Scenes From a Corporate Makeover:
*Health Care Fraud and the Refashioning of Columbia/HCA, 1992–2001*

**Edward J. Balleisen**

Part One of Four:
Fraud and the Making of a Corporate Crisis

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Part One of Four: Fraud and the Making of a Corporate Crisis

On July 16, 1997, thousands of hospital administrators, clerical workers, nurses, and physicians became acquainted with the investigative power of the U.S. government. Armed with search warrants and criminal subpoenas, agents of the Federal Bureau of Investigation (FBI) and other law enforcement bodies paid calls on hospitals and other health care centers owned and operated by Columbia/HCA, then the world’s largest health care corporation and the nation’s ninth largest employer, with over 285,000 people on its payroll. After advising hundreds of the workers to “[h]ang up the phone, step away from your desk, don’t touch your computer,” the federal agents asked for and removed truckloads of documents and computer files from almost three dozen of Columbia/HCA’s facilities in six states. Together these raids constituted one of the most far-reaching law enforcement operations in American history. One legal commentator marveled that never before had “35 search warrants…been served simultaneously on a New York Stock Exchange corporation.”

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The federal investigation of Columbia/HCA focused on wide-ranging allegations of health care fraud and soon plunged the company into a full-blown corporate crisis, characterized by intense and overwhelmingly negative press coverage, a plummeting stock price, and deepening criticism from investors, stock analysts, union activists, and government officials. In the preceding four years, Columbia/HCA had become a darling of Wall Street and seemed to be in the process of reconstructing the health care delivery system of the United States. But in the aftermath of the July raids, health sector analysts began to raise serious questions about the company’s viability. What lay behind this dramatic reversal of corporate fortune?

Nationalized Health Care the Columbia/HCA Way

In many ways, Columbia/HCA’s predicament in 1997 grew out of its pugnacious approach to business, an approach characterized by one observer as “health care on overdrive.” The company was led by Richard Scott, a Dallas health care attorney with no formal training in hospital management but with substantial experience in the negotiation of corporate mergers and acquisitions. Scott entered the hospital business in 1987, creating the Columbia Hospital Corporation in Texas and buying two hospitals in El Paso, primarily with borrowed money. The hallmark of Scott’s corporation soon became aggressive revenue growth, driven in large measure by voracious acquisitions of other health care providers. After purchasing additional care centers in Texas and Florida, Columbia went public in 1990 through a merger with a San Diego medical instruments company, borrowing heavily again in 1992 to finance the purchase of Basic American Medical, a for-profit company that operated seven hospitals, four of them in the Fort Myers, Fla., area.

From 1993 through 1995, Columbia relied on a buoyant stock price to buy or merge with much larger but struggling for-profit hospital and surgery center chains, such as Galen, HCA, Healthtrust, and Medical Care America (Exhibit 1a). After its merger with HCA, the corporation took a new name—Columbia/HCA. In 1996 and the first half of 1997, the company shifted its attention to community nonprofits, purchasing individual hospitals out of its now substantial cash flow and converting them to for-profit status. Generally nego-


tiating these latter deals in secret and demanding that hospital managers not solicit alternative bids, Columbia/HCA picked up dozens of financially troubled hospitals on the cheap. By 1997, the hospital giant owned over 300 hospitals, 100 surgery centers, and 500 home health care agencies in 38 states, concentrated primarily in the Sunbelt. At the same time, Scott acquired numerous medical clinics, laboratories, and physician practices, while making additional forays into a variety of health services and a cable television network. In just nine years, Scott put together a health care conglomerate worth more than $20 billion (Exhibit 1b).²

In the midst of this extraordinary growth, Scott’s management team endeavored constantly to cut costs. In some local markets where the company had achieved a particularly strong competitive position, Columbia/HCA pursued a classic strategy of horizontal combination, closing hospitals and consolidating staffs to remove excess capacity and increase its market power. (Scott had used this strategy from 1987 to 1992 in El Paso and in the company’s Florida markets, enabling Columbia to gain traction with Wall Street investors). Whenever
Exhibit 1b. Spreading across the nation.

The Columbia/HCA Healthcare Corporation began with the purchase of two struggling hospitals in El Paso, in 1987. In the decade since then it has grown substantially by almost any measure.
it bought a facility or chain that faced a heavy debt burden, Columbia/HCA refinanced its obligations at much lower interest rates. More generally, the company pared down administrative staff, negotiated lower rates on contract services (e.g., financial auditing), and cut the number of nurses in its hospitals, frequently replacing highly skilled nurses with less skilled ones, and less skilled nurses with unlicensed technicians. The company also vigorously sought out economies of scale in its purchase of medical supplies for everything from bandages to hip implants to medical imaging technology.

Cost-cutting initiatives were matched by efforts to enlarge income streams. In the mid-1990s, the company purchased scores of surgery centers, diagnostic and rehabilitation clinics, laboratories, and home health care agencies, as well as a pharmacy benefit management company, in the hope of achieving a version of vertical integration. The goal, in Scott’s words, was to provide “a continuum of care.” Patients might not literally have one-stop shopping for all of their health care needs, but as many of their stops as possible would be owned by Columbia/HCA, ostensibly eliminating problems for patients making the transition from the hospital to a rehab center or home health agency. (For third-party payers, whether private insurers or government benefit programs, there would be one-stop shopping.) A hospital in this scheme would serve as “the hub of an all-encompassing care network,” offering “better and more cost-effective care.”

Care networks gave Columbia/HCA substantial control over local markets and leverage with local insurers while creating significant barriers to entry. According to one former company executive, Scott envisioned health care delivery as “a lot like that board game Risk. You had to control your market by covering every inch of it. And you had to fortify your positions on the fringes with smaller hospitals and surgery centers that could keep out the competition.” Once possessed of market power in a given community, Columbia/HCA executives eschewed efforts to extend market share through low rates. Instead they developed complex variable pricing strategies akin to those of most airlines, especially at the majority of its facilities located in affluent areas. Median fees for in-hospital treatment generally exceeded those for the industry as a whole. In 1995, one study calculated the difference at eight percent, taking into account variances in geographic location and case mix.
Under Scott, the company also pursued a policy of brand creation in the hope that Americans all over the country would come to associate acute care with Columbia/HCA and that investors would come to perceive the company as a “blue-chip” firm (Exhibits 2a through 2d). Accordingly, the company added its name to all of its hospitals and surgery centers and developed a $100 million-a-year advertising campaign encompassing billboards, print and broadcast media, and sponsorships of sporting events and teams. One gimmick involved a *USA Today* “wrap”—a newspaper section laid out by the national newspaper and filled with advertising content posing as news—which *USA Today* placed around its daily paper and distributed to persons identified by the company. Many of Columbia/HCA’s television commercials touted high-quality, low-cost care, proclaiming that the company furnished “a better product at a better price,” despite evidence that its rates generally exceeded those of its competitors. Often these advertisements cited accreditation awards that actually measured financial performance. Still other ads, especially on billboards located near competing hospitals, robustly critiqued the competition.6

Scott and his management team also tried to create, in the words of one admiring health sector analyst, an “alignment of economic incentives” between the corporation and both the executives who managed its various care centers and the physicians who practiced at them.7 Local management played a pivotal role in Columbia/HCA’s daily operations, because senior executives at headquarters expended so much time and energy on growth and acquisitions. (Scott not only paid close attention to the details of particular merger and acquisition negotiations, but also spent a great deal of time visiting hospitals that he thought might be good candidates for purchase). Corporate headquarters gave its regional and local managers substantial leeway over basic questions of hospital management, but set ambitious growth targets in such areas as admissions and net revenues, with the latter generally asking for annual gains of 15 to 20 percent. Scott and his lieutenants then invested heavily in information systems that facilitated the tracking of financial performance at individual facilities. Hospital administrators who hit their targets received bonuses that approached 80 percent of base salary; those who did not faced reproach from Nashville and, for some, termination of employment. (During this period, many nonprofits also relied on managerial bonuses, but generally tied them to health-related indices rather than financial performance.) In the case of physicians, financial
Exhibit 2a. Television commercial from the national branding campaign.

“Patient Care System” :30

VIDEO: Open on SPOKESMAN outside of a patient’s room with a nurse.

SUPER: OVER SCENE ABOVE:
Columbia field report interview #14

AUDIO: SPOKESMAN: So, what’s that little gizmo you have there?

NURSE: Oh, this? I can enter a patient’s vital signs in here and transfer them anywhere. Even right to a doctor’s desk.

SPOKESMAN: Ahh, cutting out charts and paper. Smart.

NURSE: It’s just another way Columbia’s trying to make healthcare more efficient.

SPOKESMAN: Can I see? (He looks over the nurse’s shoulder.)

SPOKESMAN: I saw this movie once where they transported a guy through thin air with something like this.

NURSE: (stares at him.)

SPOKESMAN: I’m not trying to one-up you or anything. It’s just a movie I saw.

NURSE: (Looking uncertainly at SPOKESMAN and then at camera, takes device and walks away) Okay.

VIDEO: CUT TO CAMERA CARD
WITH LOGO AND TAGLINE:
COLUMBIA(sm) (LOGO)
Healthcare has never worked like this before.
For the nearest Columbia facility, call 1-800-COLUMBIA.
http://www.columbia.net

DO NOT READ:
©1996 Columbia/HCA Healthcare Corporation
Exhibit 2b. Television commercial from the national branding campaign.

“Homecare” :30

VIDEO: Open on SPOKESMAN getting out of car, outside of a house with a NURSE.

SUPER: OVER SCENE ABOVE:
Columbia field report interview #29

AUDIO: SPOKESMAN: Question. If Columbia’s a hospital, what are we doing here?

NURSE: Well, Columbia’s a lot more than just a hospital. If patients need care at home, you know we want to be able to provide that, too.

SPOKESMAN: Columbia’s doing homecare. Wow. Yard work? Roofing?

NURSE: No, no, home healthcare. I’m here for Mr. Riley’s physical therapy.

SPOKESMAN: Oh...well...yeah.

VIDEO: CUT TO CAMERA CARD WITH LOGO AND TAGLINE:
COLUMBIA(sm) (LOGO)
Healthcare has never worked like this before.
For the nearest Columbia facility, call 1-800-COLUMBIA.
http://www.columbia.net

DO NOT READ:
©1996 Columbia/HCA Healthcare Corporation
Exhibit 2c. Television commercial from the national branding campaign.

“Questions” :30

VIDEO: Open on SPOKESMAN standing outside of an emergency room. A man is walking by.

SUPER: OVER SCENE ABOVE:
Columbia field report interview #18

AUDIO: SPOKESMAN: Excuse me, sir.
VIDEO: The man stops.

MAN: Yeah?

AUDIO: SPOKESMAN: A couple of quick questions.

MAN: Oh, sure.

SPOKESMAN: Why did you choose Columbia?

MAN: What?

SPOKESMAN: The fact they have more locations than any other healthcare provider in the country?

MAN: Well, no.

SPOKESMAN: The fact that they’re tracking patient outcomes to improve care? Come on, that at least played a part?

MAN: (shakes head)

SPOKESMAN: Did you see their site on the internet?

MAN: Actually, I’m an electrician. I’m here for some wiring work.

SPOKESMAN: Well, that’s a good reason, too.

VIDEO: CUT TO CAMERA CARD
WITH LOGO AND TAGLINE:
COLUMBIAS(sm) (LOGO)
Healthcare has never worked like this before.
For the nearest Columbia facility, call 1-800-COLUMBIA.
http://www.columbia.net

DO NOT READ:
© 1996 Columbia/HCA Healthcare Corporation
Exhibit 2d. Television commercial from the national branding campaign.
Incentives took two forms: hundreds of doctors received offers to buy into partnerships that would hold up to 20 percent ownership of a local hospital network, thus giving them a stake in the network’s overall results. Others were given reduced or free rent in medical office buildings, lucrative medical directorships with minimal duties, reduced-interest or interest-free loans, vacations, and/or free pharmaceutical products for use by family members.8

Suffusing all of Columbia/HCA’s strategies was a brash corporate culture committed to hard-nosed competition and relentless expansion, and more than willing to accept public controversy over its business practices. When Columbia/HCA’s senior management perceived business opportunities, they moved quickly and did not hesitate to press home their advantages in size, political influence, and access to inexpensive capital. Many of Columbia/HCA’s acquisitions of nonprofits required expensive lobbying campaigns to elicit the support of local or state governments for the facilities’ conversion to for-profit status, as well as handsome severance packages for departing managers. In addition, a growing number of deals occurred over the vociferous opposition of local doctors, nurses, and community leaders, who worried about the consequences of Columbia/HCA buyouts for charity care or the provision of local medical services.

Such resistance frequently provoked vigorous responses. When community hospitals rebuffed the company’s attempts to take them over, the company responded in some cases by filing lawsuits and in others by building competing institutions in the same neighborhood. After a St. Petersburg, Fla., newspaper advocated an antitrust investigation of the company’s activities in the local market, Columbia/HCA canceled all of its advertising in the paper and prohibited the paper’s sale in company-owned facilities. By the end of 1995, opposition to further growth by the company had intensified across the country as administrators of financially strapped health care centers in places like San Diego and Providence declared that they would consider proposals from “ABC”—“Anyone But Columbia.” Despite a much warier marketplace, Scott held steadfastly to a goal of owning 500 to 1000 hospitals and reaching annual revenues of $50 billion to $100 billion.9

Columbia/HCA executives simultaneously sought to remold the cultural contours of the medical industry, repeatedly seeking to erase distinctions between it and other economic sectors. The company embarked on a sales initiative,
requiring all local executives to go through intensive training in how to sell their health care centers to area doctors. Scott refused to refer to community hospitals as “nonprofits,” preferring to call them “tax-exempt” competitors “that shouldn’t be in business.” David Vandewater, Scott’s chief deputy and chief operating officer, described Columbia/HCA as a firm that offered “sick care” rather than “health care,” frequently characterized treatments for illness as “product lines,” and argued that “[h]ospital operations are not much different from a ball bearing factory.” Both men contended that the charity care provided by most nonprofit hospitals did not equal the value of income foregone through tax exemptions and that their company furnished its fair share of uncompensated care. For Columbia/HCA in the mid-1990s, the more traditional nonmonetary values associated with medicine, such as giving assistance to those in need or maintaining public health, were subordinated to the values of the market. Only market discipline, Scott argued relentlessly, could restrain spiraling medical costs and thus provide genuine health care reform. “There’s no way,” Scott argued, “as taxpayers, as employers, as employees, as individuals, [that] people are going to pay what they paid in the past for health care…. We’ve got to change.”

Through early 1997, Scott’s philosophy rewarded the company handsomely. Because Scott typically avoided financing mergers and acquisitions through debt after 1992, the company maintained debt-equity ratios of around 0.5 to 1, laying the groundwork for steadily improving credit ratings. By 1995, Moody’s gave Columbia/HCA an AAA rating, enabling it to float 100-year bonds—something that only a handful of businesses had been able to manage previously. Between 1994 and 1996, the company realized revenue growth of 37 percent and increased profits before one-time charges of 62 percent; from 1992 to 1997 its stock price quadrupled and its capitalization increased tenfold, from $2 billion to $20 billion (Exhibits 3 and 4). Not surprisingly, stock analysts shared the enthusiasm of the credit rating agencies, hailing Columbia/HCA almost universally as a leading growth stock.
**Exhibit 3.** The growth of Columbia/HCA, 1992–1996.

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<thead>
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<tbody>
<tr>
<td>No. of hospitals</td>
<td>281</td>
<td>274</td>
<td>311</td>
<td>319</td>
<td>319</td>
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<tr>
<td>No. of admissions</td>
<td>1,448,000</td>
<td>1,451,000</td>
<td>1,565,500</td>
<td>1,774,800</td>
<td>1,895,400</td>
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<tr>
<td>No. of licensed beds</td>
<td>51,955</td>
<td>53,247</td>
<td>57,517</td>
<td>61,617</td>
<td>62,708</td>
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<tr>
<td>Average length of stay, d</td>
<td>6.0</td>
<td>5.8</td>
<td>5.6</td>
<td>5.3</td>
<td>5.1</td>
</tr>
<tr>
<td>Gross revenue, millions, $</td>
<td>12,226</td>
<td>12,678</td>
<td>14,543</td>
<td>17,132</td>
<td>18,786</td>
</tr>
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</table>

From company reports to the U.S. Securities and Exchange Commission.


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**Run Up, Slide Back**

Percentage change in the price of Columbia/HCA Healthcare stock since the beginning of 1992 compared with the S & P 500

Full Quaffs at the Federal Trough

Aggressive pursuit of accelerating revenue greatly influenced operations throughout Columbia/HCA’s subsidiaries. The impact of this growth culture extended to the approach that many of the company’s hospitals and home health agencies took toward reimbursement from public medical benefit programs like Medicare, the federal health insurance system for the elderly and the disabled. Appreciating the nature of the company’s aggressiveness in this area requires some understanding of the complex world of Medicare reimbursement. (Medicare-related payments accounted for just under $6.6 billion, or 35 percent, of Columbia/HCA’s total revenue in 1996).  

During the period of Columbia/HCA’s rapid corporate ascension, doctors, hospitals, and other caregivers received two basic kinds of funding from Medicare—payment for services provided to patients who were covered by Medicare (i.e., direct expenses); and in the case of hospitals, surgery and rehab centers, and home health agencies, payment for a share of capital expenditures and overhead expenses (i.e., indirect expenses). From 1983 onward, hospitals had to assign any services rendered to Medicare patients (e.g., diagnostic tests, interventions, treatments) to one of almost 500 accounting categories known as diagnostic related groups, or DRGs. Congress instituted this arrangement, known as the Prospective Payment System (PPS), in the hope of holding down Medicare spending.  

Within large medical organizations, DRG assignment usually fell to a group of specialized clerical workers known as coders. Coders read patient charts and assigned diagnosis and procedure codes based on the services described in the charts. The specification of those codes then governed the assignment of an overall DRG. In making their determinations, coders relied on guidelines and definitions furnished by the Health Care Financing Administration (HCFA [now the Centers for Medicare and Medicaid Services]), the federal agency that oversees Medicare. All bills to Medicare for acute care had to specify particular DRGs, which triggered reimbursement from the government according to an annually determined payment schedule. (The schedule incorporated regional variations in health care costs.) Congress turned to this system of grading to give hospitals an incentive to help hold down overall health care expenditures.
If expenses related to a given patient’s care exceeded the stipulated reimbursement amount, the health care provider would have to absorb the extra costs.\textsuperscript{14}

When billing Medicare for overhead or capital spending (i.e., indirect costs), health care organizations had to show that their expenses fell within a qualifying area related either directly to patient care or to overall facility management. Thus, costs related to corporate restructuring or advertising did not merit reimbursement; those related to general administration and “community outreach” received relatively low rates of reimbursement; and those constituting capital expenditures linked directly to patient care—such as the construction of new hospitals or the renovation of surgical theaters—received relatively higher levels of reimbursement. Between 1983 and 1997, there was one major exception to this scheme—outpatient services like home health care. To encourage reliance on these medical options, which most government officials and health sector analysts perceived as substantially less expensive than continued hospitalization, Congress maintained a cost-plus method of reimbursement for these services. In addition, if hospital networks included home health care, they could allocate some of their general administrative costs to the home health care side of the business, thereby increasing their recovery of indirect costs from Medicare.

Medicare coding and the determination of allowable overhead expenses have always been notoriously complex. In the 1980s and 1990s, Medicare regulations rivaled the tax code for ambiguity and convolution, while HCFA’s contracted fiscal intermediaries frequently offered conflicting advice as to how providers should interpret and apply the maze of rules that governed reimbursement policy. Medicare audits of hospital billing records (carried out by third parties under contract to HCFA) also sometimes disallowed or scaled back claims for payment, because of either billing errors or differences of interpretation. Adjustments, however, typically occurred years after initial payment from Medicare and generally brought no financial penalties or other sanctions. Recipients of excess payments simply had to refund the money to the government—without interest. Furthermore, as a result of budgetary pressures in the mid-1980s, Congress significantly reduced spending on enforcement of Medicare regulations.\textsuperscript{15}

The combination of ambiguous regulations, limited sanctions, and spotty enforcement created powerful incentives for Medicare payees to inflate reim-
bursement requests, because overshooting seemed to carry little risk. Like health care administrators throughout the nation, numerous executives at Columbia/HCA responded to those incentives, both at the company’s Nashville headquarters and at several of its hospitals and other care centers and agencies.

In Nashville, company executives carefully structured a number of acquisitions with the outer limits of Medicare rules in mind. When Columbia/HCA bought 22 home health care agencies from the Olsten Corporation in 1994, for example, it negotiated an arrangement whereby Olsten accepted a price well below market value in exchange for an understanding that Columbia/HCA would hire Olsten to manage the transferred home health agencies, as well as fifteen additional agencies, at a comparatively high rate. While Medicare regulations defined corporate buyouts as unrelated to patient care, and thus did not provide payments to offset costs associated with them, it did pay for a percentage of management expenses.16

Corporate headquarters similarly pressed at the boundaries of Medicare regulations in its approach to physician compensation. In 1991 and 1993, Congress enacted amendments to its budget reconciliation acts that prohibited physicians from receiving kickbacks for laboratory referrals or from owning equity stakes in medical businesses to which they referred patients. These two pieces of legislation—generally referred to as “Stark I” and “Stark II” after their chief sponsor, Congressman Pete Stark of California—sought to remove financial incentives from the referral process. Yet Stark II exempted hospitals from its provisions, largely because of fears that without investment from doctors, many rural hospitals would be unable to attract financing. Columbia/HCA used this “safe harbor” to its full advantage, setting up physician partnerships in dozens of local hospital networks that incorporated physician practices, laboratories, rehab centers, and home health care agencies. Since all of these facilities were part of a hospital network, Columbia/HCA argued that they fell within the “hospital” exemption. In the eyes of numerous critics, however, such arrangements gave doctors reason to send their profitable admissions to Columbia/HCA and their unprofitable admissions elsewhere.17

Outside of Nashville, managers at Columbia/HCA facilities pursued a range of strategies to increase Medicare reimbursements, taking to heart the company’s aggressive approach to business and their own responsibility for the financial performance of their health care centers. A number of hospitals rou-
tinely performed a battery of blood tests on patients, even when doctors had ordered fewer tests, or billed for a series of blood tests individually, rather than as a less remunerative bundle. When treating patients with conditions that might fit into more than one Medicare accounting box, several hospitals consistently billed for the highest-paying DRG. The company’s monthly newsletter encouraged such efforts in its “DRG of the Month” column, which advised staff how to structure treatment and coding so as to legitimate more expensive billing. In one such column, caregivers were advised that by calling in a nutritional consultant to document malnutrition in patients with bleeding ulcers, hospitals would be able to charge for DRG 154, bleeding ulcer with complications, rather than DRG 155, bleeding ulcer. With a reimbursement rate of over $16,000, DRG 154 commanded a payment roughly three times the payment for DRG 155.

Administrators also engaged in cost shifting. Some managers allocated hospital expenses to home health care facilities or treated debt payments as related to capital expenditures when they actually were used for general administration. Others submitted bills for administrative expenses resulting from non-reimbursable activities, such as running hospital gift shops or recruiting doctors. Columbia/HCA frequently charged Medicare for the salaries of individuals who had the job title of “home health care coordinator,” but whose work consisted of recruiting discharged hospital patients and whose compensation often varied with their success in such recruitment. Each of these schemes inflated the company’s claims on Medicare. In addition, many local and regional administrators set ambitious targets of as high as 85 percent for referrals of Columbia/HCA hospital patients to company-owned home health care agencies, despite federal requirements that hospitals give patients a wide choice of home health care providers. All of these practices eventually became the subject of federal investigations.

To cover the company in the event that auditors rejected or pared back questionable claims, Columbia/HCA’s accountants prepared two sets of cost reports. They forwarded to the government the reports that detailed charges for which the company’s managers hoped they would receive payment. The other reports reflected a more conservative accounting of what the government owed, and remained within company billing departments. Local executives also typically set money aside in a reserve account as a form of self-insurance
against disallowed claims, then booked the reserves as profits if auditors did not question them. But the company’s annual reports did not specify Medicare reserves, asserting only that the management “believes that adequate provision has been made in its financial statements for any material retroactive adjustments that might result from all of such audits.”

Columbia/HCA’s attempts to maximize reimbursement from Medicare and other government programs bore much in common with the approach taken by most health care providers, whether or not they were for-profit organizations. Since the rise of managed care began to crimp revenues from private insurers in the late 1980s, hospitals and other health care centers looked increasingly to squeeze every allowable dollar out of government health programs. By the early 1990s, a robust consulting industry had emerged to guide medical institutions in the ways of playing the reimbursement game, offering advice about coding strategies and overhead accounting techniques that would increase federal payments for services furnished by health care providers. In many cases, remuneration to those consultants was tied to increases in reimbursement revenues. Practices like “up-coding” and cost shifting became endemic. As one health care consultant noted early in 1997, “[e]very hospital does it, or they die.” Although industry officials knew that such activity violated legal and regulatory requirements, growing numbers considered it “akin to jaywalking.” Throughout the industry, health care businesses and institutions routinely produced alternate cost reports and set aside reserve funds to guard against rejected or slimmed down bills. By the early 1990s, the world of Medicare reimbursement came to resemble what legal theorists refer to as a “dual system,” in which the strategic behavior of individuals and organizations diverges markedly from the premises of relevant laws and regulations.

The Federal War on Health Care Fraud

The growth of health care jaywalking had a substantial impact on the federal budget. While payments from private insurers to hospitals increased by a modest annual rate of three percent in the early 1990s, Medicare inflation rose by three times as much and spending on home health care exploded, growing by 500 percent from 1990 to 1997, when it came to represent a full quarter of the
program’s disbursements to acute care centers and over eight percent of its total expenditures. In the midst of longstanding multibillion-dollar budget deficits, Medicare waste and abuse began to receive heightened attention in Washington, much as overbilling by defense contractors had emerged as a compelling issue in the 1980s. After winning the presidency in 1992, Bill Clinton identified fraud as a central contributor to spiraling health care costs and investigation of fraud as a key element of health care reform. The health care system, Clinton charged in his 1994 State of the Union Address, was “riddled with inefficiency, with waste, with fraud, and everybody knows it.” Following Clinton’s direction, the Department of Justice made fighting health care fraud its top priority in white-collar crime. Congress largely agreed with the new strategy, even after Republicans regained control of both houses of Congress in the 1994 midterm elections. In 1996 and 1997, Congress passed legislation that gave law enforcement officials their own incentives to pursue Medicare and Medicaid fraud; henceforward, a percentage of any settlement monies arising from fraud prosecutions would be used to fund future investigations in this area.  

Federal investigations into allegations of health care fraud, which grew steadily over the late 1980s and early 1990s, became even more common during the Clinton Administration. Most of the probes began when industry insiders filed lawsuits under the False Claims Act, legislation dating to the contracting scandals of the U.S. Civil War. The False Claims Act allows private citizens to sue on behalf of the government in instances where federal contractors have submitted fraudulent claims for payment. Successful suits result in triple damages, and if the government deems the evidence provided as having a crucial impact on the case’s outcome, whistleblowers can receive as much as 30 percent of any fines or settlement payments.  

As the number of probes mounted, several high-profile cases resulted in settlements that dwarfed payments resulting from earlier defense procurement cases, which totaled $385 million between 1986 and 1997. (Most of these payments resulted from voluntary disclosures by defense contractors.) Faced with allegations that its psychiatric hospitals had given kickbacks to referring physicians, admitted patients unnecessarily, and extended patient stays systematically until their insurance ran out, National Medical Enterprises (NME) accepted criminal and civil fines of nearly $400 million in 1994. In early 1997,
SmithKline Beecham paid $325 million to settle charges that it had overbilled Medicare and other government programs for medical tests and that it had offered physicians illegal inducements to steer business to its labs. Three years later, Fresenius Medical Care, a specialist provider of dialysis services, paid fines totaling nearly $500 million as a result of allegations that its employees conspired to overcharge Medicare and that it violated physician kickback statutes. Dozens of other laboratories and acute care providers—including prestigious academic medical centers, such as those run by the University of Pennsylvania and Georgetown University—coughed up lesser amounts for analogous violations. By the spring of 2000, the decade-long federal campaign against health care–related fraud had recovered more than $3 billion.

The Probe at Columbia/HCA

Columbia/HCA eventually confronted its own multipronged federal investigation. As early as 1993, its business practices began attracting attention at the Department of Justice, largely as a consequence of *qui tam* lawsuits filed by whistleblowers under the False Claims Act. When officials at Justice and other federal agencies began to take a closer look at the company, several aspects of its mode of operations made it an inviting target.

Columbia/HCA’s contentious business style drew increasing attention to itself. In a number of instances, the company’s takeover efforts spawned allegations that it offered unethical and, in some cases, illegal inducements to the executives charged with considering its offers. Managers at several Florida community hospitals, for example, contended that Richard Scott or other members of Columbia/HCA’s senior management promised them lucrative jobs if they agreed to sell to Columbia. In 1996, the company mounted a vigorous and ultimately unsuccessful campaign to enter the insurance business by attempting to buy Ohio’s Blue Cross Blue Shield. The conversion proposal, which included multimillion-dollar severance packages to the nonprofit’s directors, prompted accusations that Columbia/HCA, with the assistance of interested insiders, was seeking to purchase valuable community assets at below-market prices. Along with sharp criticism of the offered purchase price, the handsome golden parachutes—which several opponents labeled as “bribes”—
helped to scuttle the deal. In the same period, Columbia/HCA engaged in a series of running battles with the Service Employees International Union, which represented nurses at several of the company’s hospitals and was attempting to gain recognition at several others. In April 1997, a federal judge ruled that company officials, including chief operating officer Vandewater, had engaged in a variety of unfair labor practices, including reprisals against employees at a Louisville, Ky., hospital who had engaged in union activities. These incidents did nothing to earn the corporation goodwill from federal officials.

Furthermore, evidence provided by a series of Columbia/HCA whistleblowers raised serious questions about the company’s compliance with federal law. The discrepancy between the amount that some company hospitals charged Medicare and the amount listed on reserve cost reports were unusually large, often running into the millions of dollars, and those secondary reports often listed alternative charges item by item rather than setting aside a simple percentage as a reserve, which was the industry norm (Exhibit 5). Some years before being acquired by Columbia/HCA, one hospital in Fort Myers identified “nonpatient” overhead expenses only on its reserve cost reports, despite unambiguous federal rules limiting reimbursement to expenses related to medical diagnosis and treatment. At other facilities, Columbia/HCA managers or their corporate predecessors had issued directives “not to discuss the second reports with Medicare officials or to show them the documents,” though federal law required hospitals to disclose claims that stood a good chance of being rejected during an audit. In some cases, these actions followed the advice of outside auditors and consultants who advised local executives on strategies for augmenting government payments. To investigators, such evidence signaled not prudence in the face of confusing and ambiguous regulations, but rather awareness of impropriety and, hence, fraudulent intent to mislead the government. In Tampa, Fla., moreover, a former Columbia/HCA manager furnished government officials with documents that heightened scrutiny of the health care conglomerate. These documents pointed to a five-year scheme at one Columbia/HCA hospital to cover up an auditor’s error on a cost report, apparently in clear violation of the legal obligation to inform the government of such a mistake.

A consistently disdainful response to federal investigations on the part of Columbia/HCA executives intensified the determination of law enforcement offi-
Exhibit 5. Columbia/HCA’s use of reserve cost reports.

<table>
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<tr>
<th>THAT MUCH MORE?</th>
<th>THAT MUCH LESS?</th>
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<td><strong>The Government is investigating whether Columbia hospitals increased Federal reimbursement by shifting administrative costs onto their home-care agencies. In Florida, the typical Columbia agency reported far more of those cost in 1995 than rivals did, especially in the catchall “other” category, where unusual or questionable administrative charges are most readily assigned.</strong></td>
<td><strong>Investigators are examining whether Columbia failed to include certain costs in an accounting category known as nonreimbursable cost centers. Through a complex formula, decreasing the amount in this category can increase total reimbursement. In Texas, the typical Columbia hospital reported a much greater drop in this category of nonreimbursable expenses from 1992 to 1995 than other hospitals did.</strong></td>
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<td><strong>ALL ADMINISTRATIVE COSTS</strong>&lt;br&gt;As a percentage of total spending by home-care agencies</td>
<td><strong>NONREIMBURSABLE COST CENTERS</strong>&lt;br&gt;Change in the share of total spending by hospitals</td>
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<td><em>Columbia/HCA</em></td>
<td><em>Columbia/HCA</em></td>
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<tr>
<td>49.55%</td>
<td>-50.78%</td>
</tr>
<tr>
<td>Other for profit 34.57%</td>
<td>Other for profit -5.78%</td>
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<tr>
<td>Not for profit 30.25%</td>
<td>Not for profit -13.29%</td>
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<td>Government 36.02%</td>
<td>Government +0.09%</td>
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<td><strong>‘OTHER’ COSTS</strong>&lt;br&gt;As a percentage of total spending by home-care agencies</td>
<td>Figures are medians for hospitals of 100 beds or more.</td>
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<td><em>Columbia/HCA</em></td>
<td>Source: Computer analysis by The New York Times of cost reports filed by the Government</td>
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<td>Other for profit 8.37%</td>
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<td>Not for profit 7.13%</td>
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<td>Government 3.99%</td>
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cials to examine the company’s businesses in excruciating detail. Throughout
1995 and 1996, the company’s senior management simply refused to answer
requests for comment from officials of the Department of Health and Human
Services, who were conducting a civil probe of Columbia/HCA cost reports. In
March 1997, the government upped the ante, issuing criminal search warrants
at several company facilities in El Paso, as well as at the offices of more than a
dozen local physicians who owned interest in the local Columbia/HCA hospital
network. (The focus of this raid was on the possible use of financial incentives
to influence referral patterns.) In the wake of this episode, the company filed
motions in court to block the government’s access to reserve cost reports and
ordered billing offices throughout the company to stamp paperwork related to
Medicare billing as related to attorney-client privilege—and thus “confidential.” Richard Scott limited contacts with the government and repeatedly
downplayed the significance of the probe in the media. Faced with Colum-
bria/HCA’s intransigence, federal prosecutors convened grand juries, amassed
sufficient evidence to obtain criminal search warrants from several federal
judges, and planned the much wider July raids, which targeted documents re-
lating to all aspects of the company’s operations that were associated with gov-
ernment programs.

Seeds of a Management Shake-Up

Despite sizzling financial results between 1992 and the first half of 1997, Rick
Scott’s strategic vision and management style did not go unchallenged within
Columbia/HCA. Voices throughout the company’s far-flung facilities and
within corporate headquarters expressed reservations about company policies,
despite the propensity of senior management to marginalize or fire employees
who did so. Especially at previously nonprofit facilities, doctors and nurses
complained that staffing cuts had compromised patient care, airing their con-
cerns through such media outlets as 60 Minutes, PBS’s NewsHour, the New
England Journal of Medicine, and The Nation. Many hospital administrators
chafted at the goals set for surgical admissions or revenue growth at their insti-
tutions, finding annual scorecards of financial performance unseemly and the
harsh treatment of “underperforming” executives humiliating. After one de-
partment head at a Chicago hospital received a blunt censure for failing to cut
costs sufficiently in the summer of 1996, he commented that although he had spent substantial time in the “tough street environment” of the Chicago garment district, he had never before “witnessed such…demeaning, debasing, and devaluing behavior as I personally experienced on 29 August.” Some senior managers worried about the potential consequences of combining substantial performance bonuses for hospital executives with the substantial latitude that Columbia/HCA gave those executives in running their facilities. To John Leifer, a former senior vice president who resigned in 1995, this mix looked like “a prescription for disaster, because it can create tremendous pressure to make budget at times by inappropriate action.” Eventually, more than two dozen Columbia/HCA managerial employees took their concerns over reimbursement practices to the government, filing whistleblower lawsuits.27

Disquiet over aspects of Scott’s management of the company extended to its board of directors, where it centered around vice chairman Thomas Frist, Jr., the company’s largest shareholder. Frist had served as HCA’s chief executive officer before its merger with Columbia, had initiated the deal, and had anointed Scott as the person to lead the new company. A surgeon by training, Frist pioneered—along with his father, Thomas Frist, Sr.—the for-profit hospital business, launching the Hospital Corporation of America in 1968. In charge of acquisitions for the company in its early years, Frist oversaw rapid expansion in the 1970s. After serving for a time as chief operating officer in the 1980s, he took the company private in a 1989 leveraged buyout, rigorously pursuing a strategy of downsizing as a means of paying down debt. In 1992, Frist once again took the company public, but he soon faced pressure from J. P. Morgan, a major stockholder and lender, to increase the stock price to give it a means of liquidating much of its position.28 At more or less the same time, the Clinton health care initiative came out, which convinced Frist that his company required leadership with “a new energy level and enthusiasm,” as well as experience in setting up the kind of local health networks the Clinton plan advocated.29 He turned to Scott as the man to satisfy HCA’s bankers and to take advantage of health care reform. For years Frist had heard rave reviews of Scott from Richard Rainwater, a cofounder of Columbia and a major investor in HCA who had put up millions to help engineer the 1989 leveraged buyout. The speed with which Scott had gobbled up other private hospital companies
was impressive. As an outsider to the world of hospital management, he seemed poised to avoid the problems of clashing egos often created by mergers, and he artfully “spun a story” of a rationalized and “vertically integrated health care system.”

But Frist soon found himself opposing several of Scott’s enthusiastic ventures. Columbia/HCA’s branding campaign struck the vice chairman as misplaced. Having watched HCA struggle during the 1980s with ventures in health maintenance organizations, nursing homes, and health insurance, Frist viewed Scott’s forays outside the realm of acute care with skepticism. Although he considered physician investments in hospital networks to be legal, he thought them ill-advised. High turnover among midlevel managers who were pressured to hit double-digit revenue growth targets gave him pause, as did the growing enmity toward the company on the part of nonprofit hospital administrators and many public officials. Like John Leifer, Frist fretted over the company’s linkage of cash bonuses to hard-driving profit goals. In the fall of 1995, he widely distributed copies of a *Business Week* article on Bausch & Lomb that showed how unrealistic growth targets had encouraged managers to play fast and loose with their sales figures, with some developing internal black markets to give the appearance of achieving their allotted goals.

Beyond all of these concerns, Frist balked at Scott’s management team, which he viewed as a “rag tag crew,” and worried over Scott’s tendency to “freeze out” executives and directors who expressed dissent despite continual requests for wide-ranging input.

Doubts about Columbia/HCA’s direction, however, did not keep Frist from publicly supporting the company’s basic strategy and its leadership team through 1996. He embraced the commonly made comparison between Columbia/HCA and Wal-Mart, observing that his own family patronized the discount retailer, “since they have competitive prices and a very consistent level of quality.” He smoothed Scott’s entrance into the highest echelons of corporate America, introducing him to fellow executives and sponsoring his membership in the Business Council, an elite association of business leaders from the world’s largest privately owned companies. As late as the summer of 1996, Frist continued to serve as the company’s representative in negotiations with nonprofit organizations that it wished to purchase. In the summer of that year, for example, he agreed to lobby Ohio government officials as the company
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tried to gain approval for its buyout of the state’s Blue Cross Blue Shield, giving no indication of having misgivings.\textsuperscript{35}

Scott’s handling of the burgeoning investigations into Columbia/HCA, however, moved Frist to challenge Scott more forcefully. Frist was no stranger to attention from the federal government, having battled the Internal Revenue Service through much of the 1980s and early 1990s over the tax treatment of various corporate deals, and having previously faced scrutiny from various agencies over Medicare and Medicaid reimbursements. Those interactions had convinced Frist that antagonistic stances toward federal agencies often backfired. To Frist, Scott’s aggressive business tactics and defiance of federal authority were the equivalent of “raising up an antenna…and saying, ‘Lightning, strike me.’”\textsuperscript{36}

Lightning continued to strike Columbia/HCA throughout the first half of 1997. The March raids in El Paso sent the company’s stock down more than a quarter, spawned rumors of wide-ranging federal inquiries in a host of cities, and prompted numerous journalistic critiques of Scott’s empire. The \textit{New York Times} led the way with a series of hard-hitting articles throughout the spring. After analyzing data from millions of government billing records from Columbia/HCA facilities in Kentucky, Texas, and Florida, the \textit{Times} reported that Columbia/HCA hospitals billed for relatively expensive DRGs more commonly than other hospitals in the same communities and that the propensity for more expensive billing went up after the company acquired some hospitals; that its home health care agencies charged far greater amounts per patient than competitors, both as a result of higher fees and a greater number of visits per patient; and that after doctors bought equity interests in the company’s Florida hospitals, their referrals to Columbia/HCA went up and those to other local hospitals went down (Exhibit 6). The \textit{Times} also amplified charges that cost-cutting at the company had compromised patient care. Although the reporting on Columbia/HCA that appeared in the \textit{Times} and other media outlets noted that many of the company’s business practices were common among health care providers, the coverage adopted a critical tone. Rather than responding to these developments directly, senior executives at corporate headquarters redoubled their efforts with the national branding campaign and encouraged local care centers to publicize their contributions to local communities.\textsuperscript{37}
Exhibit 6. The influence on referral patterns.

THE OFFERINGS

In early 1993, Columbia offered an investment package to doctors at two Miami hospitals, Miami Heart Institute and Cedars Medical Center. A New York Times analysis found that a group of 62 doctors increased their admissions to the Columbia hospitals 13 percent over the next three years, while their admissions to other hospitals decreased 22 percent.

Admission figures are for Columbia’s Miami Heart Institute and Cedars Medical Center. They include admissions to Miami Beach Community Hospital, which merged with Miami Heart in 1993.

A stockholders’ meeting in mid-May solidified a public image of a company hunkered down behind barricades. Over a dozen reporters and several representatives of public advocacy groups came to the meeting, which was policed heavily by security guards who searched the belongings of everyone attending. Faced with critical questions about the ongoing federal investigations, many posed by representatives of nursing unions, Scott refused comment beyond noting that he was “as concerned about it as anybody,” that the company would address any wrongdoing brought to light by the probes, and that the government was then looking into the business practices of hundreds of health care providers.38

With Columbia/HCA becoming increasingly besieged in the first half of 1997, Thomas Frist began a series of maneuvers designed either to convince Scott to reposition the company or to force him from office. After the El Paso raid, Frist waited several weeks for Scott to respond meaningfully to the pressure being exerted by the federal government. After more than a month of corporate inaction, he wrote a long memo to Scott that praised his accomplishments but also pleaded for a more conservative set of business strategies and the adoption of a more cooperative posture toward ongoing federal probes. Abandoning Columbia/HCA’s “in your face” style, Frist argued, would remove the “fear factor” among the company’s critics, competitors, partners, and physicians. Allowing the company to “catch its breath” by concentrating on operations would lay a much stronger foundation for long-term growth than would ceaseless acquisitions. Changing strategic course, Frist counseled, meant “less risk” for Scott, “not only financially but also from a career standpoint.” Other directors echoed Frist’s sentiments in meetings with Scott through the spring. Anxious about the potential implications of the federal probe, the board set up a committee to assess growing allegations of illegal behavior.39

Scott brushed off these overtures, perhaps bolstered by a substantial recovery in Columbia/HCA stock, which regained two thirds of its post-March slide in the next three months. Although Scott approved the adoption in April of a companywide code of conduct and the establishment of an ethics hotline for employees to report problematic activity, he continued to predict that the government investigations would amount to nothing, while maintaining his focus on rapid expansion.40 In addition to moving ahead with plans to purchase a
money-losing, health-oriented cable television network and a $1 billion health benefits company, he launched serious discussions about purchasing dozens of hospitals in France.\(^{41}\)

Once Scott made clear that he had no intention of forsaking either his aggressive posture or his relentless pursuit of expansion, Frist began to solicit the opinions of the company’s directors, arguing that Scott had to go. His task in this regard was aided by the board’s makeup. As a result of the terms of Columbia’s deals with HCA and Healthtrust, four of the company’s nine other directors had close ties to the Frist family. (Along with his father and his brother William, a heart surgeon and U.S. senator, Frist held close to a five-percent stake in Columbia/HCA.)\(^{42}\) Frist had insisted on these arrangements, as well as the merged company’s eventually locating its headquarters in Nashville, to provide some “insurance” in the event that problems cropped up with Scott’s leadership. Scott strove to reshape the board’s membership during his tenure as chief executive officer, but had yet to dislodge a critical mass of Frist’s allies. The board’s movement against Scott gathered steam in early July after Clayton McWhorter, a Columbia/HCA director who had resigned as chairman the previous year, received disturbing intelligence from sources in the Department of Justice. According to McWhorter’s sources, if the company did not fire Scott and Vandewater and dramatically shift its stance toward the fraud investigation, the government would move to “bring the company down within ninety days.”\(^{43}\)

McWhorter’s inside information convinced Frist that the Columbia/HCA board had to force Scott out promptly, but substantial barriers stood in the way of a quick removal. With Columbia/HCA’s stock having recovered most of its losses in the four-month period following the El Paso raid, and with the financial markets generally taking a skeptical view of former chief executives perceived to be scheming against their successors, Frist and his allies on the board doubted they could muster a majority to compel Scott’s resignation. Immediately after learning of the federal government’s hostility toward the current management, therefore, Frist secured a meeting in California with Richard Rainwater and Darla Moore, Rainwater’s wife and a leading venture capitalist who had previously served as a Columbia director. Rainwater and Moore were two of the company’s largest individual stockholders and maintained close ties to Scott and other board members, though Scott had alienated Moore by limit-
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ing debate at board meetings and maneuvering to keep her off of the board’s compensation committee in 1996.\textsuperscript{44} The news of impending and potentially drastic government action against Columbia/HCA further weakened Rainwater’s and Moore’s commitment to Scott and prompted Moore to entertain the possibility of yet another blockbuster merger, this time with the nation’s second largest hospital company, Tenet.\textsuperscript{45} At the time, however, Rainwater counseled that without a significant public crisis, the board would be unlikely to move against a chief executive officer who had overseen such impressive growth in revenue, profits, and stock price.\textsuperscript{46}

The massive federal raids in mid-July and Scott’s dismissive public response dramatically shifted the board’s perceptions of its freedom of action. Interviewed on CNN’s \textit{Moneyline} on the night of the raids, Scott did not deviate from his earlier approach to Columbia/HCA’s legal difficulties. “It is not a fun day,” Scott remarked, “but as you know, government investigations are a matter of fact today in health care…. [T]he American Hospital Association came out last week and said that they believe 4700 hospitals in America are under or will be under investigation.” Scott’s performance convinced a majority of Columbia/HCA directors that change at the top was imperative. After being informed of the board’s insistence on managerial change, Scott suggested the contracting out of government and media relations, while he would retain operational control of the corporation. The board rejected this proposal and for the next few days seriously explored the option of a Tenet merger.\textsuperscript{47}

Columbia/HCA’s interest in Tenet reflected in part the considerations that drove earlier acquisitions of large for-profit chains—the opportunity to increase market power in particular markets and to lower overhead costs. The two companies had briefly considered a merger in 1996 at Scott’s initiative. But in the context of Columbia/HCA’s legal problems, the most compelling attraction in July 1997 was the presumed reputation of Tenet’s chief executive officer, Jeffrey Barbakow. Barbakow had taken over NME, as Tenet was then called, in the spring of 1993 as it confronted its own legal and financial crisis. At the time, NME faced longstanding charges of Medicare fraud and fraudulent billing of insurance companies, as well as a slew of false imprisonment suits by former patients of its psychiatric hospitals and a stock price that had fallen more than two-thirds in two years. The previous corporate leadership under chief executive officer and company founder Richard Eamer had downplayed
pending criminal investigations, assuming that NME’s supercharged financial performance would insulate it from negative publicity, much as Scott was later to do.  

After FBI raids on several NME hospitals in August 1993, Barbakow moved quickly and successfully to settle with both the federal government and insurance companies, admitting liability and agreeing to pay a total of almost $600 million. After implementing a new bureaucracy to oversee compliance with federal regulations in billing, Barbakow spent months meeting with and regaining the trust of insurers and doctors. He then sold off the psychiatric hospitals and rehabilitation centers that had caused the bulk of the company’s legal problems, as well as several overseas hospitals, leaving a core of over 30 general, acute care hospitals in the United States. In October 1994, he engineered a merger with American Medical Holdings, adding another 51 hospitals and consolidating NME’s position in several Florida and California markets. To distance the company from its tainted past, Barbakow changed its name to Tenet, hoping to foster a commercial reputation for adherence to ethical standards. By July 1997, his company’s stock had appreciated almost 500 percent from its low a few months before he took over, and Barbakow had received glowing profiles in newspapers and business periodicals stressing his credentials as a savvy negotiator and a man of principle.

Intense merger negotiations between Columbia/HCA and Tenet occurred in the days following the raids of July 16 and especially on July 23 and 24. (Preliminary talks had begun in early July, before the raids, as the Columbia/HCA board saw a merger even then as one mechanism for replacing Scott.) At one point, the two sides tentatively agreed on a deal that called for Tenet to acquire its much larger competitor, Tenet’s stockholders to receive a minority of shares in the merged company, and Tenet’s managers to gain control, with the understanding that corporate headquarters would remain in Nashville. Barbakow, Columbia/HCA directors hoped, would inspire greater confidence in the company among investors, government officials, and the general public. But after receiving a briefing from federal officials on the probe into Columbia/HCA and recognizing that eventual fines and penalties might reach well beyond $1 billion, Barbakow tried to drive a harder bargain, alienating several Columbia/HCA directors, including Frist. As the likelihood of a Tenet merger receded, the board concluded negotiations with Scott over the terms of his
dismissal, settling on a severance package and five-year consulting contract worth over $17 million, with the proviso that Scott could hold onto stock and stock options worth over $250 million. (Chief operating officer Vandewater accompanied Scott out the door, receiving a lesser but still generous payout.) On July 25, the board named Frist as the new chief executive officer and chairman.⁵²

Questions for Discussion

1. What were the key contributing factors to the deepening crisis that beset Columbia/HCA in 1997, culminating in the federal government's July raids?

2. What led Richard Scott to minimize the threat that federal investigations posed to his company and his career?

3. Place yourself in the position of a strategic adviser to Thomas Frist as he took over as chief executive officer of Columbia/HCA. What should his first actions be? What priorities would you suggest that he set for the first six months in his new role, and what kinds of information would you recommend that he seek out before making his decision?

4. What stance should business executives adopt in relation to “dual systems,” in which formal legal requirements and actual behavior diverge? How should managers go about assessing the risk that government officials might change their approach to the enforcement of previously ignored legal standards for business practices?

5. Did Thomas Frist “do the right things” by confining his criticism of Columbia/HCA’s direction under Richard Scott to internal company discussions, and by continuing to “support the team” in public? Should the Columbia/HCA board have moved more vigorously after the March 1997 raid in El Paso?

Notes

This case study was prepared in collaboration with Kevin A. Schulman as a basis for class discussion, rather than to illustrate either effective or ineffective handling of an administrative situation. The case is based on research in public sources and on interviews conducted on April 19 and May 25, 2001, with senior executives of HCA–The Healthcare Company. The interviews concerned the challenges confronting Columbia/HCA in the summer of 1997 and the company’s responses to those challenges over the following four years. This research was approved by the
University Review Committee on the Use of Human Subjects in Non-Medical Research at Duke University, Durham, North Carolina.


Although Securities and Exchange Commission regulations require that public companies disclose terms of sale, nonprofit institutions are under no such obligation. The company also operated more than 20 care centers in joint ventures with nonprofit organizations.


4 Anthony Bianco, Nicole Harris, and Stephanie Anderson, “Can Dr. Frist Cure This Patient?” Business Week, 17 November 1997, 74–6.


13 Reinhardt, 31.

    At the insistence of the insurance, hospital, and physician lobbies, Congress structured Medicare in the 1960s as a cost-plus reimbursement system, a factor that many legislators viewed as a key contributor to spiraling Medicare expenditures in the late 1970s and early 1980s.


    One should keep in mind, as Princeton health economist Uwe Reinhard has observed (op. cit.), that this regulatory complexity resulted in large part from continual Congressional tinkering prompted by lobbying from representatives of the health care industry.


    Federal prosecutors eventually alleged that, before the merger of Columbia and HCA, HCA charged Medicare improperly for nonreimbursable interest costs associated with the spin-off of Healthtrust in 1987, and that the merged company did the same thing when re-acquiring Healthtrust in 1995.


    Rick Scott scoffed at such criticism, contending that doctors with equity stakes in Columbia/HCA hospitals would be more likely to bring in uninsured patients, since doing so would be more convenient than traveling to a competing health care center.


The connections between the defense procurement scandals and instances of health care fraud went far beyond historical similarity. Most of the key federal investigators of health care fraud had cut their teeth during the defense procurement scandals.


For a comprehensive overview of how the False Claims Act works, see the Web site of Phillips and Cohen, a leading law firm in this arena and counsel to several Columbia/HCA whistleblowers (http://www.phillipsandcohen.com/).


Note that the $3 billion recovered through fraud prosecutions represented 0.1 percent of federal spending on health care during the 1990s.


30 Frist, interview.


Note that while Frist led HCA after its 1989 leveraged buyout, he also instituted managerial bonuses linked to the meeting of profit targets.

32 Frist, interview.


34 Frist, interview.


36 Lagnado et al., “‘Out of the Loop’”; Japsen, “Rise and Fall.”


40 Lagnado, “What He Knew”; Japsen, “Rise and Fall.”

41 Frist, interview.


43 Frist, interview.

44 Ibid.


46 Frist, interview.


Robert Waterman (senior vice president and general counsel, HCA–The Healthcare Company) and Bruce Moore (senior vice president, HCA–The Healthcare Company), interviews by author, Nashville, Tenn., 19 April 2001.

Sharpe, “Frist Takes Control”; Bianco et al., “Can Dr. Frist Cure This Patient?”
Scenes From a Corporate Makeover:  
*Health Care Fraud and the Refashioning of Columbia/HCA, 1992–2001*

**Edward J. Balleisen**

Part Two of Four:  
Crisis Management and Corporate Reorganization
About the Author

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In taking the reins of Columbia/HCA in July 1997, Thomas Frist confronted a daunting set of interrelated threats, not only to the company’s profitability, but also to its long-term viability. The greatest danger lay in the accelerating federal investigation of the company’s practices in claiming reimbursements from government medical benefit programs. Within a week of Richard Scott’s departure as chief executive officer, a grand jury in Tampa, Fla., handed down indictments against three Columbia/HCA administrators implicated in an alleged conspiracy to conceal an auditor’s error in the allocation of expenses on a Medicare cost report. Although these indictments covered only the three executives as individuals, they raised the specter of criminal prosecution against the company itself. Under a 1996 federal law, any conviction of the parent company for Medicare or Medicaid fraud would bar it from participation in those programs for a period of five years. Since reimbursements from these programs accounted for nearly half of Columbia/HCA’s revenues, such a penalty would have constituted a corporate death sentence.¹

¹ Health Sector Management Program (HSM-2003-02)
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Company executives had reason to believe that such a drastic outcome was unlikely, because it would entail the politically unappetizing consequence of shutting down one in every 14 hospitals in the United States. But it remained a distinct possibility, as did additional raids and indictments of Columbia/HCA executives, which might only heighten growing uncertainty about the company’s prospects. In the aftermath of the July indictments, moreover, the government suspended the processing of hundreds of Medicare cost reports—some dating as far back as 1994—citing the ongoing probes. The government’s action cut off millions of dollars from the company’s cash flow. If the Department of Justice ordered a more far-reaching suspension from participation in Medicare and Medicaid, Columbia/HCA executives might be forced into bankruptcy in months. The government, recalled later general counsel Robert Waterman, was threatening “to throw [the company] over a cliff.” At the same time, several private insurers responded to the burgeoning investigation by inspecting bills from Columbia/HCA care centers more closely, further slowing collections. In these circumstances, Frist’s highest priority was “to make peace”—or at least to gain a truce—with the federal officials whom Rick Scott had so assiduously alienated.

Scott’s removal from power represented the first step in Frist’s efforts, “a sacrifice to the Gods” that law enforcement officials and the financial markets generally expect of corporations facing serious allegations of criminal wrongdoing. Companies making such moves—such as Salomon Brothers after its 1991 Treasury auction scandal or National Medical Enterprises in 1993—often turn to an outside director with a reputation for rectitude. Salomon Brothers turned to the highly regarded investor Warren Buffet as a short-term caretaker; NME tapped Jeffrey Barbakow, a respected lawyer with experience in investment banking who had served a short and successful stint as the head of MGM Studios. Frist, as former Columbia/HCA vice chairman and chief executive officer of HCA, faced greater skepticism than did Buffet or Barbakow with regard to both his commitment to overhauling suspect business practices and his ability to negotiate effectively with government investigators. Most press accounts of Columbia/HCA’s management shake-up questioned the extent to which Frist had been “out of the loop” in his role as vice chairman; they also discussed older controversies over tax filings and reimbursement policies at HCA prior to its merger with Columbia.
Frist responded to these questions in several interviews with journalists, in which he stressed his role as an increasingly disaffected and peripheral internal critic of Scott’s management. As a board member and someone who tried to serve as Scott’s mentor, Frist insisted that he expressed his concerns but then “support[ed] the team” once Scott set firm policy. Until the government confronted the company with allegations of illegal activities, Frist maintained that it would have been inappropriate for him, as a “former CEO,” to have publicly “second-guess[ed]…somebody who never missed a quarter.” Frist further recounted his loss of influence over corporate decision making, which only intensified after he sent Scott the April 1997 memo that recommended drastic changes in company policy. The scrutiny of his past role as a publicly visible vice chairman of the board, however, made him even more mindful of the need to confirm his credentials as an agent of reform.8

Frist wasted little time charting new directions for Columbia/HCA. In his first public statements as chief executive officer, he announced that the company would give the authorities broad access to its records and pursue its own investigations into allegations of improper or illegal conduct. The investigations would be conducted by outside auditors and legal counsel with carte blanche to examine the company’s business practices. “I have to send a very strong message to Washington,” he declared on July 25, “that the new CEO of this company…understands the gravity of the situation.”9 Consciously emulating Warren Buffett’s stint as interim chair of Salomon Brothers during the Treasury auction scandal, Frist agreed to serve as chief executive officer for a salary of $1 per year.10 He further promised to put an end to investment relationships with physicians, postpone several pending acquisitions, scrap plans to build new hospitals and halt efforts to buy hospitals in the face of sustained community opposition, sell the company’s troubled home health care division (the locus of many fraud allegations), and consider other wide-ranging sales of assets.11

On August 7, less than two weeks after Scott’s firing, the company produced a twelve-point action plan that further outlined the company’s new course. In addition to restating the policy changes that Frist announced in July, the document pledged to abolish incentive-based pay for managerial staff; to effect a “total change in the culture of the company, including elimination of ‘scorecards’ and short-term profit orientation”; to abandon the national branding
campaign in favor of an emphasis on community-based service; and to implement a comprehensive program to ensure compliance with all laws and regulations. The new approach to compliance would entail multiple reviews of Medicare coding and full disclosure of reserve cost reports to the government. Finally, Frist vowed to present a new strategic blueprint for the company within 100 days. Frist was able to offer such a detailed set of policy changes so quickly because he had conceptualized most of them in the spring while developing the alternative strategic plan that he presented to Richard Scott in his April 22 memo (see Appendix).

Frist’s moves were designed in part to gain some breathing room for Columbia/HCA from federal prosecutors—to restrain the “hawks” in the Department of Justice who believed that Columbia/HCA should be brought to its knees. Frist and his legal advisers also realized that they themselves did not know, given the decentralized structure of the organization, about many of the detailed allegations emerging about the company’s business practices. Absent such knowledge, the company would be at a great disadvantage both in molding public debate and in dealing directly with the government’s prosecutors.

Senior management further hoped to shape the context of eventual settlement negotiations with the government, since Justice officials tended to accept abridged fines and penalties from corporations that cooperated with investigators and vigorously redressed the causes of criminal wrongdoing.

The rapid disavowal of so many aspects of Scott’s business philosophy had still other purposes beyond easing Columbia/HCA’s legal difficulties. Even if the government agreed to apply somewhat less pressure, Frist worried greatly about the damage that the burgeoning fraud investigation might cause to relationships with patients, employees, insurers, investors, and creditors. The impact of the company’s unprecedented marketing campaign heightened those concerns. Ironically, the company discovered the full success of this campaign only once the fraud scandal was in full swing. Heightened name recognition created by the advertising and sponsorships meant that news reports of the fraud investigation left particularly strong negative impressions among the general public. Staff at all levels of the company began reporting unnerving encounters away from work, in which friends, acquaintances, and strangers voiced the opinion that Columbia/HCA had defrauded taxpayers. Patient admissions fell off enough that Columbia/HCA registered a small decline for the
first time in the company’s history. Concerned about this development, and fearful that previously loyal physicians might be referring their patients to competing hospitals, Standard & Poor’s placed the company’s commercial paper on a credit watch.\(^\text{16}\)

At the same time, tens of thousands of employees shaken by the government raids and critical press coverage began circulating rumors of problems at the company, while investment analysts fretted over the uncertainty surrounding the federal probes and Columbia/HCA’s business plans. Insurance companies simultaneously began raising their own suspicions about billing fraud, and the managers of several large pension funds signaled their anger by filing suit against Scott, former chief operating officer David Vandewater, the board of directors, and the three indicted Columbia/HCA executives, alleging breach of their fiduciary obligation to keep the company’s operations within legal bounds. Meanwhile, the Service Employees International Union stepped up criticism of the company’s labor policies.\(^\text{17}\) Visions of plummeting hospital admissions, heightened labor conflict, dramatic employee turnover, disaffected doctors, and lost confidence on the part of insurers, creditors, and the investment community occupied the minds of Columbia/HCA executives as they crafted their approach to crisis management.\(^\text{18}\)

The challenge, as Frist articulated repeatedly both within corporate headquarters and in increasingly frequent public remarks, was to rebuild public confidence in Columbia/HCA’s management and to refashion its business style. To those ends, Frist presided over sweeping personnel changes at headquarters and called on several outside consultants. On August 4, Frist asked longtime associate Jack Bovender to serve as president and chief operating officer. A veteran executive at HCA and longtime Frist protégé, Bovender had resigned after the 1993 merger with Columbia to tend to family matters. In the following weeks, Frist fired several people in leading positions who had formerly been allied with Scott, replacing them primarily with individuals who had worked for Frist at HCA. By the end of August, eight of the highest-ranking senior managers had been replaced (Exhibit 1). Frist’s old hands worked alongside outside experts brought in to assist with crisis management and corporate reorganization—communications specialists from the public relations firm Burson-Marsteller, including Jana Joustra, who would eventually become vice president for communications; forensic auditors from Deloitte & Touche; legal
Columbia’s Housecleaning: A Scorecard

The scandal surrounding Columbia/HCA, the nation’s largest health care company has led to wholesale changes in the company’s management structure, leaving few of the most senior executives unscathed. Here is a look at the top corporate management ranks as they were in July and the executives who have departed since then.

**Top Echelon of Executives**

- **Richard L. Scott**
  - Chairman and chief executive

**Operations Executives**

- **David T. Vandewater**
  - President and chief operating officer
- **Steven T. Braun**
  - Senior vice president and general counsel
- **Samuel A. Greco**
  - Senior vice president for operations finance
- **Jamie E. Hopping**
  - President of the western region
- **Five other executives heading departments like sales and physician services**
- **Five other regional presidents**

**Executives Reporting Directly to the Chairman**

- **Robert Stearns**
  - Chief financial officer
- **Kenneth C. Donahey**
  - Senior vice president and controller
- **Lindy B. Richardson**
  - Sr. v.p. for marketing and public affairs
- **Neill D. Hemphill**
  - Senior vice president for human resources
- **David G. Anderson**
  - Vice president for finance and treasurer
- **Richard E. Chapman**
  - Senior vice president for information systems
- **W. Leon Drennan**
  - Senior vice president
- **Victor L. Campbell**
  - Senior vice president
- **Herbert Y. Wong**
  - Senior vice president
- **David L. Manning**
  - Senior vice president

Top executives of Columbia/HCA as of July who...

- Have since resigned or said they will resign
- Are still with the company

Source: Columbia/HCA
counsel from Latham and Watkins, including Robert Waterman, who would become a senior vice president and general counsel; and experts in corporate reorganization from Goldman Sachs and Arthur Andersen. Frist had relied on each of these firms while he was chief executive officer of HCA.

The new management team needed to develop a strategic plan and corporate mission statement, implement a public relations offensive to repair Columbia/HCA’s damaged reputation among key constituencies, devise a negotiating strategy with the government, and oversee internal assessments of compliance with federal and state laws. And the team had to do all of these things quickly and simultaneously. In the words of then outside legal counsel Waterman, “we had to play speed chess.”

**Downsizing**

As internal reviews of Columbia/HCA proceeded through the summer of 1997, a consensus emerged at Nashville headquarters that the company’s rapid growth had contributed significantly to its legal woes, while creating additional problems that threatened long-term profitability. For years, the company enjoyed a reputation as a “hyper-efficient juggernaut,” in part because of extremely effective salesmanship by Scott, Richard Rainwater, and the company’s public relations team. The image that they repeatedly sketched—and that the financial press often reiterated—was one of a large hospital chain predicated on volume-related efficiencies in concentrated markets. “The day has come,” Rainwater insisted, when “somebody has to do in the hospital business what McDonald’s has done in the fast food business and what Wal-Mart has done in the retailing business.” Company spokespersons rarely missed an opportunity to crow about their successes in achieving this goal. In assuring the *Wall Street Journal* that Columbia/HCA had not “overreached” in the mid-1990s, Victor Campbell, senior vice president for investor relations,

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boasted that the company’s financial results had proved that it could success fully “‘meld’ corporate cultures and ‘manage them without missing a beat.’”

David Manning, a senior vice president for governmental relations, similarly proclaimed that “Columbia is bringing an efficiency to the market in hospitals that can never be gained by an organization that does not seek to fully integrate the health system. We are well ahead of everyone else in getting our costs under control.”

But in the summer of 1997, Frist’s senior managers and outside consultants came to view the health care giant less as a successful emulator of Sam Walton’s centrally controlled enterprise and more as “a corporate roll-up” characterized by “dramatically different business cultures and infrastructures” and “a lot of chaos.” To Bovender, Columbia/HCA had become an “operational monstrosity” of “five companies jammed together,” in which managerial “best practices” from the various corporate cultures had been “blown out” and in which “everyone was doing their own thing.” As early as August 1997, Frist began to suggest publicly that “the government did us a favor” by initiating its fraud investigation, because it had prompted a management shake-up and staved off the possibility that the company “would…come down under its own weight.”

During Scott’s tenure, senior management often focused so resolutely on expansion through deal-making that it neglected the more mundane tasks of integrating the various systems and cultures that made up Columbia/HCA, preferring to delegate considerable authority to regional divisions and individual care centers. As a result, company operations lacked consistency, especially in how they approached reimbursement from public medical programs. Thus, while one hospital in El Paso systematically billed for complete blood counts regardless of doctors’ orders—one of the practices that attracted the critical attention of regulators and investigators—another hospital across town did not. And nowhere in the company did managers give systematic consideration to Columbia/HCA’s potential vulnerability to governmental investigation.

Throughout Columbia/HCA, moreover, outside accountants, lawyers, and newly appointed senior executives discovered corporate divisions and local facilities that struggled to assess costs or revenue streams accurately. The legal department in Nashville had no idea how much it had spent to respond to fed-
eral probes from 1995 through the middle of 1997. Many regional offices had not rigorously analyzed the cost implications of proposed contracts with local health maintenance organizations, or of local decisions about the size of reserves to cover managed care contracts, or of most of the 700 physician practices the company had acquired. As a result, the company increasingly accepted patients on nonremunerative terms, especially when local executives signed deals and drew down financial reserves to “max out their bonuses.”

The balance sheets of company-owned physician practices were riddled with mistakes, which after netting out required an accounting charge of $25 million. Prior to joining the company after the shake-up to head managed care operations, Scott Mercy thought Columbia/HCA “had it together on managed care better than anybody.” After analyzing its managed care business and calculating that the company needed to set aside as much as $100 million to cover likely liabilities, Mercy commented that “it blew me away just how bad it was.” Perhaps most worrying, many billing departments faced significant problems, including poor software and frequent staff turnover that led to unacceptable error rates in the charging of managed care companies.

For all of Columbia/HCA’s cost-cutting initiatives and reengineering of health care delivery, and for all its meticulously maintained scorecards of hospital admission trends and revenue targets, Mercy’s sentiments suggest that Columbia/HCA’s day-to-day operations had fallen short of the claims the company had trumpeted for years. Internal reviews reinforced Frist’s inclination to move away from a business model predicated on vertical integration. So too did the company’s financial results for the third quarter of 1997: revenue remained flat and net income fell by more than two thirds, the result of declining admissions related to bad publicity, costs incurred in the response to the federal probe, and a growing number of unprofitable managed care contracts. Together with concern about the outcome of the Medicare fraud inquiries, the third-quarter results put pressure on the company’s stock price, which fluctuated between $27 and $31 per share throughout the autumn, roughly a 33 percent drop from its highs early in the year.

In this environment, Frist and Bovender resolved to simplify the company’s holdings by looking to the original focus of HCA—acute care centers in the suburbs of large cities with fast-growing populations. (Frist had previously overseen a similar process at HCA after its leveraged buyout in 1989.) They
did so in the face of both internal and external opposition. Some in senior management argued that Scott’s vision of an integrated “continuum of care” continued to have substantial merit. Outside headquarters, investment bankers sent out a barrage of offers to structure a new leveraged buyout, while several large shareholders persisted in advocating a merger with Tenet. Viewing a leveraged buyout as too costly, and the other options as ill-suited to addressing the company’s operational deficiencies, Frist and Bovender set about returning Columbia/HCA to a more manageable size.

The two executives began by abandoning $750 million worth of planned acquisitions and construction projects and by charging the Goldman Sachs consultants to distinguish between Columbia/HCA’s core and peripheral holdings. Goldman Sachs recommended that the company shed not only its home health care agencies, recently acquired pharmacy benefits management unit, and cable television health venture, but also all of its rural hospitals, as well as scores of hospitals and surgery centers in urban areas where the company lacked strong market position or had encountered substantial local criticism, such as Louisville and Chicago. This advice established the basic parameters of a restructuring plan that Frist and Bovender laid out publicly on November 17, 1997. Columbia/HCA would split its hospitals into five new groups, three of which included non-core assets that would be spun off to shareholders. The home health care agencies, which struck Frist increasingly as “very difficult to monitor and control,” would be put up for sale, ideally as a block. The pharmacy benefits management unit would be sold in pieces. In addition, the company would halve the number of corporate divisions to 18, with attendant reductions in administrative staffing.

Carrying out the sales and divestitures proved more difficult than Frist and Bovender had anticipated. Although several companies expressed interest in the health care unit, Columbia/HCA negotiators faced complications in arriving at an acceptable valuation. Congressional action in 1997 to cut Medicare reimbursement levels affected the entire home health care industry, dimming market sentiment about the sector. Columbia/HCA’s agencies also experienced slower revenue growth as a result of modifications in recruitment strategies and negative publicity stemming from the federal probes. The developments created uncertainty regarding the agencies’ value. In the end, to find willing buyers, Frist and Bovender had to slash the original asking price of over $1 billion.
by more than $450 million and market their agencies in geographically defined blocks.\textsuperscript{38} Other restructuring transactions were slowed by ongoing internal investigations and negotiations with the federal government, which took up as much as one fifth of senior executives’ time during the first quarter of 1998 and prompted concerns over the valuation of other Columbia/HCA assets.\textsuperscript{39} Furthermore, the spin-offs of hospital groups required clearance from regulatory agencies and the Internal Revenue Service, which signaled concerns about granting tax-free status to all three planned divestitures to stockholders. In light of these reservations, senior management decided to forego one of the spin-offs, opting for individual hospital sales instead.\textsuperscript{40}

Eventually, however, the company completed a wide range of asset sales and two large spin-offs. By the close of 1998, Columbia/HCA had successfully unloaded the various segments of its home health care division, three of four units in its pharmacy benefits management division, more than 30 surgery centers, and nearly 50 hospitals. The latter were located mostly in large cities where the company had struggled to find its feet, and they were bought primarily by nonprofit hospital networks. Senior executives also backed out of several agreements to operate care centers in joint ventures with nonprofits and set up independent management frameworks for the two hospital groups slated for divestiture to shareholders. Sale of an additional 24 hospitals occurred in the following year, again mostly to nonprofits. And in the spring of 1999, Columbia/HCA successfully completed the two spin-offs. The newly created LifePoint Hospitals took charge of 38 hospitals and 15 surgery centers in mostly smaller urban markets, while Triad Hospitals took on 23 rural hospitals. After selling a final group of care centers in 2000, Columbia/HCA was left with fewer than 200 hospitals and 80 surgical centers clustered in large metropolitan areas in 22 states, along with a handful of hospitals in the United Kingdom and Switzerland (Exhibit 2).\textsuperscript{41}

A Burnished Public Image

Columbia/HCA’s new approach to public relations mirrored its downsizing campaign. In August 1997, Frist informed the company’s facilities that they

<table>
<thead>
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<th>Year</th>
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| 1998 | • Sale of 41 hospitals, and lease of 2 hospitals  
      • Sale of 33 ambulatory surgery centers  
      • Sale of 19 home health care operations  
      • Sale of 2 health services management companies |
| 1999 | • Sale of 3 hospitals  
      • Spin-off of 2 hospital management companies |
| 2000 | • Sale of 116 medical office buildings |

* Based on press releases available in the “Investor Relations” section of the HCA Web site (http://www.hcahealthcare.com/).

were no longer obligated to carry the Columbia/HCA name, because the new management wished to emphasize the local character of health care. Frist simultaneously abandoned the company’s national branding campaign, canceling its contract with the Martin Advertising Agency to create television, magazine, and newspaper spots for national audiences.42 In a matter of months, the marketing department at Nashville headquarters shrank from 60 positions to eight.43 During the same period, the company shed dozens of lobbyists at both the state and federal levels, halted its opposition to state regulation of new hospital construction, and sought to forge more cooperative relationships with nonprofit care centers. Together with the cancellation of several controversial planned hospital acquisitions and building projects and the withdrawal of several pending lawsuits against competitors, the actions lowered Columbia/HCA’s national profile. “The days when Columbia/HCA was seen as adversarial or in your face,” Frist resolved in early November 1997, “[are] a thing of the past.”44

At the same time, however, the company’s trimmed public relations squad, led by consultant and later communications head Jana Joustra, worked feverishly to shape perceptions of Columbia/HCA. According to Joustra, the public relations department under Richard Scott had essentially placed a “gag order”
on the company’s executives. The resulting “communications vacuum” facil-
ticated the circulation of rumors throughout the company, gave “union organizers
an opportunity to be heard” by hospital employees, and worsened tensions with
the news media. Drawing on previous experiences as a crisis management con-
sultant for Philip Morris, Lloyd’s of London, and Bausch & Lomb, Joustra
sought to fill the vacuum through greater engagement with the press and de-
velopment of coordinated messages from corporate headquarters. She con-
vened daily meetings of senior management to set media strategy, integrating it
with the actions of the company’s various departments, especially its legal de-
partment. Even after Frist and Bovender had assumed their new positions,
Joustra recalls, “everyone was doing things without sufficient orchestration.”
Daily conferences in a communications “war room” allowed the company to
respond quickly and with one voice to the unfolding fraud investigations.45
Throughout the latter half of 1997, participants in those sessions sought to in-
fluence daily news cycles in the hope of slowly repairing Columbia/HCA’s bat-
tered reputation. “Like actors reading their reviews,” one reporter observed at
the time, “the public relations team [began] its morning scouring everything
that had been written that day about Columbia and the investigation, with an
eye toward what angle reporters might take in the future.”46 Public relations,
Joustra argued, had to be seen by every manager as “a necessary aspect of eve-
rything a hospital company does.” Equally important, Joustra’s team asked for
and received substantial latitude in matters of tactics, such as how to frame
messages and what outlets to use in disseminating them.47
The key principle driving the public relations offensive was to focus on the
company’s present and future and to downplay its past. Press releases and pub-
lic comments stressed the actions taken by Frist and his management team to
distance Columbia/HCA from its previous business practices and legal strat-
egies. Throughout the second half of 1997 and the first half of 1998, spokesper-
sons highlighted the company’s extensive cooperation with federal law
enforcement, its adoption of a new mission statement—which committed
Columbia/HCA to putting patient care and integrity in business dealings ahead
of profit making—and its ethics and compliance initiative to ensure that
employees operated within the confines of legal and ethical boundaries (see
case HSM-2002-03). Instead of touting ambitious growth targets and plans for
expansion, representatives cautioned that the company had a great deal of
costly and time-consuming restructuring to accomplish, which would place a
and time-consuming restructuring to accomplish, which would place a significant drag on short-term financial performance. Also, whenever possible, the company sought to undercut the significance of developments in the federal government’s investigations, characterizing them as rehashed allegations or findings and emphasizing that Columbia/HCA was working hard to resolve all outstanding issues with investigators and prosecutors.48

The company also systematically disentangled the public relations efforts of corporate headquarters and those of its local operations. Frist, Bovender, Joustra, and other senior managers extended the principles implicated in their rejection of the national branding campaign, their willingness to allow local hospital networks to drop the Columbia/HCA name, and their preference for highlighting the local nature of medical care provided by the company’s far-flung facilities. From the late summer of 1997 onward, Nashville provided all comment on the ongoing federal investigation and the company’s comprehensive ethics and compliance campaign. But it generally stayed clear of “local news”—whether a glowing account of charity care at a Columbia/HCA hospital or coverage of a lawsuit alleging malpractice at another of its facilities—leaving such issues in the hands of local executives. (Under Scott, headquarters often appropriated human interest stories from its local operations as a means of buttressing the Columbia/HCA brand.) The bifurcation of communications strategy attempted to underscore the quasi-independent identity of the company’s local care centers.49

Another facet of the new public relations offensive targeted Columbia/HCA employees. With so many restructuring possibilities being floated in the year after the management shake-up, many of which entailed the sale of hospitals or other businesses, workers wondered not only about the outcome of the federal probe, but also about their future with Columbia/HCA. To quiet the internal rumor mill and limit the extent to which the fraud probe and the restructuring process distracted employees from their jobs, Joustra instituted a “Fact Sheet” that regularly circulated throughout the company, as well as a weekly e-mail forum for posing questions to senior management.50 Within weeks of becoming chief executive officer, Frist took to the road, visiting hospitals to involve local administrators and employees in the company’s reconstruction and to send a signal that senior management valued the contributions of its local executives and employees. When Frist announced the broad outlines of the company’s
restructuring plan, he did so at a Columbia/HCA hospital in Richmond, Va., with a live hook-up to additional facilities, through which he took questions from employees around the country.\footnote{51} And when company headquarters eventually did begin to sell and spin-off assets, the communications department informed workers by e-mail at the same time that it issued press releases, so that employees would not feel slighted by learning about restructuring moves in the media. The internal communications mechanisms improved the flow of information among senior managers and the company’s far-flung workforce, thus assuaging fears and suspicions among Columbia/HCA employees across the country.\footnote{52}

Columbia/HCA’s efforts to publicize its new direction by no means eclipsed news reports on the company’s aggressive past. The Florida prosecution of Columbia/HCA executives received extensive attention, as did new state probes of Medicaid billing and announcements that the Justice Department was formally joining \textit{qui tam} suits by whistleblowers. Throughout 1998, the national press devoted considerable coverage to the company’s past business practices. But positive stories about change at the company became increasingly common in this period, bolstering the company’s public standing.\footnote{53}

Two key indices suggested a more stable environment for Columbia/HCA by the first quarter of 1998. As early as autumn 1997, growth in patient admissions had rebounded significantly. After registering almost no growth in the immediate aftermath of the July raids, when news reports on the company were particularly damaging, same-facility admissions in the fourth quarter rose by 0.5 percent—far less than in previous years but better than some executives had expected.\footnote{54} Similarly, managerial turnover, which reached 40 percent in the year before Scott’s departure, declined significantly thereafter, as the removal of financial scorecards reduced pressures on local executives.\footnote{55}

A pair of constituencies tended to reserve judgment about Frist’s and Bovender’s struggle to turn around their company—large institutional investors and some investment analysts who specialized in the health sector. Incensed by the unfolding fraud scandal, several pension fund managers articulated doubts over Frist’s leadership in the fall of 1997, wondering, as one put it, “Why should [we] feel confident that [he] will put the proper [reform] measures in place, when he was on the board the whole time these abuses were taking place?” Before Frist and Bovender unveiled their plans to downsize in November 1997,
several health sector analysts manifested impatience with what they perceived as the company’s preoccupation with law enforcement probes to the exclusion of cost cutting. After the announcement of the company’s restructuring plan, a number of analysts questioned the ability of the company to achieve long-term growth through a focus on operations. Sheryl Skolnick of BancAmerica Robertson Stephens typified this concern, noting that “[w]e don’t know just how these 230 hospitals and 115 ambulatory surgery centers will be positioned in their marketplace and if they’re still planning on operating an integrated delivery system.” To observers like Skolnick, downsizing and a less aggressive style might “make the federal investigators happy, but it [might] not be best for shareholders.” Investors and analysts alike clamored for evidence that downsizing and concentration on improving operations would put Columbia/HCA solidly back in the black.56

**The Cost-Cutting Mantra**

The strategic path adopted by Frist and Bovender rested on the assumption that a smaller, better focused Columbia/HCA would yield more efficient operations. Without asset expansion as an engine of revenue growth, the company had to squeeze costs to achieve solid earnings; and, in November 1997, when Frist and Bovender publicly sketched the outlines of their restructuring plans, they committed themselves to annual growth in net revenue of 4 percent and annual growth in earnings per share beyond 10 percent. Other developments soon made cost cutting all the more imperative if the company was going to come close to those targets. Passage of the Balanced Budget Act of 1997 slashed Medicare reimbursement rates, especially for hospitals and home health care, while health maintenance organizations simultaneously drove increasingly tough bargains with care providers. The financial performance of all American hospitals soon registered the results of those changes on their balance sheets. Columbia/HCA was no exception, and its earnings took additional hits as a result of severance packages, restructuring charges, and expenses related to the federal investigations. In the final quarter of 1997, Columbia/HCA lost $1.29 billion, and although it avoided a loss in 1998, earnings remained anemic in comparison to pre-1997 results. The new management team’s assessment of
staffing ratios and labor relations, which concluded that many hospitals required additional nurses and that the company should move to bargain with nursing unions, only heightened pressure to trim expenses elsewhere. So too did the decision to invest approximately $1 billion per year to keep the physical and technological infrastructure of Columbia/HCA facilities competitive, and thus attractive to local doctors, who tended to demand access to the latest diagnostic and surgical equipment. To many health sector analysts, a Columbia/HCA that eschewed a steady diet of acquisitions would do very well just to keep out of the red.  

Reduction of middle management through consolidation of corporate divisions promised to pare administrative costs somewhat, as did the discontinuation of various practices to recruit physicians, such as the granting of reduced office rent. The divestiture of the company’s weakest hospitals and surgical centers was likely to further improve its overall cost structure. But Frist and Bovender needed more dramatic savings to demonstrate that downsizing would pay dividends in the long term. In a July 1998 “Strategy Statement,” they indicated how they expected to find such savings—by concentrating on “old-fashioned” details of supply, financial management, accounting, and billing. This statement carefully linked Columbia/HCA’s new operational goals to the company’s public relations initiative. Frist and Bovender conceded that such details “may not sound as exciting or inspirational…as a vision of aggressive acquisition growth or of fundamental change of the health care system,” clear references to how the company did business under Scott. But they insisted that attention to fundamentals would “create significant value” over the medium term.  

In the following three years, Columbia/HCA embarked on a series of schemes designed to bring that promise to fruition.  

Bovender began by requiring local hospital executives to get “back to the basics.” Under Scott, the message to local managers was to direct their energies systematically toward mechanisms of growth; Scott went so far as to encourage hospital administrators to obtain brokerage licenses to facilitate the financial syndication of their facilities. The new management at headquarters chose a different tack, asking its local managers to go through a “balance sheet training program” to remind them of the importance of keeping costs in line with revenues.
One area that received close attention was medical supplies. Although Scott had long boasted of Columbia/HCA’s access to volume purchasing discounts, Frist and Bovender saw considerable room for improvement in management of the company’s supply chain. Within months of the July 1998 strategy statement, they intensified longstanding efforts to ensure that local facilities took advantage of national purchasing contracts, which offered progressively steeper discounts with higher volumes. The company also negotiated deals with suppliers that granted exclusive access to its hospitals in exchange for increased discounts, particularly on more expensive items like cardiac stents. The company began setting up its own regional warehouses and signing its own contracts with shippers to improve control over inventory management. Internet ventures complemented the company’s endeavors. In 1999, Columbia/HCA launched a group purchasing organization, HealthTrust Purchasing Group, partly to assist LifePoint and Triad. HealthTrust created a business-to-business Web site that streamlined the ordering process for all Columbia/HCA facilities.60

At the same time that Columbia/HCA redoubled longstanding efforts to reengineer its supply networks, Bovender spearheaded efforts to standardize procedures relating to financial management, accounting, and billing, collectively referred to as the “Shared Services Initiative.” Headquarters in Nashville centralized insurance purchasing for all of its facilities and mandated that all care centers use the same approach to valuing fixed assets or setting reserve accruals for managed care contracts. Most importantly, the company began the process of consolidating back-office functions in a series of ten regional service centers, which would use expensive, state-of-the-art information technology, automate as many processes as possible, and rely on a smaller but more intensively trained workforce than previous counterparts in Columbia/HCA hospitals. The centers would report to Nashville, not to local managers, and eventually would handle billing and debt collection for all company facilities. Two other centers would administer coding operations and billing to government payers for the company’s care centers. By the spring of 2001, seven of the regional centers were up and running, handling bills and collections for 35 percent of the care centers. Their work helped almost immediately to reduce the company’s bad debts, which fell from 7.7 percent of total revenues in 1998 to 7.5 percent in 2000.61
In the short term, however, the initiatives contributed only modestly to Columbia/HCA’s financial results. From 1998 through 2000, supply costs as a ratio of total revenues increased slightly, from 15.5 percent to 15.8 percent, reflecting general inflation in medical technologies and pharmaceuticals. Whatever the long-term potential of the company’s Shared Services Initiatives, they required substantial start-up costs. Victor Campbell, senior vice president for investor relations, estimated that the investments necessary to create the centers—along with the cost of severance packages for laid-off administrative personnel at individual care centers—would eventually total $160 million.

Despite short-term limitations in the cost-cutting drive, the company posted respectable earnings in 1999 and 2000, when it changed its name to HCA–The Healthcare Company. Excluding nonrecurring items, earnings per share grew by 38 percent in 1999 and by 24 percent in 2000. Although those figures partly reflected several billion dollars in stock buybacks made possible by the company’s asset sales, they also resulted from solid increases in same-facility patient revenues, which rose to more than 5 percent in 1999 and to more than 6 percent the following year. After falling steadily through 1998, reaching a nadir of $17 per share in early 1999, the company’s stock price appreciated in 1999 and 2000, reaching over $40 by the end of the period.

Revenue growth came from two major sources. In 1999, Congress restored many of the cuts in Medicare reimbursements that it had mandated in 1997. Those earlier reforms had reduced the company’s federal payments by almost $400 million dollars in 1997 and 1998. Even more important, Columbia/HCA put in place centralized reviews of proposed managed care contracts, which generally resulted in more favorable deals for the company. From 1998 onward, Columbia/HCA refused contracts based on capitation or downstream financing and sought arrangements with preferred provider organizations rather than health maintenance organizations. In 2000, the company’s tougher approach to negotiations with insurers enabled it to attain average price increases of roughly 7 percent from managed care companies, exceeding the increases of the previous few years (Exhibits 3 and 4).


<table>
<thead>
<tr>
<th>Variable</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
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<tbody>
<tr>
<td>No. of hospitals</td>
<td>309</td>
<td>281</td>
<td>195</td>
<td>187</td>
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<tr>
<td>No. of admissions</td>
<td>1,915,100</td>
<td>1,891,800</td>
<td>1,625,400</td>
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<tr>
<td>No. of licensed beds</td>
<td>60,643</td>
<td>53,693</td>
<td>42,484</td>
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<tr>
<td>Average length of stay, days</td>
<td>5.0</td>
<td>5.0</td>
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<tr>
<td>Gross revenue, millions, $</td>
<td>18,819</td>
<td>18,881</td>
<td>16,657</td>
<td>16,670</td>
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</table>

From company reports to the U.S. Securities and Exchange Commission.


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**Nodes of Decentralization**

Despite Bovender’s and Frist’s efforts to streamline operations, impose common business practices, and invest more control with corporate headquarters, they also sought to give local executives more autonomy in administering the core functions of their care centers—diagnosis and treatment of patients. Their intent, as expressed in the July 1998 strategy statement, was “to centralize
processes and decentralize decision-making.” The provision of quality health care, they insisted, could never follow the model of McDonald’s or Wal-mart (nor, by implication, Holiday Inn, whose business strategy served as a template for the Frist family when they created a private hospital company in the late 1960s.) The hospital business was now “about Grand Strand [Hospital] in Myrtle Beach and about some baby born there”—it involved intensely personal experiences and relationships.65

This perspective supported Columbia/HCA’s decision to cut layers of regional administration and give the people who administered Grand Strand and other care centers more say over day-to-day medical operations and long-term strategy related to patient care. According to Bovender, from the beginning of 1998, local managers enjoyed more freedom to determine the mix of medical services they would offer, to direct physician recruitment and relations, and to oversee physical plants. They also received substantially greater flexibility in marketing their services to the local community and in developing joint ventures with area nonprofits.66

At the local level, corporate reconstruction did not occur without tension. Executives of hospitals and surgery centers sometimes viewed attempts to take away control over subsidiary business functions with suspicion. The move to regional service centers struck local financial officers as especially threatening, because almost no hospital had previously gone without billing offices of their own.67 But senior managers in Nashville pointed to evidence that their mix of central control and local autonomy produced solid results. Turnover among managers of care centers continued to fall in the three years following the July 1997 raids, facilitating the reconstruction of a managerial pipeline for internal promotions. Over the same period, physicians, employees, and patients reported improved ratings on satisfaction surveys.68 And after a dip in 1998, same-facility equivalent admissions (both inpatient and outpatient) grew by 2.7 percent in 1999 and 2.8 percent in 2000—solid results in the industry if not equal to the heady levels the company enjoyed prior to the crisis caused by the federal fraud investigations.69 These measures of performance also strengthened the conviction of senior executives that incentive bonuses tied to short-term financial results were not necessary to motivate a managerial workforce in the for-profit hospital business.70
Questions for Discussion

1. What explains the dramatic divergence between Columbia/HCA's reputation for efficiency before its managerial shake-up and the wide-ranging shortcomings in its operations that the new management team identified?

2. In light of the rapid growth of Columbia/HCA during the 1990s, were the systemic operational shortcomings that came to bedevil the company likely or even inevitable?

3. How, specifically, did downsizing and the move to focus on operations help to turn around Columbia/HCA's financial results?

4. What key principles of crisis management are suggested by the contrast between Richard Scott's approach to the federal investigation and Thomas Frist's approach after he became chief executive officer in July 1997? How would you evaluate the advantages and disadvantages of having someone like Frist, rather than an outsider, oversee the response to crisis management at a company in Columbia/HCA's position?

5. Does the Columbia/HCA case suggest distinct principles of effective “crisis management” within regulated industries that are heavily dependent on government payments and public trust?

6. What case, if any, can be made for pursuing the kind of vertically integrated brand of health care envisioned by Scott, or for a national branding campaign on behalf a health care company?

7. What kinds of incentive structures for middle managers are appropriate in the health sector?

8. How should managers of complex acute care networks or companies distinguish between business areas that call for decentralization of managerial decision making and those that require centralized direction and uniform business practice? Has Columbia/HCA developed a model in this regard for all acute care organizations?
Notes

This case study was prepared in collaboration with Kevin A. Schulman as a basis for class discussion, rather than to illustrate either effective or ineffective handling of an administrative situation. The case is based on research in public sources and on interviews conducted on April 19 and May 25, 2001, with senior executives of HCA–The Healthcare Company. The interviews concerned the challenges confronting Columbia/HCA in the summer of 1997 and the company’s responses to those challenges over the following four years. This research was approved by the University Review Committee on the Use of Human Subjects in Non-Medical Research at Duke University, Durham, North Carolina.


5 Waterman, interview.

6 Ibid.


8 Lagnado et al., “‘Out of the Loop’”; Bianco et al., “Can Dr. Frist Cure This Patient?”


11 Eichenwald, “Two Leaders Are out”; Sharpe et al., “Frist Takes Control.”

13 Waterman, interview.


18 Moore, interview; Joustra, interview.

19 Anita Sharpe, “Bovender Joins First Team at Columbia/HCA,” Wall Street Journal, 5 August 1997, A3; Bianco et al., “Can Dr. Frist Cure This Patient?”

20 Frist, interview.

21 Waterman, interview.

22 Ibid.


24 Waterman, interview.


27 Bovender, interview.

28 Waterman, interview.

29 Ibid.

30 Bovender, interview.

31 Eichenwald, “Working under a Cloud.”
Crisis Management and Corporate Reorganization


33 Lagnado, “Columbia/HCA May Need More Time to Map Strategy.”

34 Wallace, interview.

35 Bovender, interview. According to Bovender, shareholders’ preference for a merger with Tenet grew stronger as Columbia/HCA’s stock price slid through late 1997 and early 1998, but abated once the stock rebounded slightly in February of that year.

36 Moore, interview.

37 Eichenwald, “Columbia/HCA Halting Merger and Capital Plans”; Bianco et al., “Can Dr. Frist Cure This Patient?”


39 Bovender, interview.


43 Joustra, interview.

44 Eichenwald, “Columbia/HCA is Abandoning National Focus”; Eichenwald, “Reshaping the Culture.”

45 Joustra, interview.

46 Eichenwald, “Working under a Cloud.”

47 Joustra, interview.

49 Joustra, interview.  
See also Bruce Japsen, “The Rise and Fall,” Modern Healthcare, 8 September 1997, 35.

50 Joustra, interview.

51 Bianco et al., “Can Dr. Frist Cure This Patient?”

52 Joustra, interview.


For examples of laudatory press coverage, see the stories on Columbia/HCA’s ethics and compliance campaign, cited in case study HSM-2002-03.


55 Bovender, interview.


59 Bovender, interview.


66 Bovender, interview.
67 Ibid.
68 Frist, interview.
69 “Columbia/HCA Reports 1999 Results”; “HCA Reports 2000 Results.”
70 Waterman, interview.
April 22, 1997

Dear Rick:

The Columbia story, beginning in 1987 up to this very moment, is truly remarkable. An amazing group of assets has been assembled in an unbelievably short period of time without a major mistep [sic] and, in fact, many good things have been accomplished. As a result, it is my belief that both our shareholders and our customers will be well-served if we move from a growth emphasis to an operational emphasis for the next two to three years. I have enclosed a memo to you composed of my thoughts, comments and suggestions regarding a course of action for Columbia/HCA for a three to five year period based upon my hopes for the company and you as its CEO to achieve the greatest success possible. By the year 2002, Columbia/HCA, and you as its CEO, have the opportunity to earn the respect and admiration of all as one of a select few (top 15) really great corporations. While not necessarily easy, if the right strategy and execution occurs, my wishes for Columbia and you personally are quite realizable from the vantage point you now enjoy.

The reason my family owns more shares (25.3 million) today than when HCA merged with Columbia in 1993, and you likewise own more shares (9.4 million), is our common belief in the opportunities within the United States healthcare system, and particularly the provider side, for one to receive a fair return on investments which render a quality product to fulfill needs for a reasonable cost. We also both believe that Columbia/HCA is ideally positioned to capitalize on the opportunities presented by our ever changing environment. I also made my decision based upon my belief that you possess all the raw attributes, and the will to develop them, that are necessary to become not only an outstanding CEO for Columbia/HCA, but in doing so become one of the nation’s premier business leaders.

Needless to say, I have much beyond monetary gains riding on you. You have had in the past, and doubtless will have in the future, critical decisions to make, but few more momentous than those you will make over the next three to six months. I
Appendix (cont.)

have confidence you will make the right ones and what you and Columbia do between now and 2002 will establish a launching platform for you to achieve and exceed all your present dreams over the following ten years. Leadership attributes of patience, tolerance, humility and unswerving commitment to integrity and high ethical standards will serve Columbia well over the next three to five years.

Sincerely,

Tommy
A Proposed Revised Three to Five Year Strategic Direction
for Columbia/HCA
April 22, 1997

Assumptions:
1. The United States healthcare system will continue to evolve through incremental change over the next five years.
2. The United States economy will remain relatively stable, i.e., inflation, interest rates, etc.
3. Tax exempt hospitals will continue to represent a significant majority position on the provider side.

Comment:
If any of the above assumptions vary significantly, Columbia’s management must have the flexibility and ability to move timely to capture the opportunities presented.

Goals:
1. EPS - growth no less than 15% compounded over the next five years.*
2. Columbia stock be no less than $90.00 per share in March 2002.*
3. Columbia and its leadership be admired and recognized for excellence among and within the healthcare industry and corporate America.

*Stock and EPS information from Vic Campbell

<table>
<thead>
<tr>
<th>EPS @ 15%</th>
<th>Stock @ 15%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2.22</td>
<td>$45.00</td>
</tr>
<tr>
<td>2.55</td>
<td>51.75</td>
</tr>
<tr>
<td>2.93</td>
<td>59.50</td>
</tr>
<tr>
<td>3.37*</td>
<td>68.50 = 3 years</td>
</tr>
<tr>
<td>3.88</td>
<td>78.70</td>
</tr>
<tr>
<td>4.46</td>
<td>90.50 = 5 years</td>
</tr>
</tbody>
</table>

* If $3 billion share buyback EPS would go to $3.70 in 1999 (18 ½ % compound growth)
Appendix (cont.)

<table>
<thead>
<tr>
<th>Proposed Strategic Direction</th>
</tr>
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</table>

**Step I**

Action: Freeze all syndication activity of hospitals and/or markets.

Why:

1. It is not that important to the success of our company. There are many tools and resources available to Columbia today that weren’t present in the past.
2. Regardless of legality, it is a lightning rod for our present and future critics.
3. Perceived as a conflict of interest and unethical behavior. It is a complex issue that the public does not understand and as long as the majority of hospitals are tax-exempt and cannot joint venture hospitals with physicians, it will be used against us.
4. Disgruntled maverick physicians who may or may not be partners will use physician joint ventures against Columbia in their lawsuits and in the media to cast the company in an undesirable light.

How:

1. Communicate with our present physician partners explaining:
   1. How much we appreciate our relationship
   2. Statement stressing that together we provide high quality, friendly, low cost services that causes non-partner as well as partner physicians to use our facilities.
   3. That we will continue with them until laws are enacted that preclude such arrangement. (Although we should quietly examine over the coming year so the merits of dissolving existing physician joint ventures. If the answer is to unwind partnerships we would have to undertake a buyout program they would accept.)
   4. Why we are ceasing to syndicate our hospitals and markets with physicians.
   5. A letter to all of our existing surgicenter partners stating we will continue to joint venture ASC and why.
2. A carefully constructed public release.
3. Determine what should or should not be said in a conciliatory statement to government officials.
Step II

Action: Stop national branding campaign on television and national print media.

Why:

a. It reinforces the perception of a giant, in your face, aggressive company.
b. Ads appear in markets new to Columbia or markets where Columbia currently has no presence. Ads serve as a catalyst for rumors, etc. and as another rallying point that coalesces a highly fragmented not-for-profit hospital sector that may be threatened.
c. Television ads are too “cute” and do not project an image that is appropriate or desired for a company aspiring to be the most admired in the healthcare industry.
d. Continuing ads will reinforce the association of the Columbia name with El Paso, FBI, and other negative media coverage.
e. They hury our acquisition and joint venture efforts of not-for-profits.

How:

a. Immediately pull ads even if already contracted and paid - all markets.
b. Review ad agency relationship.
c. Develop a strategy for local markets with appropriate message that is delivered with warmth and presents Columbia and the local affiliates with class.
d. Let local markets determine what is appropriate message (i.e., which product lines) or if certain locally recognized individuals might be good spokespersons for us.
e. Proper controls and guidelines should be developed.
f. Commission a completely independent study of company’s public relations and image.

Step III

Action: Lower internal and external profile of government relations activity.

Why:

1. Too aggressive and heavy handed.
2. It tends to reinforce gorilla image.
3. Post ’96 election scrutiny of election abuses and needs for reform may set Columbia up as example for need to reform.
## Appendix (cont.)

### How:

2. Work through established credible third parties such as FHS, AHA, AMA and recognized respected state and local lobbyists.
3. No corporate funds used for state, local or foreign political contributions.
4. Seriously consider no company PAC money for political contributions. Work through FAHS PAC.

### Step IV

**Action:** Limit (not stop) acquisitions of United States tax exempt hospitals for 24 to 36 months.

**Why:**

1. Let market calm down. Remove the fear factor that is coalescing our enemies.
2. Safer and better use of capital is a significant stock repurchase program.
3. Slowdown of good acquisitions is happening and will continue to occur for some undetermined period of time. If word is properly disseminated it may actually bring one or two really good acquisitions to the table.
4. Surfing in new markets and especially in entrenched tax-exempt markets with known liberal/organized labor culture rallies the critics and creates harmful media coverage in our existing markets.
5. May give Columbia opportunity to build or rebuild relationships with some of the other investor-owned companies.
6. Give us a chance to re-examine joint venture/consolidation opportunities with other investor-owned companies. We should renew efforts to joint venture certain markets, i.e., New Orleans, Las Vegas and Macon.
7. Gives Columbia time to “catch its breath.” To redirect its emphasis to operations; proving the merits of its integrated market strategy; refine its product lines; document quality outcomes, benchmark its best practices. Gives Columbia chance to develop and complement more timely its core “information systems” strategy along with other promising programs such as 1-800-Columbia and Senior Friends.

### Step V

**Action:** Limit new hospital construction to projects where there is clearly demonstrated need or to replacement projects.
Appendix (cont.)

Why:

1. Socially irresponsible action to build additional capacity in a market with well-documented over capacity.
2. Bad long term commitment of capital.
3. In your face, win-lose, adversarial approach that undermines all aspects of our long term goals.
4. Capital is far better spent for short and long term ROI to implement a significant stock repurchase program.
5. It is far from proven how geographically complete a local, state, regional or national network of owned hospitals needs to be or the trade offs of building out networks by other means such as affiliations or joint ventures with third parties.
6. Removes unnecessary potential of adversarial issues with NFP and investor competitors who someday may be acquisition candidates.
7. Creates antitrust issues and added costs with investor owned competitors who may some day be merger candidates.

How:

1. A thorough review by senior management and board of directors of existing proposed projects.
2. A thorough presentation of proposed strategy to board of directors.
3. Downsize the M & A resources. Redeploy and redirect M & A human resources.

Step VI

Action: Limit international expansion to existing markets in United Kingdom and Switzerland.

Why:

1. Better use of funds can be made with stock repurchase.
2. None of the following conditions exist which lead other United States corporations to international expansion.
   a. Export products - i.e., P&G, GM
   b. Lower cost of manufacturing, i.e., labor, etc.
   c. Higher margins justify greater risks.
   d. Less risk - i.e., government
   e. Offshore tax advantaged money.
   f. Serve clients - E&W, Arthur Andersen, McKinsey, etc.
Appendix (cont.)

3. No export of capital necessary.
5. P&L impact

How:
1. Clear statement from CEO
2. Funding limitations
3. Downsizing of staff

Step VII

Action: Stock Repurchase

Why:
1. Underleveraged balance sheet
2. Strong cash flow
3. Favorable P.E.
4. Quality, well-established assets
5. Lower company profile for three to five years
6. Less risk/higher rewards
7. Higher returns and EPS growth
8. Regain PE ratio advantage versus our competitors, and longer term positions us to complete our geographical market strategy through investor owned and tax-exempt acquisitions.
9. Enables CEO and senior management to subtly [sic] and gradually prepare themselves and the company for the following ten years (2000-2010).

How:
1. Make tough decisions regarding capital and people.
2. Make every effort to be overly fair to individuals impacted.
3. Communicate clearly to public.
4. Make significant commitment - i.e., $3 billion. If really serious about buying back 30-40% of stock over next five years, then a large Dutch Tender Auction should be considered on the front end with a follow-on maintenance re-purchase program for remaining period.
Appendix (cont.)

**Step VIII**

Action: Shift to an operational phase from a growth phase.

Why:

1. Less capital for M&A.
2. Maximize the potential of assets that have been rapidly assembled.
3. Develop and implement additional measurement, monitoring and compliance tools.
4. Develop and institutionalize values.
5. Validate the value added of the Columbia integrated model.

How:

1. Zero base all current programs and initiatives.
   a. Field feedback for value and prioritization.
   b. Those programs that are going well, give more focus, i.e., Info Systems; Product Line Development.
2. Slow centralization process
   a. Examine present and planned corporate staff for new mode.
3. Increase emphasis on HRD.
4. Focus on AR’s
5. Refine benchmarking and best practices in both operations and clinical programs.
6. Continue and enhance quality initiatives
   a. JCAHO commendations
   b. Mercer/HCAI
   c. Measurement of outcomes

Implications for Rick Scott:

1. Value of RLS’ stock holdings will be greater in 1999, 2002, and 2012 than will be the case of continuing present aggressive growth strategy and corporate style of management.
2. Less risk, not only financially but also from a career standpoint.
3. More likely to emerge as one of corporate America’s recognized leaders in the 2000 to 2010 period.
4. Quality of life and especially with family will be much better, i.e., more time with children; less tension; better R&R, etc.
5. Will have more time to devote within community and selected national activities such as The Business Council.
6. Become appreciated and beloved among the Columbia employees.
7. Over a three to five year period, during with Columbia is in a non-adversarial mode, you will have the opportunity to build the relationships and trust with key investor owned and NFP leaders who will look to us as attractive partners.
8. If in fact the goals of EPS at 4.46 and stock in the $85-90/share range can be reached by continuing an aggressive expansive strategy of growth versus that suggested above, you will, at 49 years of age be facing a much greater challenge of continuing growth on a much larger base.

Rick, it would be helpful to me and hopefully to you to use the foregoing as talking points in a discussion with you and David. In the end, I fully realize that you will have to lead the company in the direction you feel best and do it your way. Having expressed my thoughts to you, I stand ready to help you not only transition through this difficult period, but going forward over the coming years.
Scenes From a Corporate Makeover:
*Health Care Fraud and the Refashioning of Columbia/HCA, 1992–2001*

**Edward J. Balleisen**

Part Three of Four:
Ethics, Compliance, and a Revamped Corporate Culture

Case Study HSM-2003-03
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About the Author

EDWARD J. BALLEISEN is the Hunt Family Assistant Professor of History at Duke University, where he teaches courses on nineteenth-century America. His research explores the evolving “culture of American capitalism.” He is the author of *Navigating Failure: Bankruptcy and Commercial Society in Antebellum America* (2001).
Part Three of Four: Ethics, Compliance, and a Revamped Corporate Culture

As efforts continued to redirect Columbia/HCA’s strategic orientation and rebuild its business operations after the onset of the Medicare fraud scandal, legal challenges assailed the company’s senior management. At no time since the 1997 federal raids (see case HSM-2002-01) had top executives been able to concentrate solely on questions of business strategy. Indeed, the magnitude of the various probes into Columbia/HCA’s business practices stretched historical precedents. Federal law enforcement officials wished to reconstruct reimbursement patterns resulting from an enormous number of patient interactions at Columbia/HCA hospitals, home health care agencies, and other care centers, over periods of up to eight years. Some of the questions that guided their investigations, such as whether home health care visits by company agencies were medically necessary, required complex statistical analysis of millions of patient visits. Other questions, such as whether the company illegally structured compensation to physicians, or whether it improperly charged the govern-
ment for unallowable overhead expenses on cost reports, necessitated the piecing together of tens of thousands of financial arrangements. By themselves, the various segments of the Columbia/HCA probe would have constituted some of the most extensive federal law enforcement inquiries ever. In addition, the precise contours of the federal legal offensive kept changing as the government periodically unsealed *qui tam* whistleblower lawsuits that it had decided to join as a party. By 1999, the company had become apprised of 30 such lawsuits, with the ongoing possibility that other suits remained under seal.¹

Other legal investigations and actions complicated the lives of Columbia/HCA lawyers and executives still further. In 1998, the Securities and Exchange Commission opened a formal inquiry into the possibility of illegal insider trading in the months before and after the March 1997 raid in El Paso. Several states’ attorneys general initiated examinations of possible abuses of Medicaid reimbursement rules by Columbia/HCA. Shareholders brought suits against Richard Scott, David Vandewater, the three executives indicted for Medicare fraud, and the company’s board of directors prior to the management changes of July 1997 (which included Thomas Frist), alleging breach of fiduciary duty to safeguard shareholders from illegal behavior within the company. A slew of employee health benefit plans and individual patients filed class action lawsuits that alleged systematic overbilling for medical services rendered. Sharing similar concerns, the legal representatives of several insurance companies informed Columbia/HCA that they also were considering legal action predicated on the findings of governmental investigations into overbilling.²

In some respects, the responses of Columbia/HCA’s senior executives to this welter of legal attacks resembled their approach in other areas of crisis management. Eschewing the confrontational approach taken by the company’s lawyers under Richard Scott, Thomas Frist’s new legal team adopted a much more conciliatory and open posture. They not only immediately halted efforts to keep federal officials from seeing a wide range of company records, but also sought to facilitate access to company documents and personnel. The company’s spokespersons, including Frist and Jack Bovender, consistently emphasized that Columbia/HCA wished to resolve all issues concerning government reimbursement practices, and its lawyers began a lengthy series of contacts with prosecutors to bring about such a result. Those interactions included the sharing of findings from the company’s internal investigations.³ Perhaps most
important, Frist moved quickly to put in place a vigorous ethics and compliance program that would ensure adherence to all legal requirements directed at medical providers.

“Doing the Right Thing”

From his first hours as chief executive officer, Frist sent out word that under his leadership Columbia/HCA was going to place patient care, upright business dealings, and compliance with the law ahead of profit targets. This message, he was convinced, was essential to rebuild trust in the company, whether on the part of federal prosecutors, institutional investors, affiliated physicians, employees, or the general public. If the company adopted these new values, Frist argued internally and in public speeches, profits would follow, so long as the company paid careful attention to basic issues of management. If it did not, controversies and criticism would continue to hinder its operations and reputation. “The only way this company can succeed in the future,” Frist told a meeting of institutional investors in September 1997, “is to put patients first.”

Newly installed chief operating officer and president Jack Bovender repeatedly took a similar line. From his first day on the job, he declared that “we’ve got to create a culture in which [employees] know we value honesty and integrity more than anything else. We will not tolerate business practices that go over the line.”

To ratify the shift in corporate priorities, Frist and Bovender convened a senior management retreat in September 1997 to discuss a new set of values to guide the company. After hammering out a tentative mission statement at the retreat, they launched scores of focus groups throughout the company to consider the draft and suggest revisions. In early November, Frist inaugurated a formal corporate mission statement, little changed from the September draft, during a speech broadcast to thousands of Columbia/HCA workers. The new declaration of purpose said nothing directly about revenues or profits. Instead, it pledged “high-quality, cost-effective health care in the communities we serve” and promised “absolute honesty, integrity, and fairness” not only “in the way we conduct our business,” but also “in the way that we conduct our lives” (Exhibit 1).
Exhibit 1. HCA Mission and Values Statement, 2000.*

Mission and Values Statement

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we will strive to deliver high quality, cost-effective healthcare in the communities we serve.

In pursuit of our mission, we believe the following value statements are essential and timeless:

• We recognize and affirm the unique and intrinsic worth of each individual.
• We treat all those we serve with compassion and kindness.
• We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives.
• We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect, and dignity.

* From “A Tradition of Caring,” the HCA code of conduct published in 2000.

Even before the November inauguration of the corporate mission statement, Frist and Bovender set about creating a new department that would set formal ethical standards and ensure compliance with all laws and regulations, whether in regard to billing practices, the provision of emergency medical care to patients in need, patient confidentiality, or relations with physicians and suppliers. To oversee this undertaking, they turned to someone with substantial experience in the field of ethics and compliance, Alan Yuspeh. An attorney by training, Yuspeh had worked for more than a decade as the coordinator of the Defense Industry Initiative on Business Ethics and Conduct, playing a key role in the efforts of that sector to respond to the defense procurement scandals of the 1980s. This organization served as an ethics and compliance clearinghouse for defense contractors, “a forum to exchange ideas on how to do business properly, and to talk with government officials… [about] how to [ensure] compliance with the rules.” Before that, he had served as general counsel to the Senate Armed Services Committee and as a private attorney specializing in issues of corporate ethics and compliance. In the context of heightened media attention fostered by the fraud scandal, Yuspeh’s appointment to the position of
senior vice president for ethics, compliance, and social responsibility drew substantial press coverage, raising the stakes associated with Columbia/HCA’s efforts in this arena.

After accepting Columbia/HCA’s October 1997 offer to create a new department that would oversee business conduct throughout the organization, Yuspeh spent several months learning the intricacies of the company’s operations, both at the Nashville headquarters and in its many facilities around the nation. He soon concluded that the processes needed at Columbia/HCA were “remarkably similar” to the “architecture” of internal monitoring and self-regulation that had been developed in the defense industry. The largest companies in both industries “were dealing with very complex kinds of regulatory schemes,” both faced complicated accounting standards associated with receiving government payments, and both faced the “challenges of educating people” about their responsibilities across a set of far-flung facilities. Although there would have to be an “entirely different body of technical detail,” Yuspeh became convinced that the best practices among defense contractors would serve well as models for the health care industry.\(^7\)

Following the lead of military suppliers, Yuspeh and his lieutenants set about developing a comprehensive set of legal and ethical standards for company employees. Columbia/HCA had developed such a code of conduct in April 1997, a month after the first federal raid in El Paso, but Yuspeh viewed it as unwieldy and full of legalese. In crafting a new code, Yuspeh strived for accessibility and comprehensiveness. Instead of addressing only issues that had been raised by the federal fraud probes, such as diagnosis related group (DRG) coding, disclosure of reserve cost reports, and physician recruitment, he laid out a broad set of obligations that all Columbia/HCA employees owed to its various stakeholders. Those responsibilities ranged from workplace conduct, employment practices, and insider trading to business courtesies, marketing efforts, and the management of information systems. Yuspeh posted a draft code on the company’s intranet, soliciting employee comment and incorporating dozens of suggestions into the final product, which was published in February 1998 (Exhibit 2). Alongside the code of conduct, Yuspeh and his assistants developed a more technical set of procedures for persons charged with such sensitive tasks as coding, billing, and preparing cost reports for government payers.\(^8\)
Exhibit 2. Excerpts from the 2000 code of conduct.

**Our Fundamental Commitment to Stakeholders**

To our patients: We are committed to providing quality care that is sensitive, compassionate, promptly delivered, and cost-effective.

To our HCA colleagues: We are committed to a work setting which treats all colleagues with fairness, dignity, and respect, and affords them an opportunity to grow, to develop professionally, and to work in a team environment in which all ideas are considered.

To our affiliated physicians: We are committed to providing a work environment which has excellent facilities, modern equipment, and outstanding professional support.

To our third-party payers: We are committed to dealing with our third-party payers in a way that demonstrates our commitment to contractual obligations and reflects our shared concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare. We encourage our private third party payers to adopt their own set of comparable ethical principles to explicitly recognize their obligations to patients as well as the need for fairness in dealing with providers.

To our regulators: We are committed to an environment in which compliance with rules, regulations, and sound business practices is woven into the corporate culture. We accept the responsibility to aggressively self-govern and monitor adherence to the requirements of law and to our Code of Conduct.

**Relationships With Our Healthcare Partners**

We will take great care to assure all billings to government payers, commercial insurance payers and patients are true and accurate and conform to all pertinent Federal and state laws and regulations. We prohibit any colleague or agent of HCA from knowingly presenting or causing to be presented claims for payment or approval which are false, fictitious, or fraudulent.

We will operate oversight systems designed to verify claims are submitted only for services actually provided and services are billed as provided. These systems will emphasize the critical nature of complete and accurate documentation of services provided. As part of our documentation effort, we will maintain current and accurate medical records.

Any subcontractors engaged to perform billing or coding services must have the necessary skills, quality control processes, systems, and appropriate procedures to ensure all billings for government and commercial insurance programs are accurate and complete. HCA prefers to contract with such entities that have adopted their own ethics and compliance programs. Third-party billing entities, contractors, and preferred vendors under contract consideration must be approved consistent with the corporate policy on this subject.

From “A Tradition of Caring,” the HCA code of conduct published in 2000.
Once the guidelines were in place, Yuspeh and his staff turned their attention to issues of training, administrative structure, and communications, giving their highest priority to coding and billing processes as a result of the pending federal investigations. The ethics and compliance office worked closely with relevant senior management to develop intensive training modules concerning the new policies and procedures. Yuspeh eventually selected several dozen people as “responsible executives” who would focus on continual assessments of compliance risk in their particular spheres of competence, as well as refining compliance procedures and developing training materials (Exhibit 3). By 1999, the modules were available on the company’s intranet, as well as on CD-ROM. For the rest of the company’s workforce, Yuspeh’s department produced a training video that presented employees with workplace situations that raised issues of ethics or compliance with the law, and the department put in place programs to ensure that every person working for the company would go through a basic training session that included the video. Instead of focusing solely on issues raised by the government fraud investigations, the training exercises addressed broader issues of obligations to patients—including confidentiality of medical records—which would be relevant for the majority of Columbia/HCA employees. Concerned that participants engage with the material in these exercises, Yuspeh constructed sessions around discussion of the concrete scenarios acted out on the video.

To oversee such training at the company’s many facilities, corporate headquarters created the position of “ethics compliance officer” (ECO) at every care center. Rather than hire new personnel to fill the positions, the company asked every hospital or care center to assign one of its four top executives to the new duties. This arrangement, Yuspeh hoped, would show employees that top management identified with the ethics and compliance initiative. Local executives, Yuspeh insisted in 1998, “need to be very careful about the messages they are sending, so everyone knows our compliance efforts aren’t just window dressing.” To further underscore the commitment of company management to compliance issues, Yuspeh persuaded the board of directors to establish a compliance committee, to which he would regularly report, as well as an ethics and compliance steering committee, which included Frist, Bovender, and several other senior executives (Exhibit 3). In addition, the company added attention to
Exhibit 3. Columbia/HCA ethics and compliance organizational structure.

ethical conduct and compliance to performance reviews of all managerial staff.\textsuperscript{10}

As a first step in training the new ECOs, Columbia/HCA held a series of two-day seminars in February 1998 on the new approach to ethics and compliance. Hundreds of local executives took part in these seminars, where they heard presentations given by the company’s lawyers urging them “not to push the envelope,” received intensive overviews of the new code of conduct, and obtained guidance on how to set up training programs for their own employees. According to Yuspeh, the response of local executives was generally positive, despite the additional workload associated with taking on the responsibilities of an ECO. Stunned by the implications of the burgeoning federal investigation, most managers of Columbia/HCA hospitals and other care centers welcomed the opportunity to put internal ethics and compliance mechanisms in place. They also accepted their obligation to serve as examples for the workforce under them. These individuals took on the tasks of creating local ethics and compliance committees and training department heads in their facilities, who would then train workers under them. The ECOs also had the obligation to disseminate training materials to local employees, to ensure that training took place throughout the local organization, and to oversee the investigation of potential violations of the company’s policies or standards.\textsuperscript{11}

The rationale for the new code of conduct, Yuspeh maintained in public speeches and interviews with journalists, was not simply to show federal prosecutors that Columbia/HCA was committed to abiding by the law. “Our goal is to articulate our values and aspirations,” he told one interviewer in 1999, “to make certain that all employees know what the law is [and] let them know we expect them to do the right thing.” But avoiding illegality, Yuspeh repeatedly insisted, was just the starting point for the new Columbia/HCA. As he declared in a July 2000 address to the Business Ethics Conference, “if your performance measure as to business practices is simply to complete each day of work without being indicted, then you haven’t set the bar very high.”\textsuperscript{12}
Reporting and Monitoring Structures

In case some Columbia/HCA employees did not internalize the new emphasis on integrity, Yuspeh developed reporting and monitoring structures, again drawing heavily on the experience of the defense industry. From the outcome of previous government fraud investigations in both the defense and health care sectors, Yuspeh and other senior executives knew that any settlement with the government would be predicated on the company’s making serious investments in oversight and enforcement. A key reporting mechanism was an ethics hotline, a version of which the company had put in place in the spring of 1997 in response to the first federal raid. (Telephone hotlines for employees and subcontractors had become standard operating procedure in the defense industry in the late 1980s and early 1990s). Although the company continued to encourage workers to take their complaints about unethical or illegal behavior to their immediate superiors or local executives, Yuspeh viewed some form of independent complaint process as an essential component of an overall ethics and compliance effort. He beefed up the resources available to the hotline considerably, increasing its full-time staff to five case managers and two investigators, and made sure that its number was posted conspicuously throughout all Columbia/HCA facilities. Callers could remain anonymous and would speak with persons employed by an outside contractor. When the hotline received a complaint or allegation, independent investigation by someone not implicated by the caller ensued and, if the caller so requested, on the basis of a redacted set of facts that wherever possible protected the identity of the person making the allegation. In all cases, the original complainant had access to the results of any inquiry. The hotline also existed to assist employees who wanted advice about how to handle situations that they did not see as clearly covered by the code of conduct or the compliance guidelines (Exhibit 4).

From April 1997 through May 2001, the ethics line handled more than 3600 calls. Initially, as many as one out of every five calls sought advice about how to handle a situation at work, but that figure dropped markedly over subsequent years as ECOs became more visible to workers throughout the company’s care centers. Most calls came from patients who challenged their bills or employees who disputed personnel decisions concerning raises or promotions; a relatively small number alleged serious infractions of the company’s code of conduct.
Exhibit 4. Complaint flow chart for the ethics hotline.

- Call is placed to the Ethics Line
- Call, letter, email, etc., is received in Ethics and Compliance Department
- Compliance Line Staff captures information from caller according to HCA protocol. Callers are given response call-back date and case number.
- The intake information is taken by a Case Coordinator, Case Manager, Investigator, or AVP Corporate Integrity. A case number is provided to the caller.
- The data is retrieved by the E&C staff.
- Cases are reviewed and assigned a Case Manager by the AVP. Cases providing insufficient information or not presenting E&C issues are closed without investigation.
- Case Manager/Coordinator contacts the caller (if not anonymous) to review the issues and to provide caller with the Case Manager/Coordinator’s name and telephone number for future contact.
- Caller is asked if he/she wishes to be identified in the investigative report. Caller may choose to be anonymous to the investigator by having his/her name redacted from the report that goes to the facility ECO/investigator.
- The case is sent to an investigator via email in a password-protected Word document. A 21-day investigation period is normally assigned.
- An investigation is conducted at facility or by corporate. Occasionally, outside resources are utilized.
- Case Manager/Coordinator reviews submitted investigative report to verify all issues have been properly investigated. If not, the case is sent back for additional investigation.
Exhibit 4. Complaint flow chart for the ethics hotline (cont.).

If Case Manager/Coordinator finds investigative report complete, a Close-Out Memo to the AVP is prepared detailing the procedure and summary of investigation.

AVP reviews the Close-Out Memo and either approves or disapproves the summary of the investigation and the corrective action, if appropriate.

The Case Manager/Coordinator closes the case accordingly as “Substantiated,” Unsubstantiated,” etc. Corrective action, if any, will be noted in the memo.

When the Close-Out Memo has been approved by the AVP, the Case Manager/Coordinator contacts the caller with the results of the investigation.

If the caller is anonymous, an email message is sent to the Compliance Line or to the caller’s anonymous email address letting them know the investigation results. The caller contacts the Compliance Line to obtain the results.

The identified caller is contacted by the Case Manager/Coordinator and given the results of the investigation.

Case Manager/Coordinator advises ECO when the case is closed in the E&C Department.

Case Coordinator closes case in Ethics Administration System. Hard copies of documents are placed in permanent, secured files in the E&C Department.

Source: Company materials.
and/or legal violations. In the vast majority of cases, ethics and compliance case workers and local ECOs handled complaints internally, substantiating allegations about 40 percent of the time (Exhibits 5 and 6). Substantiated allegations resulted in a variety of actions, including warnings, reprimands, and suspensions. At least in some cases, Columbia/HCA responded to demonstrated violations of its code of conduct by firing executives, as when the company confirmed that two hospital administrators in Texas had altered records it supplied to an accreditation body, or when it verified that two managers at a Tennessee hospital had changed documents to increase Medicare reimbursements. In a handful of instances, the company referred matters to outside legal authorities.

Other institutional mechanisms set up by Yuspeh focused on “real-time monitoring” of business operations, especially DRG coding. Yuspeh’s department identified areas in which the company was especially subject to compliance risk—such as bundled laboratory tests and determinations of medical necessity—paying close attention to conduct targeted by ongoing federal investigations and fraud alerts sent out by government regulators. They then developed automated monitoring systems using sophisticated database management software that would flag any troubling patterns. Thus, the company began to keep track of coding rates for respiratory illnesses, because various investigations had identified comparatively high rates of coding for gram-negative pneumonia (a relatively highly compensated form of the disease) at Columbia/HCA hospitals. When statistical deviations from national or regional

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<tr>
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<td>128 (10)</td>
<td>95 (10)</td>
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</tr>
<tr>
<td>Total</td>
<td>231 (100)</td>
<td>1228 (100)</td>
<td>915 (100)</td>
<td>850 (100)</td>
<td>364 (100)</td>
</tr>
</tbody>
</table>

Values are reported as number (percentage) unless otherwise indicated. Source: Company reports.
Exhibit 6. Typical fact situations raised by calls to the ethics hotline.

**Case Study I**

The caller does not believe she should have been charged for a test that was administered by the pathologist. On May 21, the caller and her spouse requested chemical blood work at the Nameless Medical Center. The caller and her spouse received blood tests and analysis for diabetes. The caller is upset because the pathologist charged her and her spouse $161.00 for the tests. To the caller’s recollection, the pathologist did not touch the blood sample nor did she perform any services regarding the blood work, therefore, she is not entitled to any money for the services. The caller stated “If they (pathologists) don’t touch it they don’t get paid for it.” The caller does not believe she should have been charged for the blood work because she is an employee at the hospital, and that the pathologist never touched the blood sample.

**Case Study II**

The hospital ECO was provided information by an employee of a services company that provided psychological services to the hospital, that there were a lot of things going on that were against regulations, policies and that laws also may have been broken. The employee stated that initial team conferences and team interdisciplinary conferences were being documented as taking place when they didn’t and that dates were being changed to comply with regulations. She also stated that she was being pressured by her supervisor to alter patient medical records by back dating records to comply with state and federal regulations and she admitted that she had instructed subordinate staff to also alter medical records. The employee discussed the issue with her supervisor, who became upset, and pressured her to rescind her allegations.

**Case Study III**

A patient was treated in Emergency Department at the So and So Medical Center on 02/22/YY after being diagnosed for back pain of undetermined cause. The patient later called the Business Office complaining that the incorrect code had been placed on her bill and the insurance company denied her claim. The patient notified her personal physician, who did not have admission privileges to the So and So Medical Center. The code was changed by one of the BO employees on 3/30/YY based upon the request by the patient’s personal physician. The BO supervisor discovered this alteration.

**Case Study IV**

The caller was removed from corporate payroll and had her pay reduced 10%. The caller reported that she returned from vacation to find that she had been removed from corporate payroll and placed on hospital payroll without her knowledge or agreement. She also noted that there had been a change in her salary. The caller does not believe that the changes were done in an ethical manner and feels that the actions were retaliatory because of a confrontation she had with the CEO. The caller believes that the actions taken in her case were inappropriate and in direct conflict with the Code of Conduct and the Corporate Mission and Values Statement.

Source: Company materials.
norms appeared in this or other coding domains, Yuspeh’s team of auditors could proceed to analysis of patient demography and, if warranted, analysis of the original medical charts on which clerical workers based their coding decisions. If they identified a problem with policies or procedures for particular codes, or if new issues emerged as a result of shifts in government policy, they did not simply correct mistakes, but tried to evaluate the causes of excessive error rates, devise adjustments, and implement the adjustments throughout the company.\textsuperscript{17} As Yuspeh characterized this effort in January 1999, “on the monitoring side we are really looking at how to identify trends in order to get our arms around systemic changes in those areas.”\textsuperscript{18}

Through 1998 and 1999, Columbia/HCA officials in charge of monitoring and auditing became more appreciative of the complexities associated with ensuring legal compliance with the Medicare program. Accordingly, they moved to consolidate activities relating to Medicare coding and billing, incorporating them into the company’s “Shared Services Initiative” (see case study HSM-2002-02) and setting up two regional service centers that had sole responsibility for administration of bills for Medicare patients. Through this arrangement, Columbia/HCA hoped to gain full advantage from the specialized training required to maintain compliant coding procedures, while simultaneously removing some of the ambiguity in Medicare coding regulations. Since the two billing centers dealt with a variety of fiscal intermediaries contracted by the Health Care Financing Administration, they were able to identify inconsistencies in coding rules, leading in some cases to more consistent direction from the federal government.\textsuperscript{19}

Although Columbia/HCA’s implementation of an ethics and compliance program benefited enormously from the example of defense industry self-regulation, two issues presented challenges unique to a large-scale health care company. The first involved the degree of operational autonomy enjoyed by local care centers. Unlike defense contractors, which functioned more along the lines of military authority, with clearly defined chains of command, Columbia/HCA continued to cede substantial power to local executives, even after it began to centralize several back-office functions. After visiting numerous care centers in 1998 and 1999 to assess the growth of an organizational culture committed to legal compliance, Yuspeh realized that the initial program had been conceived too much as “a staff-to-staff delivery system.” By concentrating extensively on contacts with local ECOs and managers in charge of sensi-
tive processes like coding and billing, the ethics and compliance program at corporate headquarters had given insufficient attention to local executives, who more than anyone else set the organizational tone in their facilities. From mid-1999, the company incorporated those executives more substantially into the program. The second challenge not present in the defense industry concerned health care centers’ unusual relationship with physicians, who generally lacked the status of employees but who were essential providers of care and whose actions often had important implications for legal compliance. In the case of Columbia/HCA, the company depended on literally thousands of independent doctors to treat their hundreds of thousands of patients, as well as to supply sufficient information about treatment to allow for proper DRG coding, or to furnish enough diagnostic information to allow hospital administrators to determine whether they had to ask Medicare patients to sign a consent form acknowledging that the government may not pay for ordered tests. For doctors who were “very busy” and “focused on patient demands,” cooperation in such matters of compliance often proved “very, very difficult.” Columbia/HCA’s response to this problem was to target its communications to physicians about compliance issues, leaving specific strategies up to the “responsible executives” for given issues at each care center.

The Benefits and Costs of Self-Regulation

The price tag of Columbia/HCA’s compliance campaign proved relatively modest. Since local executives took on the duties of local ECOs, the company avoided the expense of hiring several hundred administrative officers. Annual budgets for billing compliance totaled around $3 million, with an additional $5 million allocated to an auditing/monitoring staff of 45 and a further $4 million set aside for Yuspeh’s department of ethics, compliance, and social responsibility. Start-up costs for the new Medicare billing and coding centers came to roughly another $10 million. In a company that took in almost $17 billion in 2000, these figures represented less than 0.2 percent of total revenues.

Nonetheless, Columbia/HCA enjoyed substantial dividends from the investments. The adoption of a rigorous compliance program shored up the com-
pany’s reputation. Press coverage of compliance initiatives was generally extremely laudatory. Within the health care industry, the company received plaudits both for the content of those initiatives and for making its code of conduct and general compliance procedures available on the Internet as part of its “corporate social responsibility.” Columbia/HCA officials, moreover, partly attributed improved ratings on surveys of patient satisfaction and a rebound in the growth of patient admissions to the ethics and compliance campaign. Treating major stakeholders “in a predictably fair and ethical manner,” Yuspeh contended in his speech to the Business Ethics Conference in July 2000, meant having “loyal customers, reliable suppliers, and dedicated employees.” In a company with close to 200,000 far-flung workers, even after considerable downsizing, company executives were loath to argue that the ethics and compliance initiative has transformed the hearts and minds of its employees and the doctors who work in its facilities. But they did contend that the program reinforced the honorable inclinations of persons who had chosen to go into health care and who “want to do the right thing”; they also expressed confidence that the company lacked “rogue operators” and that, should any such individuals gain employment, they would have great difficulty shielding illicit activities.

One incident that speaks to the company’s improved external standing concerns its relations with Infact, a public advocacy group and corporate watchdog. Three months before the federal government’s July 1997 raids, Infact inducted Columbia/HCA into its corporate “Hall of Shame,” where the company joined such embattled giants as Philip Morris, Dow Chemical, and Waste Management. In explaining this move, Infact cited Columbia/HCA’s privileging of shareholder value above patient care, its expensive marketing campaign, its aggressive use of lobbyists to influence public decision making about its purchase of nonprofit health care organizations, and allegations that it sought to avoid exposure to uninsured patients. After becoming aware of Infact’s action at the 1998 Columbia/HCA annual meeting, Thomas Frist opened a dialogue with the activists, keeping them abreast of the company’s efforts to improve patient care and to ensure legal compliance throughout its facilities. Frist and Yuspeh also addressed concerns that Infact had raised about the company’s political involvement, noting that it had dramatically curtailed its campaign contributions and lobbying activities. In July 2000, Columbia/HCA also revised its code of conduct, committing itself to taking public stances on issues of public
policy only when they related to “the larger public interest,” to discourage the “revolving door” between the corporate and government worlds, and to prohibit the pressuring of employees to make contributions “as a means of expressing corporate priorities on public policy issues.” As a result of these reforms, Infact removed Columbia/HCA from its Hall of Shame in August 2000.25

For all of the beneficial consequences resulting from the priority given to ensuring legal compliance and ethical business practices, some senior executives noted that the campaign created at least some managerial tribulations. According to general counsel Robert Waterman, reporting of “ghost” problems by employees became common, and in some discussions of business strategy, executives both at local facilities and at corporate headquarters found themselves “held hostage to the most conservative person in the room.”26 Some executives encountered a time-consuming burden of assessing whether business decisions in areas such as the management of doctors’ office leases required reporting to governmental authorities. In addition, the new policies on physician relationships frequently created resentment among doctors, who did not always look kindly upon having their investment syndications unwound, being charged for pharmaceuticals required by them or their family members, or facing increases in office rent to reflect market rates.27

Legal Strategies

Along with Columbia/HCA’s newfound openness with federal investigators, the development of a far-reaching ethics and compliance program dramatically improved the company’s relationship with the government. So too did the company’s February 1999 execution of letters of credit to the Department of Justice totaling $1 billion, which Columbia/HCA offered to cover its obligations created by any settlement. (The company was careful to insist that its action, which facilitated Justice Department approval of a stock buyback plan, did not constitute an admission of wrongdoing). As prosecutors came to view the company’s new management team as sufficiently deferential and trustworthy, they shied away from using search warrants to obtain information. Instead, they relied on agreements that called for managers to keep records and turn
them over to law enforcement agencies, as well as a series of voluntary govern-
ment audits.\textsuperscript{28}

Despite warming relations, serious settlement negotiations had to await the
collection and processing of enormous amounts of evidence by both parties in
the dispute. Each side also wanted to see the outcome of the Florida prosecu-
tion of four Columbia/HCA executives for Medicare fraud, which only got un-
der way in the spring of 1999. After a three-month trial in which the four
defendants had the benefit of topflight legal counsel paid for by Colum-
bia/HCA, a federal jury in Tampa found two of the four executives guilty. The
verdicts strengthened the government’s position, since its prosecutors could
now point to proven criminal wrongdoing within the company.\textsuperscript{29}

The legal team at Columbia/HCA, however, refused to accept settlement o-
fers, regardless of terms or cost. One sticking point concerned the structuring
of any criminal guilty plea by the company, because such a plea technically
would require long-term suspension from federal medical benefit programs.
Another related to the fines the government was proposing. In evaluating gov-
ernment offers, company attorneys first developed what they considered to be a
reasonable range for a potential agreement. They then calculated projected le-
gal costs and estimated the degree of risk associated with taking outstanding
issues to court. So long as the government’s asking price exceeded these esti-
mates, Columbia/HCA continued to negotiate.\textsuperscript{30}

On May 19, 2000, the company finally reached a tentative agreement to set-
tle civil charges relating to up-coding, laboratory billing, and home health care.
The accord called for civil fines of $745 million, then a record payment to the
government (the company’s legal fees and investigation-related costs since
1997 totaled an additional $200 million). The accord also included a detailed
corporate integrity agreement that committed Columbia/HCA to keep its ethics
and compliance structures in place for at least eight years. Although the com-
pany admitted no wrongdoing, the deal was predicated on resolution of the
pending criminal investigation by the end of the year. It also left two pieces of
the civil probe outstanding—those relating to cost reports and physician kick-
backs, the two most complicated issues confronting Columbia/HCA and the
government. A week after the announcement of the conditional settlement, the
company changed its name to HCA–The Healthcare Company, which Frist de-
scribed as a return to the values that suffused “the old HCA.” The change, Frist
asserted, “means there’s a company up there with…not only a financial balance sheet but a moral balance sheet.”

In mid-December, the government and the renamed HCA reached an additional agreement on all criminal allegations. Two of the company’s defunct home health care subsidiaries pled guilty to four counts of conspiracy to commit Medicare fraud, which made them ineligible for the federal program; the company also accepted criminal fines and penalties totaling $95 million and agreed that a hospital it had closed in 1999 would also be barred from participation in federal medical programs. But the rest of HCA’s subsidiaries and facilities and its corporate headquarters remained eligible for Medicare and Medicaid funding.

As of the autumn of 2001, HCA had yet to settle either of the two remaining segments of the Medicare fraud probe, which involved thousands of individual issues that theoretically could each go to trial. In mid-March and early April, the Department of Justice joined eight *qui tam* lawsuits relating to the cost report and physician kickback allegations. These suits, initially brought by internal whistleblowers, alleged systematic violations of federal regulations and laws and estimated illegal payments at around $600 million. The suit included accusations relating to corporate restructurings made by HCA in the late 1980s, long before its merger with Rick Scott and Columbia, when Frist served as chief executive officer. If the government won these cases at trial, they could claim triple damages, or around $1.8 billion. In response, HCA filed countersuits two weeks later for millions of dollars related to cost reports left unprocessed since the federal raids against Columbia/HCA facilities in July 1997. Health sector analysts generally expected a final settlement of somewhere between $200 and $700 million, taking into account HCA’s claims against the government. In April 2001, the company stated publicly that it was willing to go to trial if the Justice Department did not offer terms that senior executives viewed as reasonable, arguing that “it would not be responsible for us—to our shareholders, employees, or patients,” to accept a deal not warranted by the company’s past actions.

The company also continued to defend itself vigorously against the large number of other fraud-related actions pending against it. Plaintiffs in many of these cases were buoyed by the guilty verdicts obtained in Tampa, as well as by the civil and criminal settlement agreements with Columbia/HCA. In addition
to certifying that the company and its employees had engaged in wrongful acts, those outcomes made “a treasure trove” of evidence available to plaintiffs’ attorneys, such as those representing institutional investors who alleged breach of fiduciary responsibility by Columbia/HCA’s 1997 board of directors. Lawyers for private insurance companies were particularly aggressive in ratcheting up their demands, arguing that Columbia/HCA’s past practices of “lab unbundling,…DRG upcoding,…[and] home health fraud” distorted claims on their clients as well as those on the government.34

For both HCA’s critics and its defenders, a pivotal issue concerned how one characterized billing practices at the company before 1997. In the eyes of Justice Department officials and the lawyers representing whistleblowers and other plaintiffs against the company, Columbia/HCA’s corporate ethos generated widespread fraud. “The company pressured managers to increase government reimbursements,” one qui tam attorney declared after the May 2000 announcement of the tentative partial civil settlement, “which led to many different scams that boosted profits.” Those scams were “endemic,” according to another whistleblower lawyer, and were “not solely a product of the Columbia era,” since some incidents occurred as early as 1987.35 Frist, Bovender, and their defenders in the commercial press saw things very differently. HCA’s senior executives conceded that many individuals in the company “pushed the envelope” with regard to reimbursement claims, and that some clearly angled to “beat the system” and went “beyond the pale.”36 But they strenuously denied that the company ever engaged in a systematic, orchestrated scheme of fraud, emphasizing the decentralized character of reimbursement management before July 1997, the ambiguities suffusing reimbursement regulations, and the majority of company hospitals and personnel not implicated in wrongdoing.37

Questions for Discussion

1 In what ways, if at all, does a formal “corporate mission statement” shape the day-to-day activities of a complex business organization? How significant is the behavior of senior management in setting the tone for such an entity?

2 How much priority did Columbia/HCA’s ethics and compliance campaign give to “ethics” and how much to “compliance”?
3 How can one measure change in corporate culture? What kind of analysis would
you pursue if you were charged, as an outside consultant to HCA’s senior man-
agement, to assess the impact of the company’s refashioning on the actual work-
ings of company-operated care centers?

4 To what extent did considerations of business ethics guide Columbia/HCA’s corpo-
rate reconstruction, as opposed to considerations of prudence, business strategy,
and public relations?

5 What lessons does the Columbia/HCA case offer to organizational managers faced
with government probes into business practices or settlement negotiations con-
cerning allegations of illegality?

Notes

This case study was prepared in collaboration with Kevin A. Schulman as a basis for class dis-
ussion, rather than to illustrate either effective or ineffective handling of an administrative situ-
ation. The case is based on research in public sources and on interviews conducted on April 19
and May 25, 2001, with senior executives of HCA–The Healthcare Company. The interviews
concerned the challenges confronting Columbia/HCA in the summer of 1997 and the company’s
responses to those challenges over the following four years. This research was approved by the
University Review Committee on the Use of Human Subjects in Non-Medical Research at Duke
University, Durham, North Carolina.

1 Robert Waterman (senior vice president and general counsel, HCA–The Healthcare

22 July 1997, A3; “Overbilling: Lefevers v. HCA,” Health Care Fraud Litigation Reporter,
6 (June 2001): 11.
For a list of investigations and related lawsuits, see HCA–The Healthcare Company,

3 Waterman, interview.

4 Columbia/HCA, “Frist Vows to Put Patients First” [press release], 22 September 1997;
Anita Sharpe, “Bovender Joins Frist Team at Columbia/HCA,” 5 August 1997, Wall Street
Journal, A3.

5 Jack Bovender (chief executive officer, HCA–The Healthcare Company), interview by

6 Lucette Lagnado, “Columbia Names Lawyer Alan Yuspeh to Head Hospital’s Ethics
Overhaul,” Wall Street Journal, 14 October 1997, A1; Alan Yuspeh (senior vice president,


13 Bovender, interview.


16 Yuspeh, interview.

17 Yuspeh et al., “Above Reproach.”


21 Alan Yuspeh, “Keynote Address,” Health Care Compliance Association Annual Institute, 24 October 1999, 8–9; Yuspeh, interview.

22 Yuspeh, interview.

Fraud, December 1998, 1; Yuspeh, “Restoring Momentum to the Business Ethics Movement,” 554.

24 Yuspeh, interview; Waterman, interview.


26 Waterman, interview.


30 Waterman, interview; Bovender, interview.


The full text of the corporate integrity agreement is available on the HCA Web site.


The complaints of the whistleblowers are accessible at the Web site of the Department of Justice (http://www.usdoj.gov/civil/cases/alderson/march15_2001/index.htm).


In 1999, a federal district court dismissed the consolidated shareholder suits because the facts on record did not indicate a “conscious board decision” related to fraudulent Medicare reimbursements. In February 2001, however, a three-member federal appeals court panel reinstated aspects of the suit, ruling that “the particularized facts are sufficient to create a reasonable doubt as to the disinterestedness of at least five of Columbia’s directors,
including Scott [and] Frist,…by alleging facts that presented a substantial likelihood of director liability for intentional or reckless breach of the duty of care.” See McCall v. Scott, 239 F. 3d 808 (3d Cir. 2001).


36 Bovender, interview.

37 Bovender, interview; Frist, interview; Waterman, interview.

Scenes From a Corporate Makeover:
Health Care Fraud and the Refashioning of Columbia/HCA, 1992–2001

Edward J. Balleisen

Part Four of Four:
The “New” HCA and the Prospects of the For-Profit Hospital Sector

Case Study HSM-2003-04
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About the Author

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Part Four of Four: The “New” HCA and the Prospects of the For-Profit Hospital Sector

Although HCA’s settlement with the government in December 2000 constituted the largest civil fraud payments in American history, in many ways it represented only “a modest rebate” on the company’s robust earnings from public sources. Even if outstanding claims against HCA come to an additional $500 million, the total of fines and penalties (assumed here to be $1.35 billion) would equal only about 2.5 percent of the company’s and its predecessors’ combined revenues from the federal treasury between 1990 and 1997 (approximately $50 billion). And while the uncertainty surrounding the ongoing probe continued marginally to depress its stock price, the company argued that the investigation ceased to have a significant impact on its operations from the middle of 1998 onward.¹ HCA’s streamlining over the following three years strengthened its balance sheet substantially and potentially laid the groundwork for a new phase of expansion (Exhibit 1).
The company’s name change in the spring of 2000 (from Columbia/HCA to HCA–The Healthcare Company) by no means effaced all memories of the fraud scandals that beset it in 1997 and 1998. But, by the spring of 2001, the company had regained a substantial measure of respectability in the health care industry, in the financial markets, and from the news media. With its turn away from voracious expansion, and with the ongoing consolidation among non-profit hospitals, HCA no longer found itself the subject of constant public attacks from its competitors. Concerns about the federal fraud probe rarely troubled health sector analysts or institutional investors, and journalists who ripped HCA during 1997 and 1998 adopted a more respectful tone toward the company. Indeed, nothing pleased HCA’s communications department more than the disappearance of the company from the national limelight. Instead of daily coverage of revelations about questionable business ethics and fraud on American taxpayers, the company began receiving episodic commentary on its quarterly earnings announcements and strategic blueprints, like most Fortune 500 businesses.\(^2\) HCA, senior vice president for investor relations Victor Campbell observed on the occasion of its name change in May 2000, was meant to be “the invisible brand.” Senior executives believed they were achieving that goal.\(^3\)

One marker of HCA’s regained standing was its ability to attract highly regarded people to serve on its board of directors. Thomas Frist wanted to create a stronger component of outside directors upon taking over as chief executive officer in 1997; he began to have success in this regard in early 1998. Nine eminent people accepted offers to serve on the company’s board between

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<table>
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<td>178</td>
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<td>No. of admissions</td>
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<tr>
<td>Revenues, millions, $</td>
<td>18,681</td>
<td>16,657</td>
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Source: Company reports to the U.S. Securities and Exchange Commission.
March 1998 and April 2001, including former chief executives of United Parcel Service and Capital Cities/ABC, the current chief executive of Deloitte & Touche, and economist and presidential adviser Martin Feldstein (Exhibits 2 and 3).  

In early 2001, Frist considered his reinvention of Columbia/HCA to be largely complete. “As far as I’m concerned,” Frist asserted in an April 2001 interview, “our company is as well-run and highly principled as any, especially in health care.” Three months earlier, Frist relinquished the position of chief executive officer to his protégé, Jack Bovender, staying on as chairman of the board. In late July, Frist turned over that post to Bovender, as well. After taking over from Frist, Bovender remained upbeat about HCA’s prospects, even in the absence of significant acquisitions. The company’s hospitals, he observed to the press, were concentrated in some of the country’s fastest growing urban markets, like Tampa, Miami, and Houston. While demographers expected the U.S. population to grow about 4.5 percent over the subsequent decade, projections for most of HCA’s key markets tended to be much higher, often running into double digits. This demographic profile, together with the aging of the Baby Boomer generation and the continual emergence of new medical technologies, convinced Bovender that demand for acute medical care would continue to grow in HCA strongholds. Also, in light of the dominant position that his company maintained in those markets, he expected to be able to extract
“fair rates from the managed care players,” which would absorb the almost certain growth in labor and supply costs brought on by the nation’s nursing shortage and the continual development of expensive new drugs and medical technologies. For the moment, HCA’s senior management was content to focus primarily on the company’s current care centers. They contemplated an increase in annual capital spending on those facilities by as much as 25 percent, to $1.5 billion, and expressed confidence that an emphasis on operations would continue to produce annual earnings growth of approximately 15 percent for the following five to ten years.5

At the same time, Bovender did not rule out possible expansion, in either the United States or Europe (HCA already had a strong position in London and Switzerland). With the introduction of regional service centers, Bovender viewed the company as having an incentive to spread costs across a large group of domestic facilities. With regard to the European Union, HCA eyed possible ventures that would emulate their London operations, where the company’s hospitals eschewed emergency departments, limited their offerings to particu-
larly remunerative specialties like cardiology and orthopedics, and primarily served affluent private patients who did not wish to wait for treatment in the public sector. HCA’s interest in Europe intensified after the British government decided to allow private hospitals to relieve especially persistent surgical delays in the National Health Service (NHS), receiving payment from the NHS, and after other European countries signaled that they might similarly furnish avenues for privately owned hospitals to gain reimbursements from public health budgets.\(^6\)

Perhaps the most important dimension of Columbia/HCA’s fraud scandal and eventual refashioning, however, involved not its impact on the company itself, but rather its long-term consequences for the hospital sector as a whole. Columbia, Columbia/HCA, and HCA—The Healthcare Company cast a long shadow over American health care for more than a decade. The rapid growth of Columbia and then Columbia/HCA under the leadership of Richard Scott spurred consolidation throughout the industry, especially among nonprofits, as numerous hospitals staved off acquisition and conversion to for-profit status by affiliating with more powerful local and regional networks. Given the pressures created by the emergence of managed care, the inexorable rise of health care costs, and the endemic problem of hospital overcapacity, such consolidation was likely regardless of Columbia/HCA’s acquisitiveness. But as one Cleveland health sector analyst commented about the processes of rationalization in his city, “it’s…fair to say that Columbia was the catalyst for major changes in [our] healthcare landscape.” The same dynamic played out in numerous other cities throughout the country.\(^7\)

The federal investigation of Columbia/HCA had similarly far-reaching effects. As Thomas Scully, then president of the Federation of American Hospitals, noted in December 2000, the intense scrutiny of Columbia/HCA’s reimbursement practices “scared everyone in the healthcare field.” After seeing the scope and impact of the federal investigation on Columbia/HCA, almost every American hospital organization of any size moved quickly to develop a comprehensive compliance program, typically headed by a newly created high-level oversight department and generally incorporating the creation of a detailed code of conduct and the setting up of a telephone hotline for anonymous reporting of alleged improprieties. Often hospital executives in charge of these new programs modeled them explicitly on Columbia/HCA’s ethics and compli-
ance policies. A key conduit for this transmission was the Health Care Compliance Association, a quickly expanding industry group in which HCA representatives played a prominent role. To some observers, moreover, the Columbia/HCA probe encouraged not just “extremely aggressive compliance activities,” but also “underbilling,” as health care managers came to fear the knock at the door from federal agents. Certainly this episode has come to serve as the primary touchstone for health care attorneys. Legal guides for health care executives on the subject of legal compliance invariably began with an analysis of the massive investigation of Columbia/HCA.\(^8\)

Columbia/HCA’s inward turn similarly influenced strategic planning in the health care industry, leading other private companies, such as Tenet, to re-evaluate their own operational practices. Reengineering of supply chains, group purchasing programs, and close appraisals of proposed managed care contracts became standard operating procedures among large-scale operators of acute care centers; developments like these were greatly facilitated by the process of consolidation that swept through the industry.\(^9\) At the turn of the millennium, HCA remained a bellwether for the management of American health care.

As more foreign governments contemplate increased reliance on the private sector for health delivery, the company also began to play that role on a wider stage. In countries such as the United Kingdom and Australia, which were implementing steps to open up a greater portion of the health sector to private enterprise, critics of for-profit hospitals seized on the aggressive practices of Columbia/HCA prior to 1997 as a leading argument against moving away from nationalized medicine.\(^10\) As a result, the eventual outcome of HCA’s effort to soften its image and to inject concern for ethics and legal compliance into its organizational culture will likely have a significant impact on the ability of American health care companies to export their services abroad, as well as on the structure of the health sector worldwide.
Questions for Discussion

1. How would you assess the benefits and pitfalls associated with strategies of horizontal combination and vertical integration in the acute-care segment of the health care industry?

2. To what extent do the complex internal mechanisms necessary to ensure legal compliance with Medicare and other federal medical benefit programs constitute a significant “barrier to entry” into the acute-care sector?

3. What are the appropriate parameters for discussing “business ethics” by providers of health care?

4. Examine HCA’s history page on its Web site. Should the company’s Web site be more forthright in its presentation of the corporation’s past? How does a corporation’s engagement with its history shape its current culture?

5. What does the Columbia/HCA case suggest about the relative financial pay-offs that large-scale health care organizations can achieve through either (a) trimming costs or (b) achieving sufficient market power to be able to pass on rising labor, equipment, and supply costs to insurers and, through them, to patients?

6. What does this case suggest about how business strategies tend to move through particular industries, or about the ways in which business plans that focus on growth give way to ones focused on operations, and vice versa?

7. To what extent does HCA’s current business strategy offer guidance to other privately owned acute care companies; large-scale nonprofit health networks, which typically provide care to a broader cross-section of the population; and governmental policymakers?

8. Can HCA’s corporate leaders count themselves lucky that the company’s brush with fraud allegations occurred during the 1990s boom, rather than in its aftermath?

Research Exercise

You are a health care analyst for a large brokerage company. Your boss has asked you to examine HCA’s financial reports and press coverage on the company since the autumn of 2001. She suggests that you especially track coverage in the New York Times, the Wall Street Journal, and Modern Healthcare. Your assignment is to write a memo that situates current HCA strategy in a larger historical context and that assesses the company’s prospects for the short to medium term.
Notes

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4 For access to announcements of these appointments to the Columbia/HCA and later HCA board of directors, see http://www.prnewswire.com/micro/HCA/.


10 In January 2001, BBC Radio aired a documentary about new British policies that make it possible for the National Health Service to pay for some elective surgeries in private hospitals. The documentary focused on allegations of fraud against Columbia/HCA in the United States.
See also Jeremy Lawrence, “Health Check: ...How Did HCA Slip Through the Net?” *The Independent*, 3 May 2001.