

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Physicians Learn Tough Lessons Under Capitation

Many physicians in California are struggling financially and learning bitter lessons about how to survive under declining capitation rates. The California Medical Association says about 90% of the state's physician groups are on the brink of bankruptcy or closure. A report released last fall by consultants in the Walnut Creek, Calif., office of PricewaterhouseCoopers, CPAs and consultants, predicted that some 34 physician groups in the state would have filed for bankruptcy by year-end.

The causes of the current crisis are both complex and unique to California, but regardless of how California's physician organizations arrived at this precipice, they must now figure out how to back away safely.

Since capitation is widespread in California, it plays an important role in the health of the physician services industry. Under a capitated reimbursement schedule, a health plan pays a physician organization a fixed amount for each HMO member under the group's care.

For some, the idea behind capitation is simple. It is designed to bring medical decisionmaking back to the physician level and, by compelling doctors to share in the financial risk of overutilization, create incentives for cost-effectiveness. But the reality of capitation has proven to be far more complex, creating business, clinical, and ethical dilemmas that have never before been part of the practice of medicine.

"We fight all the time to make sure we have enough money to take care of our patients properly," says Ronald Bangasser, MD, a family practitioner and medical director of Beaver Medical Group, a 132-

physician multispecialty practice in Redlands, Calif. The group derives 80% of its income from capitation. "It's an experience I never thought I would have when I started practice."

Paying the Price

Among the lessons the Beaver Medical Group has learned about capitation is that utilization review is necessary and that the group must focus on preventive care to be successful. "Capitation has made us look at our utilization, which we didn't do in any way, shape, or form before capitation came along," Bangasser says. "In addition, we're much better at flu shots and mammograms and Pap tests now."

Beaver Medical Group is one of a growing number of physician practices in California that takes on pharmacy risk in its capitation agreements, which many experts believe is a dangerous strategy, if the cost of pharmaceuticals rises sharply.

Bangasser's group also learned the hard way about the down side of saying no to a managed care plan's capitation offer. "About five years ago we walked away from an HMO whose rates we didn't like," he says. Given the size of most HMOs, however, what health plans call rate negotiations are generally one-sided affairs. "In about two days' time 6,000 people got transferred from our practice," he says. "That was 11% of our total population of patients, and included some major local employers like the fire department, the police department, the junior college."

As bad as it was for his group, says Bangasser, it was worse for patients. "They paid the greatest price," he says. Two years

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We All Could Suffer From Lawsuits Against HMOs

Last fall, Aetna Inc., Aetna-US Healthcare, Humana, Cigna, PacifiCare, and other HMOs were sued by plaintiffs' attorneys, alleging the health plans had engaged in unfair and misleading trade practices. The lawyers said the health plans had violated consumer protection laws in California and other states. No doubt many physicians cheered and many likely agreed with the charges as filed. But the issue may be more complicated than simply good versus evil, as the trial lawyers might have us believe. In fact, it is too early to know what effect these suits might have on physicians.

Don Frederico, a lawyer specializing in class action suits for McDermott, Will, and Emery, in Boston, says the legal theories involved have yet to be tested. One theory, for example, is that HMOs have a fiduciary duty under the federal Employee Retirement and Income Security Act (ERISA) to report their relationships with physicians to HMO enrollees.

The theory of fiduciary liability could be difficult to prove and likely will first need to survive several motions to dismiss the suits, Frederico says. Another hurdle is a pending U.S. Supreme Court decision due later this year on whether an Illinois HMO breached its legal duty to a patient with a ruptured appendix by denying a test to diagnose her abdominal pain and by not revealing its financial arrangements with doctors to hold down costs.

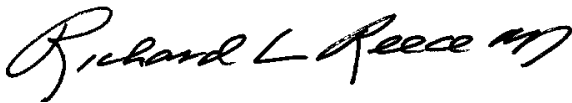
Whatever the outcome of the suits, Gary Davis, an attorney for McDermott, Will, and Emery, in Miami, says physicians will get little if any economic relief. Trial attorneys will benefit the most, he says, and only a small amount of money will go to plaintiffs. Physicians may receive only the emotional satisfaction that right has been done, but if managed care plans are left to suffer financially, physicians could suffer too. For this reason, Davis believes any effort to reform the health care system ought to be done in Congress and the state legislatures, not in the nation's courtrooms.

Conversely, Timothy Norbeck, executive director of the Connecticut Medical Society, believes allowing patients to sue their HMOs is good because it may force health plans to deal more openly. "It could make HMOs reveal the coercive, pernicious, and unilateral policies that edge out physicians who refer too much and which compel physicians to participate in all HMO products and to accept all conditions an insurer imposes upon doctors, now and in the future," he says.

As one might expect, Aetna CEO Richard Huber says the lawyers who have sued on behalf of patients are "like a pack of marauding wolves trying to look for a weak buffalo, and they may have found the wrong one."

Perhaps the best answer lies in asking a different question. Last year, the AMA and the Connecticut Medical Society ran ads in newspapers against Aetna that concluded by asking, "Whenever health care is the issue, this should be the only real question: Is it good medicine?"

For these reasons, it is hard to believe any good can come of lawsuits against those organizations that deliver health care. Even if we are dissatisfied with HMOs, we need managed care plans to organize the delivery system, at least until a more effective and more caring organization is developed.



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United Creates Openings for Physicians

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

UnitedHealth Group has made perhaps the best and smartest response to the growing backlash against managed care. In a bold move in November, the MCO in Minnetonka, Minn., effectively closed its utilization review (UR) division.

Not only does this decision to discontinue second-guessing physicians before approving medical treatments save money, but it raises the current level of debate in Washington and state legislatures significantly. By itself, the decision will save \$128 million by allowing United to shed its small army of people whose main job was to question doctors about clinical decisions. United argues that its UR department approved more than 90% of its physicians' decisions anyway. So, why conduct utilization review at the cost of losing money, infuriating doctors, and frustrating patients?

More Than PR

The nation's second largest managed care organization, United covers 14.5 million people in 30 states. Given its size and reach, United has the potential with this one move to smooth relations with patients and physicians, attract new customers to its plans and new physicians to its panels, and establish a competitive advantage over its rivals. But United also may have dodged a legal bullet from class-action lawsuits by lawyers accusing HMOs of practicing medicine and it may have forced other large MCOs to take similar actions.

"This is great," commented Timothy Norbeck, executive director of the Connecticut State Medical Society. "It's the first major dent in the armor of managed care. We've always known that hav-

ing doctors making medical necessity decisions saves money."

Indeed, several health plans have already concluded that utilization review costs more money than it saves. "We used to do a lot of it, but we have cut back drastically over the past several years," said Kurt Silgar, a senior vice president for Blue Cross Blue Shield of Massachusetts, in Boston. What's more, some health plans have reduced the number of procedures for which physicians must call for precertification, according to *The Boston Globe*.

The question, then, for many health plans is why didn't they drop UR long ago? "Why did it take these guys 10 years to figure this out?" asked Uwe Reinhardt, a health care economist at Princeton University. Robert Blendon, a health policy professor at Harvard Medical School, said the answer to this question is obvious. United had to get the dreadful image of HMOs off the front page, he said. "Other HMOs have to do what United's done," he continued. "They have to say they're not in the business of denying care."

Even Aetna Inc. said it may follow United's lead. "The trend is clear and we're participating in it," said Aetna Chairman Richard Huber. Aetna's Chief Medical Officer Arthur Liebowitz, MD, added, "There's not a lot of value in reviewing everything a doctor does." Aetna and Humana have been named in class-action lawsuits brought on behalf of patients who claim health plans have been practicing medicine. Humana said it would continue UR.

"There will be a vigilant period of watching to see if United Health's plan is working," said Gary Frazier, analyst with Deutsche Banc Alex Brown, a financial

services company in New York. John Erb, a health benefits consultant for Arthur Gallagher & Co., in Boca Raton, Fla., said United's approach could result in higher insurance premiums for consumers and health care purchasers. If health plans see costs rise because UR controls have been removed, plans will pass those costs on to consumers and other payers, Erb explained.

Watchful Waiting

Nathan Kaufman, a health care consultant for Superior Consultant Co., Inc. in San Diego and a member of the *Practice Options* editorial Advisory Board, believes United's move to eliminate UR may have negative consequences for physicians. "We're only hearing half the story," Kaufman says. "The other half is that the only way United can get away with this is to extract heavy discounts from doctors or kick overutilizers out of the plan."

Charles Inlander, president of the People's Medical Society, a consumer health advocacy group in Allentown, Pa., says UR has helped to protect patients against overly aggressive physicians. "This is a double-edged sword for patients," he explains. "Patients will no longer be rejected for treatment, but consumers may also fall prey to unnecessary and ineffective procedures."

Critics also complained that United's policy of discontinuing UR for physicians did not extend to mental health providers. For years, behavioral health care specialists have complained that MCOs are more restrictive toward them than they are toward any other specialists. They also believe that MCOs are biased against behavioral health care because it can be

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United is betting that physicians are a self-disciplined, self-organizing, and self-selected group of professionals who value autonomy, professionalism, and performance and will respond positively when given comparative, practical, and relevant data at the point of care.

(Continued from page 3)

expensive and is misunderstood, and that United's decision not to eliminate UR for behavioral health care is more evidence for that argument. Officials at United defended their decision to continue UR for mental health conditions, saying behavioral health care is much less tangible than other forms of medical care.

Whether United's move is good or bad will be decided over time, of course. But for now, most observers are positive about United's decision, and such positive reactions are important for any large public company, especially for a large MCO today. The most significant issue for physicians may be that managed care is changing and, in many ways, United is leading the change. By collecting and using extensive data on physicians, United is educating its physicians on best practices and improving care while it aims to cut costs.

Evidence-Based Medicine

It is clear that United took this action because it believes physicians will respond to evidence-based medicine. Most physicians operate in an information void, failing to recognize that their clinical and business practices are intertwined. This void accounts for most of the practice variation among doctors.

Recognizing that physicians operate in an information void, United has been collecting and reporting clinical information to physicians to help them deliver the best, most cost-effective care. United understands that physicians will respond positively to data that remind them about missed tests or failures to prescribe the right treatment at the right time, United officials have said.

Two years ago, United launched a quality-measurement initiative to track performance without engaging in second-guessing. In this initiative, United gathered data from billing records on 42,000 physicians in 17 states and issued reminders to physicians to prescribe beta-blockers for heart attack patients, to test the glucose and glycosylated hemoglobin levels in diabetic patients, and to prescribe mammograms for women over 50. It also reminded physicians who did not

United had to get the dreadful image of HMOs off the front page. "Health plans have to say they're not in the business of denying care."

—Robert Blendon, Harvard Medical School

meet these criteria that they were outside the normal boundaries of care. Once these outliers were identified, United sought to find out why they were not administering care as prescribed.

Since United was founded and is run by physicians, it should come as no surprise that it has learned that using UR to question physicians' decisions is counterproductive. Such questioning alienates physicians and costs physicians about 10% to 15% in overhead costs each year. Indeed, unlike most MCOs, the executives who run United understand these issues. William McQuire, MD, is the CEO. Archelle Georgiou, MD, is the chief medical officer, and Lee Newcomer, MD, is the senior vice president for health policy. These three physicians make many of the top decisions and represent the company to the media and the public. As a result of their management, United has always been leery of certain common managed care practices—total capitation and gatekeepers—and it has fostered direct access to specialists.

Roberta Goodman, an analyst with Merrill Lynch & Co. Inc., financial analysts in New York, has said, "Utilization review is an intrusive and ultimately non-productive process. In any event, United was already known as more deferential to its participating physicians than were many other managed care companies."

In fact, a deep knowledge of the physician culture by health care corporations is essential for success. This lack of understanding—the gulf between administrators and clinicians—has brought down many physician practice management companies, hospital-based physician corporations, and MCOs.

Ending UR was a deliberate and studied decision by Newcomer, a member of the editorial Advisory Board of *Practice Options*. United has already cut UR from six of its plans and proved it could save money by doing so, Newcomer has said.

He also has said that United's quality initiatives preceded by two years the current political discussions about HMO reform.

Options for Physicians

By making evidence-based medicine a pillar of managed care, United is simply forcing the health care delivery system to the next logical level of development: care based on what's best for patients. This concept is certainly not new. In fact, it is one of the basic ideas behind HMOs when Congress was considering the HMO Act in 1973.

Indeed, United's move signals the beginning of the end not only of UR, but of two other pillars of orthodox managed care: global capitation and integration into large organizations. Some physicians have said United's decision marks the end of managed care and that it is an event similar to the fall of the Berlin Wall. These physicians want to believe that managed care has discarded one of its core tenets: that bureaucrats can micromanage medical decisionmaking to deliver improved care at lower cost.

But physicians should not be so quick to judge.

Managed care is simply evolving. New forms of management will replace the old forms of micromanaging. Management of health care costs will not end. Cost control will now be done after the fact rather than before—by computer monitoring of physician performance and by more sophisticated forms of reimbursement, such as global fees for episodes of care.

Since the early 1970s, managed care has been evolving as patients and physicians have developed many other options besides the closed-panel HMO. Today, patients and physicians can participate in PPOs, point-of-service plans, and variations on traditional indemnity plans that use medical savings accounts, discounted cash payments, and flexible spending

plans. Health plans continue to respond to the market by loosening access to specialists, offering more choices, and by using independent appeals processes.

Evolution means that the original pillars of managed care are crumbling, in part because physicians have rejected them but also because patients do not understand or appreciate them. But they are crumbling because they are being replaced with more effective alternatives. Today, we have more information about health care and the quality of care than ever before. The Internet is changing how almost every business operates and health care is no different. Information is allowing health plans to do what they have always done—manage costs—more efficiently.

Therefore, one of the best options for physicians today is to collect data on their own practices and share those data with consumers and managed care companies through e-mail and over the Internet through their own Web sites.

Physicians will respond positively to data that remind them about missed tests or failures to prescribe the right treatment at the right time.

The Value of Data

Unquestionably, United's act is a victory for physicians. It shows that physicians have political power and it gives them leverage to pressure other HMOs to drop UR and to encourage patients to enroll in health plans that do not have UR.

If other managed care companies follow United's lead, physician overhead could drop significantly, and for many practices, overhead can represent as much as 50% of revenue. Geraldine Sussman, an assistant for a solo practitioner in Manhattan, says she works with five HMOs and could save at least three hours each week on paperwork and phone calls for approvals if all five dropped UR.

But in order to make managed care work without UR, physicians will need to

discipline themselves to practice evidence-based medicine. Also, physicians will need to be much more savvy about information systems and to use the Internet, e-mail, and computers of all kinds (including handheld devices, laptops, and desktops) to collect real-time information to improve practice efficiencies, gather data on outcomes, and report on patient satisfaction.

When United dropped UR, it sensed that physicians are a self-disciplined, self-organizing, and self-selected group of professionals who value autonomy and high performance and who will respond positively when given comparative, practical, and relevant data at the point of care. Now, it's up to physicians to prove that United's move was the right one. ■

Five Steps to Effective Contracting

By Thomas M. Gorey, JD

There are many reasons to form a physician organization. Physicians may want to gain economies of scale, enhance market clout, and provide better patient care through closer professional collaboration. Yet, most often the driving factor is that physicians are interested in positioning themselves for managed care contracting.

Regardless of the reason for forming a new physician group or network, physicians are likely to encounter some unexpected problems along the road toward accomplishing this goal. Being aware of these potential problems can smooth the process toward successfully implementing a contracting strategy. Five of the most common problems physicians will face when forming a new group or network are:

1. Lack of information or naivete regarding payers
2. Inadequate information systems to support the contracting effort
3. Inadequate or inequitable physician compensation systems
4. Going for short-term gains rather than a long-term relationship with payers
5. Nonexistent or underdeveloped medical management processes

Lack of information or naivete regarding payers. Unfortunately, the planning efforts of many physician organizations can be summed up in the saying, "Build it and they will come." In many cases, physicians have built an organization on an untested foundation that assumes payers will be interested and ready to contract with them. When the reality sinks in that health plans and other payers may not be interested in contracting with the new physician group, or are not interested in the type of contracting arrangements

Thomas M. Gorey, JD, is president and CEO of Policy Planning Associates, a health care consulting firm in Crystal Lake, Ill., that assists physicians in organizational strategy development.

the group envisioned, there often is surprise and disappointment. Taking some simple steps during the planning process can help avoid this unfortunate result.

First, it is important to gather as much information as possible about the payer market. Consider the stage of market evolution and consolidation, by asking questions such as:

- What is the overall level of managed care penetration in the market?
- What type of managed care contracting is most common: discounted fee-for-service or capitation?
- To what extent is the payer market fragmented (meaning no health plan controls the market) or consolidated (a few large plans control the market)?

Second, assess the likely future evolu-

tion of the market, although this process is fraught with uncertainty. One lesson physicians have learned over the past five years is that managed care is not like a tidal wave sweeping over the country from west to east. Outside of major metropolitan areas, managed care—defined simply as risk contracting—has had a much smaller effect on physician contracting efforts than many experts expected. As a result, those physician organizations that formed in anticipation of the emergence of managed care and the expectation that opportunities for risk contracting would abound have had to adjust their strategic thinking.

Understanding how to solve unexpected problems when forming a new physician group or network can help the organization succeed.

In sharp contrast are those well-developed managed care markets in which capitation is widespread—here, a new physician group or network will need to begin operating quickly to be successful. When a group starts up quickly to take advantage of changes in a particular mar-

ket it may need to assume some substantial contracting risks, despite a lack of experience in managing risk.

Third, gather as much information as possible about the specific health plans in the market. Among the questions to ask are:

- Who are the major health plans and other payers in the market?
- What is the market share of each payer?
- What types of contracting arrangements does each plan use?
- What published financial and performance data exist on each plan?

Often, particularly in smaller communities, the medical director of the health plan is a physician who is familiar and accessible. Talking with the medical director formally or informally can provide an opportunity to gather useful insight into

the plan's contracting arrangements and preferences. This information can provide a realistic foundation on which to structure a new group's contracting strategies.

Another important source of information can be the benefits managers for some of the area's major employers. Talking with these professionals can yield information on trends in corporate health plan arrangements and their preferences for health care delivery. Invariably, the physician network planning process involves at least a discussion about contracting directly with self-insured employers. In fact, this strategy is talked about far more that it is actually implemented. For this reason alone, a conversation with a corporate benefits manager can provide an important reality check.

Inadequate information systems to support the contracting effort. Having a payer market that is ready and willing to contract with a new physician group or

network is important. It is also important, however, for the physician group to have an organizational infrastructure that can support the contracting effort. In addition to having appropriate human resources—namely an experienced administrator or director of contracting—the group must have an information system capable of tracking the costs of providing various services. Without an adequate system, the group would be unable to manage costs under capitation effectively.

Whereas an existing group may have years' worth of clinical records that can be culled for useful data, a new physician group may have to compile its own database. One shortcut that some groups have used is to obtain data from health plans or local hospitals. This strategy can work initially but physicians should be aware of two potential problems. First, data collected by payers for payment purposes usually are not useful or reliable when physician groups use these data for assessing physician practice patterns and tracking costs. Second, hospital data can be useful for analyzing inpatient utilization trends, but they do not help in the important task of compiling a database on outpatient utilization. A fledgling physician organization will need data on outpatient utilization when participating in any new contracting ventures.

Inadequate or inequitable physician compensation systems. Related to a group's contracting strategies are its plans for physician compensation. Groups formed in anticipation of enhanced contracting opportunities often overlook the fact that no amount of contracting success will be sufficient to overcome an inequitable compensation scheme. While achieving true equity in physician compensation plans is probably an unattainable goal, a group must find a common ground around which all of its members can be reasonably content. Reaching common ground on this issue may be more difficult in a multispecialty group than in a single-specialty group because there usually is more income variation among members of a multispecialty group. What's more, the group may need a system to subsidize physicians who generate less income than others do.

For groups that plan to seek risk contracts, the physician compensation for-

Physicians have learned that building long-term relationships with payers can be in their best interest.

mula may involve passing along some of that risk to member physicians. Some groups that contract through capitation arrangements choose to pay members a salary or they may use relative value units. Other groups pass along some risk, either through subcapitation or by creating various withhold pools.

Often, multispecialty groups implement a model that compensates specialists through capitation—to discourage excessive utilization of specialty services. Primary care physicians will get fee-for-service payments—to encourage the use of preventive and health maintenance services. Regardless of the compensation scheme used, the long-term goal is to align physician incentives so that all primary care and specialist physicians have an incentive to act in a manner to enable the group to be successful under capitation.

Going for short-term gains rather than a long-term relationship with payers. In some physicians' minds, payers may be considered "the enemy." But if a new physician group or network is to succeed in managed care contracting, payers need to be viewed as customers. Over the past few years, many physician groups have learned that building long-term relationships with payers can be in the best interests of physicians, payers, and patients. With a long-term relationship in place, it is possible to avoid year-to-year negotiations and to focus instead on implementing new programs and services designed to enhance patient care. Once a solid relationship is in place and a physician group has demonstrated its capabilities and reliability, payers usually will be reluctant to alter that relationship, even for minor cost savings. Unfortunately, the chronic problem of high turnover among health plan executives, in many cases due to industry consolidation, can make it difficult to sustain a stable, long-term relationship.

To develop relationships with payers, some new groups accept risk contracts even though they lack experience in managing risk. Others enter into agreements that call

for low payment rates because such contracts can help cover fixed costs, build the network's book of business, and let the network experience risk contracting.

Once a group has a relationship with a payer and the payer has a record that it can use to evaluate the group's performance over time, some physician groups have found that payers are willing to review payment rates based on claims experience and to make appropriate modifications. Doing so assumes, however, that the physician group has solid data to support its claims.

Nonexistent or underdeveloped medical management processes. Unless a medical group or network can achieve clinical and administrative efficiencies—and improved outcomes—it is not likely to succeed in managing risk. A number of different approaches are used to improve outcomes while controlling costs, including disease management programs, outcomes measurement systems, practice guidelines, and clinical protocols. To demonstrate their value to payers, many groups also compile patient satisfaction data to provide an objective measure of the perceived quality of care the group provides.

A group's medical management process plays a key role in its ability to succeed in managed care contracting. Compiling data on physician referral and utilization patterns, sharing those data with the physicians, and having the group's medical director use those data to affect physician behavior can be effective. Although physicians often resist payers' efforts to coerce changes in practice patterns, a carefully constructed peer-to-peer program designed by physicians to effect change gently—and not so gently if necessary—can foster the types of behavioral changes needed to succeed.

Forming a new physician organization can be a formidable undertaking. Assuming that a prime motivation in forming a new group is to enhance the physicians' contracting opportunities, the physicians should pay careful attention to these issues to avoid failure. ■

“When excess capacity was built up, the demand-side revolution began, more ferociously in California than anywhere else, and market power shifted from the overblown supply side to a mean-spirited demand side, and the agents of the demand side—that is, the business community—were the HMOs.”

—Uwe Reinhardt, Princeton University

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ago, Beaver renegotiated with the HMO and regained its contract, but that didn't mitigate the irreparable disruption to continuity of care, to say nothing of the erosion of goodwill.

Today, the Beaver group is financially stable, Bangasser says, due in part to a strong utilization review and quality management team, which helps control over- and underutilization. Although most of the group's income comes from capitated payments, 97% of physician salaries are based on productivity, just as they would be under a fee-for-service plan.

“Our doctors aren't focused on how

much capitation money we get,” says Bangasser. “We have a hardworking culture, and they know the more patients they see, the more hospitalizations they do, the more they'll get paid.” What's more, the amount the physicians are paid gets adjusted periodically according to how much money the group takes in from insurers.

Will the California experience begin to unfold in other managed care markets across the country? Opinion is divided. Some experts say the troubles California physicians are facing have already spread to other markets. Other observers, however, say the issues in California cannot be duplicated elsewhere. “There are few

other markets with the degree of physician group organization and the level of capitation that exists in California,” says Joy Grossman, associate director of the Center for Studying Health System Change (CSHSC) in Washington, D.C. “I don't see the California experience as a bellwether. It's more of a cautionary tale.”

Indeed, the cautionary message is that under capitation there is not enough money for physicians to deliver care, says Nathan Kaufman, president of the Kaufman Group, in San Diego, a division of Superior Consultant Co., a health care information and management consulting

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Report Shows What Went Wrong in California

Long viewed as the bellwether of the nation's managed care industry, California has the country's fourth highest penetration rate for managed care at 46%. Also, capitation is more prevalent in California than in most other parts of the country.

According to a report issued last spring by the Center for Studying Health System Change (CSHSC), in Washington, D.C., more than 72% of physicians in Orange County, California, receive capitation payments for at least some of their patients. This compares with 56% for physicians in other metropolitan areas nationwide. Only Seattle, at 73%, is higher. Situated between Los Angeles and San Diego, Orange County has a population of more than 2.5 million residents.

Evidence of the turmoil in California has come in many forms. Within the past 18 months, two national physician practice management companies filed

for bankruptcy. FPA Medical Management Inc., in San Diego, had acquired 600 physician members in Orange County alone and failed in July 1998, disrupting key arrangements for the delivery and financing of care for thousands of patients. In March, MedPartners Provider Network, a health care services plan subsidiary of MedPartners Inc., in Birmingham, Ala., also faltered, owing more than 4,000 California physicians an estimated \$100 million, according to a report by the California Medical Association.

In California, primary care physicians earn \$60,000 to \$75,000 annually, according to a report from consultants Pricewaterhouse Coopers. Such a salary is about 50% less than the national average of \$120,000 per year for physicians in family practice, pediatrics, and internal medicine, according to the AMA. The low salaries, says PWC, are the result of both lower-than-average

premiums and the effects of capitation. To make ends meet, many California physicians have two jobs, the PWC report says.

However alarming, the turbulence in California, should come as no surprise to anyone familiar with that state's health care economy, says Princeton University economist Uwe Reinhardt. “When the supply side—doctors and hospitals—drove the health system, they determined what kind of treatments were given and what the fees would be,” says Reinhardt. “But then excess capacity was built up, and the demand-side revolution began, more ferociously in California than anywhere else. The market power shifted from the overblown supply side to a mean-spirited demand side, and the agents of the demand side—that is, the business community—were the HMOs.”

When any industry has excess capac-

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firm in Southfield, Mich. The two items bankrupting physician groups are pharmacy costs and out-of-network care, he says.

"A physician group has no business taking on pharmacy risk," Kaufman says. "There is no up side." Also, as much as 30% of physicians' capitation pools are depleted by out-of-network use, he says. "Patients are getting around the system," he explains. "They end up in your competitor's office and you still have to pay."

Conversely, groups can lose when patients get too much care in-network. With loosely structured point-of-service plans, health plans pay reduced capitation rates assuming patients will get some of their care out of the network. When patients rely on network physicians for everything, those physicians lose money.

Proceed With Care

To ease the burden of capitation, Kaufman's firm advises physicians to form single-specialty groups. "If you take 20 orthopedists who together cover all subspecialties, and have an affiliated surgery

center, and are doing drug trials and instrument trials, you can succeed because you'll have alternative sources of revenue as well as efficiencies," he explains.

Another strategy is to use what are called blended rates that combine capitation with fee-for-service payments. In an article in JAMA, Oct. 6, James C. Robinson, PhD, MPH, described how seven San Francisco IPAs have experimented with reimbursing physicians using a combination of prospective and retrospective payment mechanisms.

Having found that capitation alone prompted physicians to resist taking on new chronically ill patients, the IPAs offered doctors a risk-adjusted capitated rate for primary care services. The IPAs also supplemented the rate with fee-for-service payments for visits to patients in subacute, skilled nursing, emergency, or home settings; preventive services such as mammograms; and for procedures that are often referred out, such as colon cancer screening. Based on similar experiences in other industries, blending capitation and fee-for-

service payments outperforms results when compared with those that rely on either form of payment, Robinson said.

Kaufman agrees, saying those physician groups that can minimize the financial risk of delivering care will be more likely to succeed in the current California market. "Get your overhead down, try to position your group as a dominant player that health plans need, and don't assume too much risk," he says. Also, those groups that combine sophisticated business skill with basic common sense will be more likely to survive than those groups that lack basic business sense.

Also, Kaufman has a warning for physicians in all markets and particularly those in California. "Remember that what may sound good and look good, and even be good in the short term, may not be good over the long haul," he says. "Doctors used to believe that there was a pot of gold at the end of the global capitation rainbow. It turned out not to be true."

—Reported and written by Ann B. Gordon, in Wayland, Mass.

(Continued from page 8)

ity and the demand side tries to manage it, that sector will experience financial turmoil, as happened to the airline and the hotel industries, Reinhardt explains. "California is a market with a supply-side surplus, which is not a pretty thing if you are on the supply side," he says.

Others say, however, that some of California's problems resulted from unusual circumstances that were not foreseen. "California experienced a unique confluence of events," says Joy Grossman, associate director of the CSHSC. "At the same time that more physician groups were taking on greater risk, costs were rising faster than expected and premiums weren't. There were also significant increases in costs, more mandated benefits that increased costs, and greater use of loosely managed plans like point-of-service plans that resulted in higher costs for capitated groups."

In a report issued last fall, "Healthcare: An Industry in the ER," PricewaterhouseCoopers described a

domino effect that has been building for years among California's health purchasers, health plans, provider systems, hospitals, and physicians. Employers formed purchasing cooperatives in the mid-1990s, increased their clout and negotiated premium decreases; health plans consolidated into large plans and shifted risk and administrative functions, such as claims adjudication, provider credentialing, and utilization review, to providers; and the Balanced Budget Act of 1997, lowered Medicare reimbursement and physician revenue sharply.

Indeed, the biggest factor may be a decline in revenue. PWC reported that capitation rates in California fell from a high of \$45 per member per month in the period from 1990 to 1993, to a low of \$29 PMPM from 1997 to 1999, a drop of 35%. From 1990 to 1999, the cost of living according to the Consumer Price Index rose 25.2%, PWC said.

A survey in 1998 by the California

Medical Association showed that California pediatricians received an average of \$24 per child per month in capitated payments. But a 1998 Towers Perrin study showed that physician costs for treating children averaged \$47 per child per month, meaning California pediatricians were losing an average of \$23 on each patient each month.

In addition to low capitation rates—many of which are locked in for years through long-term contracts—many physician groups in California also have accepted too much risk, the PWC report says. Physicians may have hoped the increased risk would pay dividends or they believed they had no choice. In addition to accepting capitated payments for primary and specialty care, some physician organizations also have assumed some risk for hospital utilization and pharmacy costs. Some have accepted global capitation—a single payment for all medical services, including outpatient and inpatient costs.

—ABG

Hospital-Based Practice Is Cut Loose

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

Recently, an internist who is part of a large multispecialty group wrote to us to say that for a number of years his group had been employed by a hospital that was part of a large integrated delivery system. Recently, the hospital announced that it was divesting itself of the multispecialty group, saying it had been losing more than \$100,000 per physician per year.

The physician asked, "How could this be? We are busier than we have ever been. Is this "supposed" loss just an accounting trick resulting from a reallocation of overhead? If our group has to restart our practice, where do we go to negotiate our separation, to acquire capital, to seek management expertise, and to get money to recruit new physicians?"

Frequently, physicians write to express their fears that their HMO or hospital affiliate will drop their group. Their fears are not unreasonable considering an emerging trend among managed care organizations (MCOs) called "vertical-disintegration." Last year, James Robinson, a professor of health economics at the University of California at Berkeley, wrote that vertical disintegration refers to a shift MCOs are making in which they go from owning physician groups to simply contracting with them for services.

HMOs and hospital systems have begun to realize that owning physician groups does not pay because the overhead and administrative costs associated with owning groups tends to restrict the health plan financially instead of allowing it to expand. In fact, studies have shown that it is not unusual for a hospital that has acquired physician groups to lose

\$100,000 or more per physician per year on these acquisitions.

Also, when a hospital or HMO employs a physician, the doctor loses some of the financial incentives to deliver high quality care that he or she had in private practice, say critics of hospitals that have acquired physician groups. Physicians in private practice are aware

that much of the increased revenue should be reinvested in building the business.

Trying to realize the advantages of this business model, some groups have affiliated with IPAs that have a large enough patient base upon which to draw, regardless of whether they are affiliated with a hospital, HMO, or integrated delivery

If the group drafts and follows an effective business plan and is diligent about reinvesting capital in the business, increased revenue eventually will flow to the physicians.

that they are likely to realize a financial reward for delivering high quality care through increased profits and patient referrals. Recognizing these facts, Kaiser Permanente, which is one of the oldest staff-model HMOs in the nation, has begun contracting with independent physician groups instead of employing them in efforts to reduce costs and increase physician productivity.

Pursuing Success

It is not unusual, therefore, for busy physicians to learn that their employer is seeking to divest itself of the group. Typically, the first question a physician in this situation will ask is how can he or she succeed in private practice. To build a successful practice, physicians must operate their practices under the traditional rules of business ownership and management. The physicians may need to take a pay cut in the initial years and they will need to reinvest earnings in the business to promote growth.

Reinvestment may come in the form of spending on marketing or on information systems or medical technology. If the group drafts and follows an effective business plan and is diligent about reinvesting capital in the business, increased revenue eventually will flow to the physi-

cians. Business strategists will say that much of the increased revenue should be reinvested in building the business.

Indeed, physicians facing the prospect of having to establish a private practice may want to seek the advice of skilled financial professionals and business consultants in their market. Other physicians may be willing to offer recommendations about successful organizations in your market. A source of information on IPAs is the IPA Association of America in Oakland, Calif. (www.tipaaa.org). The IPAAA can assist physician groups that need business advice.

Physicians also should consider contacting a financial adviser who specializes in health care consulting because these professionals have the skills, experience, and knowledge about what physicians will need to be successful in an independent practice. A financial adviser can also help physician groups make decisions about partnering with IPAs. These decisions will be important in shaping the physician organization and positioning it for long-term success. ■

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Multispecialty Group Seeks Options

Question: I'm an internist in my 40s. Our multispecialty group on the West Coast has 150 members. We're well established, but three years ago, we joined with a half dozen other large clinics to form a private physician practice management company (PPMC). For reasons I won't go into, we're withdrawing from the PPMC because we're on the verge of bankruptcy. I'm looking for career options in other parts of the country, particularly in my native south. Are there better opportunities in other parts of the country, or will the rest of country join the West Coast in the race to pay physicians ever lower amounts on the premium dollar? Do you have any advice for a troubled physician who wants to live out his career in an environment of stability, tranquility, and security?

Answer: Few internists on the West Coast would consider their environment to be stable, tranquil, and secure. As many readers know from recent press reports, the market on the West Coast—and California in particular—is in turmoil primarily because of three factors: high managed care penetration, low premiums, and capitation.

High managed care penetration forces the primary care physician to accept HMO contracts in order to have sufficient volume in his or her practice. Because of the low premiums, these HMO contracts typically pay far less

Editor's note: Readers of *Practice Options* are invited to call our toll-free line to speak with Richard L. Reece, MD, editor-in-chief. Often, Reece poses questions from readers to members of the newsletter's editorial Advisory Board. In this column, Advisory Board member Nathan Kaufman, president of The Kaufman Group, in San Diego, a division of Superior Consultant Co., in Southfield, Mich., responds to a reader's questions.

than traditional fee-for-service contracts have paid. Since many of these contracts are capitated, the physicians are at risk not only for their own services, but also for specialty utilization, for the cost of pharmaceutical usage for their patients, and for many other factors not directly related to the physician-patient relationship.

What's more, experience has shown that multispecialty groups tend to be less tranquil than single-specialty groups. Many multispecialty groups are replete with conflicts related to compensation and allocation of overhead among physi-

and capitation rates. Many of these publishers offer information on their Web sites and will send information by mail for a fee. The Web address for InterStudy is www.hmodata.com.

Another source of information would be physician search companies that advertise in medical journals. These organizations have been retained by hospitals to recruit physicians into their markets. In addition, you might focus on joining an internal medicine group rather than a multispecialty group and avoid affiliating with PPMCs.

Among other options you might

“Experience has shown that multispecialty groups tend to be less tranquil than single-specialty groups. Many multispecialty groups are replete with conflicts related to compensation and allocation of overhead among physician specialties. These conflicts exist in single-specialty groups but to a much lesser extent.”

—Nathan Kaufman, Superior Consultant Co.

cian specialties. These conflicts exist in single-specialty groups but to a much lesser extent. Adding an outside PPMC to the mix further complicates the issues. It is common for members of the physician group to have conflicts with PPMC management. The combination of factors you presented will create just about the least stable, tranquil, and secure environment possible for an internist.

There continue to be many markets with higher premiums where managed care is limited to reimbursing on a discounted fee-for-service basis. In these markets, physicians with an affinity for their patients are capable of building large successful practices. These markets are typically in suburban and rural communities. Interstudy, of Minneapolis, is one of several organizations that collect and publish data on HMO penetration

consider are finding a hospital willing to provide an income guarantee to help several physicians or a physician group get established in a new market. Getting an income guarantee is recommended over taking a salaried position because you would be able to continue to build your business while having at least one source of guaranteed income. If you take a salaried position and the hospital suffers a financial loss, it might want to discontinue its relationship with your group.

Ultimately the stability, tranquility, and security of your practice will be based on selecting the right market, joining the right group, providing quality care, and satisfying your patients. While there are no guarantees, there certainly are better situations in other markets than those on the West Coast. ■

Studies Show Physician Assistants Help Raise Group Income, PA Executive Says



Stephen Crane, PhD, is the executive vice president of the American Academy of Physician Assistants (AAPA) in Alexandria, Va., and has

rich and varied experience both in academics and in lobbying. Crane has held faculty positions at the University of Michigan and Boston University. While at BU, he served as director of the Pew Health Policy doctoral program. Prior to joining the AAPA, Crane was vice president of the Association for Health Services Research and national program director for the Robert Wood Johnson Foundation's Investigator Grants in Health Policy Research Program. Richard L. Reece, MD, editor-in-chief, conducted this interview.

Q: When did the concept of physician assistants evolve, and why?

A: The physician assistant, or PA, concept evolved in the mid-1960s principally in response to the then-perceived shortage of physicians around the country. The thought was that an individual with prior health care experience could receive additional medical education to enable him or her to work in an expanded capacity with physicians. In effect, such individuals would extend the existing supply of physicians without having to wait eight years for the production of a fully trained physician. Eugene Stead, MD, of Duke University is considered the father of the profession. He took a small band of returning Vietnam corpsmen in 1965 and produced the first PAs.

Over time, the PA concept has expanded and become much more sophisticated. The education program for PAs has been solidified into a two-year program that is offered by institutions around the country. There is now a national certification examination for all physician assistants, and PAs are authorized to practice in 49 states, the District of Columbia, and Guam.

Q: Why is the PA concept a powerful one?

A: The concept has taken hold because of the tremendous flexibility and adaptability of the profession. This flexibility and adaptability comes from the basic training that all PAs receive in primary care. This solid education prepares the PA to work in a variety of specialties and practice settings.

A second factor contributing to the success of the PA concept is the profession's commitment to a team approach to care. PAs are totally committed to working with physician supervision. PAs do not want to practice independently, nor do they want independent reimbursement. PAs believe that medical teams need clearly delineated direction, which should come from a physician. The PA's job is to work with physicians to provide affordable care to as many people as possible. Under managed care, physician

time with patients and enjoy the satisfaction of patient care delivery and the benefits of a profession that allows them to grow over time, to change their focus if desired, and to pursue their particular personal and professional interests in medicine.

Q: What is the educational background of a PA, and what are the continuing medical educational requirements?

A: Typically an individual coming into the PA profession will have, on average, four years of health care experience as well as a bachelor's degree. Being admitted to a PA educational program is very competitive. Currently, only one in 10 applicants is admitted to PA school, even with a recent increase in the number of PA programs around the country.

Q: What is the current supply of physician assistants?

A: Approximately 4,500 PAs are graduating each year and we expect this number to increase slightly

"PAs are totally committed to working with physician supervision. They do not want to practice independently, nor do they want independent reimbursement."

assistants represent a cost-effective way of getting care to more people. PAs also augment the quality of care because of the time they spend in talking with and educating patients about their conditions.

Q: Why do individuals choose a career as a PA?

A: People are choosing the PA career for several reasons. First, they want to practice medicine with physicians and provide direct patient care. Second, they wish to avoid the long period of training and high cost of education associated with medical school. Third, they may wish to minimize the administrative hassles and burdens that often come with being a physician. Finally, they're looking to spend

over the next few years. The number of accredited PA programs has grown from 55 in 1993 to 116 programs as of last year. As a result, the number of graduating PAs has more than doubled. We would expect the numbers to continue to grow over the next few years since there are a few more programs seeking accreditation, although the rate of growth in the number of programs has declined.

Q: Are there certain areas of the country in which PAs are in greater demand?

A: Southern California and New England are popular places for many health professionals to locate, including PAs. In other areas of the coun-

“In 1998, 54% of PAs were working in primary care, and about one-third were in communities of less than 50,000. The PA profession has retained its commitment to providing access to care for those who don’t have other care immediately available.”

try, such as the North and South Central regions, there aren’t enough PAs for the demand. Truly the demand varies from region to region and situation to situation.

Q: *What is the current gender mix of physician assistants?*

A: The physician assistant profession started out as a male-dominated profession. Since 1984 the proportion of women in PA schools has exceeded that of men. As a result, the number of women in the profession now exceeds the number of men. Currently, the gender mix of the PA profession is 52% women and 48% men, and we just turned that corner two years ago. In terms of those students currently in school, about 65% are women and 35% are men.

Q: *What are the trends in using PAs in primary and specialty care?*

A: The statistics for 1998, for which we have the most recent data, show that 54% of PAs were working in primary care, and about one-third were in communities of less than 50,000. The PA profession has retained its commitment to providing access to care for those who don’t have other care immediately available.

Since 1990, the proportion of PAs working in family/general medicine grew from 32% to 40% of all PAs. The largest non-primary care specialty area today in which PAs work is surgery; approximately 20% of all PAs work in various surgical specialty areas. Many PAs work in the operating theater, while others work in pre-op and post-op care. It’s not unusual to find a PA who does all of that for a surgeon. It depends upon the type of practice and the needs of the situation.

Physician assistants are valued team members in working with specialists. They can acquire the techniques and knowledge necessary to work in a specialty area and build on their educational base of primary care. Every six years, all certified PAs are required to take a recertification examination that reviews and

tests their basic medical knowledge to help ensure their continued competence.

Q: *Is it common for PAs to continue their education to become physicians?*

A: It is not common for PAs to go on to become physicians, although about 1% to 2% of all PAs have become physicians. We find that the individuals who come into the profession do so because they truly want to be a physician assistant. Most entrants into the profession have some prior medical or health care experience and so for them the PA profession represents a terminal professional choice.

We also know that satisfaction within the profession is very high. We completed a member satisfaction survey last year and more than 90% of PAs said that if they had to do it again they would become a PA.

Q: *Are there any data to show the effect of PAs on the economic circumstances of medical practices?*

A: Many physicians are hiring PAs to make their practices more cost-effective. The Medical Group Management Association, in Englewood, Colo., has data regarding the economic return on PA practice. According to MGMA, the cost of producing one dollar of income for a primary care practice in 1997 using a PA is about 36 cents.

In 1995, the AMA published the results of a survey that showed that solo physicians who employ PAs reported a higher net income for the practice yet lower fees for patient office visits. A review of records for medical office visits made in 1997 by patients enrolled in the northwest region of Kaiser Permanente who presented for four common diagnoses also showed the total cost for a patient visit managed by a PA is less than a visit managed by a physician.

Q: *I read recently that among primary care physicians in California, the ideal ratio is 1.4 physicians to 1.0 physician assistants, driven by a ceiling on capitation*

rates. What is the most cost-effective ratio of physicians to physician assistants?

A: I have not seen that particular study. The AMA, however, completed a report about a year ago regarding the appropriate ratio of supervising physicians to PAs. Their conclusion was that it’s best left up to the individual practice situation to determine the optimal economic ratio of PAs to physicians.

Q: *What is the usual means of reimbursement of PAs?*

A: PAs typically are salaried professionals. More than 85% of all PAs in the country are salaried.

Q: *What is the median salary of a physician assistant?*

A: According to the 1998 AAPA Annual Physician Assistant Census, the median salary for PAs is about \$65,000. Of course, salary varies with specialty, geographic location, and experience. On the high end are PAs in some of the surgical specialties, while PAs earn lower salaries in primary care.

Q: *In how many states are PAs licensed to prescribe in the office setting?*

A: PAs have prescriptive authority in 46 states, which means the physician has the authority to delegate the prescribing of medications to a PA. PAs may be granted the authority to prescribe controlled substances by a supervising physician in 37 states.

Q: *Do physician assistants practice independently in some settings, or practice in a satellite office away from the physician?*

A: Physician assistants never practice independently. All state laws require that PAs work with supervising physicians, who delegate all of the PAs’ responsibilities. PAs can practice autonomously, as in the case of PAs who serve in rural clinics, but they will always have a supervising physician to whom

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they are accountable. This practice is totally consistent with the policies of the AMA, the American Academy of Family Physicians, and other major medical professional organizations.

Q. *What are the major issues today in the PA profession?*

A. The major challenge today is continuing the evolution of the PA profession to meet the rapidly changing demands of the health care system and to work in concert with other members of the health care team. PAs are a valued resource because they are flexible, adaptable, and cost-effective providers of a wide range of services in many different settings. They truly are the utility players who can increase the effectiveness and efficiency of the physicians and the organizations for which they work.

The hallmark of the PA profession is its emphasis on the team approach to care. The health care delivery system has moved away from a piecemeal, cottage industry approach that characterized health care delivery for decades. Today, care is much more integrated and coordinated. Integration and coordination benefit the patient by increasing the continuity of care. PAs working in a team approach with physicians and other health care professionals epitomize this integrated and coordinated approach to care delivery. In a team approach to care, patients are at the center of the system, as they should be. PAs and other health professionals must continue to work with managers and payers to promote systems that work for patients, not against them.

Q. *Are these the issues discussed at your national meetings?*

A. The major issues at our 1999 conference in Atlanta related to concerns about the PA work force and the implications for the supply of physicians. We continue to be challenged by questions of how to continue to increase the value of what we do for our patients, to determine how best to work with physicians, and to develop our understanding of ourselves as a profession for the future.

Q. *When was the American Academy of Physician Assistants founded?*

“In the future, much of health care will be provided through group practice organizations integrated into a loose framework of delivery systems, not large corporate systems. We likely will see more local control as opposed to global control.”

A. The American Academy of Physician Assistants was founded in 1968 by some of the first people trained as PAs. AAPA is the only national professional organization representing PAs in all medical and surgical specialties. We've grown from that small band of Vietnam-trained military personnel to approximately 34,000 clinically practicing PAs. The membership of our organization is 31,500, representing clinically practicing PAs, PA students, and supporters of the profession.

Q. *How do the members of AAPA communicate with each other?*

A. We have a biweekly newsletter, *AAPA News*, and a peer-reviewed journal, *Journal of the American Academy of Physician Assistants (JAAPA)*. We also have a nationally acclaimed Web site—www.aapa.org—that has had close to four million hits a year. This site provides thorough information on the background, education, and training of PAs.

Q. *How can a physician considering recruiting PAs access the AAPA?*

A. Physicians can call our employment service number at 800/237-9851 in order to place an advertisement in our journal and our newsletter. That is probably the best way of advertising a position to a national group of PAs. Also, I would recommend contacting any of the PA schools that are in the practice's area or in a nearby state. Each state has an AAPA chapter, which can be helpful in pointing physicians toward PAs who are looking for a job. Information about these state organizations and PA programs can be found on the AAPA Web site. Statistically, PAs still have many good opportunities, so the competition for PAs is strong. PAs also are looking for new opportunities and there is a good market of PAs who have substantial experience.

Recently we started a new information

service for supervising physicians. All physicians currently supervising or wishing to hire a physician assistant should visit the Network for Supervising Physicians Web site at www.supervising-physicians.com. The network is designed to help physicians connect with their colleagues who employ PAs. This service will provide a bimonthly newsletter on the optimal utilization of PAs, an information center to answer specific questions about supervising PAs, and an information broker to identify specialized resources that benefit not only the physician but the health care team as well.

Q. *Do you have any closing comments about the future of the physician assistant profession?*

A. As I look at the data, it's clear that PAs increasingly are being used in single- and multispecialty group practice settings, which bodes well for the future of the profession. In the future, much of health care will be provided through group practice organizations. These practices may be integrated into a loose framework of delivery systems, but not the large corporate systems that we have seen in recent years. We likely will see more local control as opposed to global control.

Second, I think the economics of group practice favor PAs. In a medical practice that needs to adapt quickly to a changing environment, the PA's education in primary care allows him or her to bring a lot of value to the practice.

Third, PAs significantly increase patient satisfaction. This is very important in a competitive environment.

Finally, a PA allows physicians to spend more time on patients who may need the care that only a physician can provide. Not only does this increase the efficiency of a practice, but it may also increase the physician's satisfaction as well. ■

Compliance with Guidelines Low in Emergency Asthma Care

Asthma care given in the emergency room of an urban tertiary care hospital differs significantly from that recommended in national guidelines, researchers report in the September issue of the *Annals of Allergy, Asthma and Immunology*.

Carl J. Milks, MD, and colleagues from the University of Medicine and Dentistry of New Jersey, in Newark, compared documented emergency asthma treatment with procedures recommended in the 1991 National Asthma Education and Prevention Program.

The researchers retrospectively reviewed a random sample of 181 charts of patients treated for asthma and reactive airway disease in an emer-

gency room over one year. Compliance with guidelines was assessed by noting adherence to criteria including documentation of history, assessment of the severity of the attack, treatment, and disposition.

The attack history "...was documented consistently over all age groups." However, the frequency of beta-agonist use, although documented in 82% of children ages five and younger, was noted in only 15% of adults. Previous emergency room visits, hospitalizations, and associated procedures were documented in 70% of patients.

Peak flow readings were obtained in 31% of children and 62% of adults. Treatment with inhaled beta-agonists

was high at 92%. But "...steroids were started in the emergency room in 71% of the children and less than half of the adults."

Prescriptions were documented as being given in about 84% of children and 35% of adults.

The investigators conclude that one limitation of the study was that it covered documented treatment rather than actual treatment given, suggesting that, in fact, "...emergency room practice is somewhat better than recorded." Nevertheless, they point, in particular, to the low use of steroids, which "...has persisted despite the educational efforts of various organizations and committees."

Medicare Commission Leader Introduces Reform Bill

The chairman of the failed bipartisan commission on Medicare introduced in bill form a revised version of the plan the panel narrowly failed to approve in March.

Sen. John Breaux, (D-La.), along with two other commission members from the Senate, Bill Frist, MD, (R-Tenn.), and Bob Kerrey, (D-Neb.), said they hoped the bill they were formally introducing would serve as a starting point for a debate expected to take place beginning next year.

"Medicare is not nearly as good as it should be—or as it can be," said Breaux at a Capitol Hill news conference. His new plan, he said, "will require that the medical industry compete for the first time for the privilege of serving Medicare beneficiaries."

The proposal builds on the "premium support" plan devised by the commission and supported by 10 of its 17 members (11 votes were required for formal approval under the panel's rules). Under what the new bill calls a "competitive premium system," private plans and traditional Medicare would both offer standard and high-option packages. High-option plans would be required to offer both prescription drug coverage (with an actuarial value of at

least \$800 per year) and a "stop-loss" for out-of-pocket expenses of \$2,000 annually.

Every beneficiary would get a discount on drug coverage of at least 25%, and low-income beneficiaries would get more help. Higher-income beneficiaries would be taxed on the value of the discount.

In addition to making prescription drug coverage available to all beneficiaries through the traditional Medicare program—the lack of which was a key complaint of those who voted against the commission's plan—the new proposal also addresses other areas of concern.

Gone, for example, are controversial proposals to raise Medicare's eligibility age from 65 to 67 years, and to combine the deductibles for Parts A and B, which would have raised costs for many beneficiaries.

Breaux said he does not yet know how much the program would cost or save Medicare, but he expects an analysis from the Congressional Budget Office in time for the debate most think will occur next year. "This is a starting point. This is a marker," Breaux told reporters. "But this should hopefully begin the debate."

Effective Evidence-Based Technology Assessment Requires Physician Involvement

Both the effective assessment of new technologies and the appropriate implementation of those found to be beneficial require the active involvement of clinicians, according to an article in *JAMA*, Nov. 17.

John M. Eisenberg, MD, director of the federal Agency for Health Care Policy and Research (AHCPR) in Rockville, Md., writes that technology assessment "...weaves together evidence-based health care, outcomes research, cost-effectiveness analysis, ethical considerations, and studies of both patient preferences and practitioner behavior. While most agree that health care technology has advanced physicians' ability to improve their patients' health and quality of life, there has been considerable disagreement about which technologies to use, Eisenberg says. How much is too much, he asks. Also, health care providers need to determine whether the technologies clinicians use are providing value for the cost, he notes.

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Editor-in-Chief

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