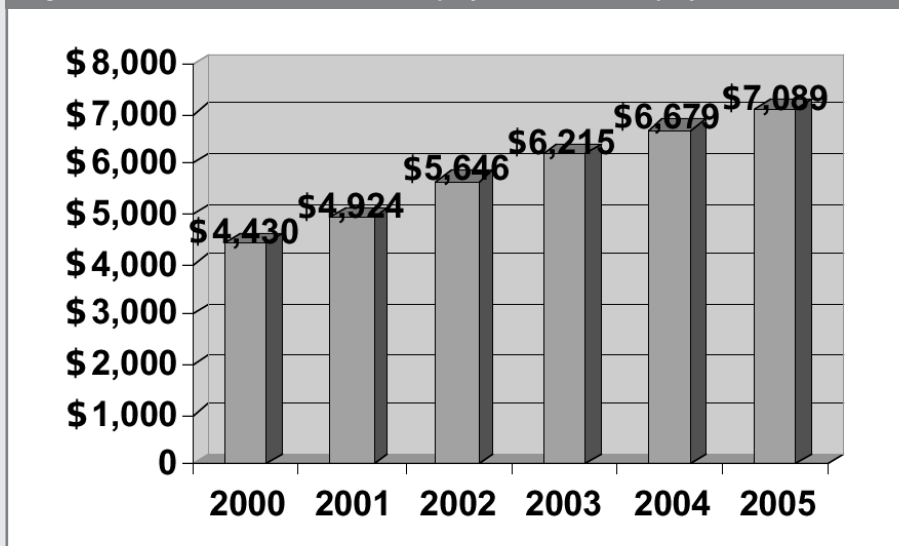
New York, NY—Employer health benefit costs increased 6.1% in 2005, according to a report by Mercer Health and Benefits LLC (see Figure 1). The report predicted a similar increase (6.7%) in 2006.

The 6.1% increase translates into \$7,089 per employee (see Figure 2).

Employers lowered their 2005 cost increases, in large part, by cost-shifting. An individual

deductible for in-network care is now required in 80% of PPO plans, up from 73% in 2004. Among large employers (500 or more employees) the median deductible rose from \$250 to \$300; the median small employer deductible did not change. The use of coinsurance as a means of sharing the cost of office visits increased, from 5% to 9% of all PPO sponsors. HMO plans also experienced cost shifting. For example, 64% of HMO plans now require a hospital deductible. That compares to 55% in 2004.

Fig. 2. Total Health Benefit Cost Per Employee for Active Employees



SOURCE: National Survey of Employer-Sponsored Health Plans, Mercer Health and Benefits LLC.

Employers say that in the future, they will focus on “promoting informed and responsible spending by employees for health care” as well as care management (i.e., a range of programs designed to improve employee health care) as strategies for managing health care costs.

Results of the study represent about 600,000 employers and more than 90 million full-time and part-time employees.

California Study Finds More Treatment Does Not Improve Care for Chronically Ill

Baltimore, MD—California hospitals vary in the amount of money they spend on health care for Medicare patients in the last two years of their lives, but more spending doesn’t necessarily equate with better care, according to a recent study.

The study, performed by the Dartmouth Medical School, examined Medicare data at 226 California hospitals between 1999 and 2003 regarding the medical costs in seriously ill patients’ last two years of life and the intensity of care provided in the last six months of life.

The report concluded that in California regions that have more hospitals, ICU beds, physicians and specialists, patients receive significantly more services at greater cost but with no marked improvement in outcomes.

According to the research, hospitals in Los Angeles received an average of 60% more for inpatient reimbursement for Medicare patients during the last two years of life than Sacramento-area hospitals (the least expensive region). Patients in Los Angeles had 2.3 times more physician visits; 3.3 times more visits to medical specialists; 2.31 times more days in intensive care; and 1.62 times more days in the hospital than similar patients in Sacramento.

The increased level of care did not translate into increased patient satisfaction. In fact, 57% of hospitals in Los Angeles received a below-average patient care rating of quality despite having the most expensive cost of treatment, averaging \$43,506.

According to the study, more than \$1.7 billion could have been saved over five years in Medicare spending in the Los Angeles area hos-

pitals, if medical practice patterns and spending had matched those of Sacramento and had not been focused on “often futile” patient care.

“Most patients believe more is better in our current health care system. The evidence suggests more conservative practices are often better,” said Elliot Fisher, MD of Dartmouth Medical School, co-author of the report.

The study was published as a Web exclusive in November in the journal *Health Affairs*.

Health Care Costs Rise, Lowest Rate Increase in Six Years

Washington, DC—Legislation has been introduced to reduce health care disparities and improve the collection of racial, ethnic and socio-economic determination data for use by health care researchers and policymakers.

The Faircare Act, sponsored by Senator Joseph Lieberman (D-CT), requires that any agency that receives funds from the Department of Health and Human Services (HHS) must collect demographic data on patients receiving assistance under HHS programs.

The legislation also allows for grants for 100 demonstration programs—50% at hospitals and 50% at community health centers—to collect, analyze and report the data. It also proposes increased Medicare payments for facilities that successfully reduce health care disparities.

The legislation has been referred to the Senate Committee on Finance.

IOM Calls for Improved Cancer Survivor Care

Washington, DC—Cancer survivors need specialized care but are not always getting it, according to a report by the Institute of Medicine (IOM). IOM is recommending that each cancer patient receive a “survivorship care plan” that would summarize information critical to the individual’s long-term care, such as the timing and content of follow-up visits; tips on maintaining a healthy lifestyle and preventing recurrent or new cancers; legal rights affecting employment and insurance; and the availability of psychological and support services.

IOM is calling on medical and nursing schools to incorporate survivorship issues into

their curriculum and encouraging practicing physicians to participate in continuing medical education programs that discuss how to care for cancer survivors.

In addition, IOM is asking employers to implement programs that assist cancer survivors, both throughout and after treatment, and is advocating that insurance companies design benefits, payment policies and reimbursement mechanisms to facilitate coverage.

IOM says that the number of cancer survivors in the U.S. has more than tripled to almost 10 million over the past 30 years, intensifying the need for changes in the way that cancer survivors are treated.

Labs to Face Increased Scrutiny

Northfield, IL—The College of American Pathologists (CAP), which accredits more than 6,000 laboratories worldwide, will begin unannounced routine inspections starting next spring, as part of an overhaul of the way it inspects and monitors performance of participating laboratories.

CAP will invest \$9 million over the next two years to strengthen its inspection process and monitor its accredited laboratories for compliance. It has instituted a new checklist to better assess each laboratory’s quality management plan. It has also instituted a new patient safety inspection checklist that focuses on analysis and reporting, verification and communication of life-threatening or life-altering information and identification, communication and correction of errors in a timely manner.

“The CAP believes these initiatives will enhance the consistency and effectiveness of our inspection process, strengthen monitoring of laboratory quality between inspections and reaffirm public confidence in the accreditation process,” said R. Bruce Williams, MD, chair of the CAP Commission on Laboratory Accreditation.

The overhaul comes following a discovery of problems in 2004 with laboratory tests for HIV and other diseases processed at the Maryland General Hospital and Reference Pathology Services in Maryland, which had been CAP-accredited facilities. ■