

PHYSICIAN PRACTICE OPTIONS™

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A PRACTICAL RESOURCE TO SUCCEED IN HEALTH CARE

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Medicare-risk HMOs Are Rapidly Gaining Market-share Dominance

If Medicare patients represent a large part of your patient mix, you may want to consider the activities of Medicare-risk HMOs in your market. In general, Medicare patients comprise 40% to 60% of hospital patients, and 25% to 40% of all outpatients. Therefore, a shift of these patients to HMOs could affect your practice profoundly, especially if you were excluded from the Medicare network. Your best option may be to become part of the physician network of the Medicare-risk HMO.

By definition, a Medicare-risk HMO is simply an HMO that contracts with the federal Health Care Financing Administration (HCFA) to care for the Medicare population in its area at a capitated rate. In other words, a Medicare-risk HMO is paid a monthly fee for each Medicare patient enrolled, regardless of the level of illness. To make a profit under this arrangement, the HMO must deliver care efficiently.

Many factors are causing Medicare-risk HMOs to grow at the rate of 50% to 60% annually. Among those factors are the following:

- Politicians trying to restrain the growth of Medicare spending;
- For-profit HMOs seeking growth and new markets;
- Hospitals and physicians forming provider-sponsored networks (PSNs) to contract directly for Medicare patients and to bypass HMOs;
- Corporations seeking lower health care costs for retirees and less exposure under a relatively new accounting standard that forces them to account for future

retiree health care costs on current balance sheets;

- Seniors searching for lower costs, wider access, and richer benefits, and
- Practice management companies investing in physician groups to prepare them to accept capitation.

Preparing for Growth

Today, only 9% of seniors belong to HMOs, and the managed care industry would like that to grow to at least 30% of all seniors, especially since some 40% of all HMOs have services designed specifically for the Medicare market. Participating plans serve 40 metropolitan areas in 28 states, and about half of the U.S. Medicare population has an option to enroll in a Medicare-risk HMO. The number of HMOs offering Medicare-risk products grew 60% from 1993 to 1994. As of April 1, HCFA had 202 Medicare-risk contracts in 25 states. Some 52 applications were pending, and 37 existing plans were seeking authorization to expand. Additionally, HMOs have found that Medicare-risk arrangements offer an opportunity for them to seek new members from a previously untapped source, employer group retirees.

The financial benefits for health care purchasers of switching from a Medicare fee-for-service plan to a Medicare-risk HMO are significant. Medicare-risk HMOs could cut the annual growth of federal Medicare spending from 10% to 6%. Corporations that enroll retirees in Medicare-risk HMOs could save as much as \$1,000 per retiree annually versus Medicare fee-for-service costs. Seniors say out-of-pocket expenses

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What the Consolidation Trend Means for Physicians

Consolidation among health care companies continues apace. Aetna plans to spend \$8.8 billion to buy U.S. Healthcare, a managed care organization in Blue Bell, Pa., with 2.8 million participants in the Northeast. Columbia/HCA Healthcare Corp., Nashville, Tenn., agrees to acquire Blue Cross & Blue Shield of Ohio for \$299.5 million and is discussing possible acquisitions with many other Blues plans.

Consolidation also is rampant among physician organizations. Within the last two years, physician management companies such as PhyCor, Caremark, and MedPartners/Mullikin, have become nationwide enterprises employing thousands of physicians and generating annual revenue of \$500 million to \$1 billion.

These acquisitions demonstrate that large health care companies believe managed care will be successful well into the future. These companies are positioning themselves to capture the last bastion of fee-for-service health care—the 35 million member Medicare market. These acquisitions also show that these companies anticipate the shift of power back to hospitals and physicians at the expense of insurers.

At the same time, hospitals and physicians are working separately and together to form large organizations to gain bargaining leverage with HMOs. Hospitals and physician management companies are acquiring doctors' practices in record numbers, transforming medical practices into large groups, networks, and publicly traded physician management companies. Those physicians who are part of this transformation are seeing that the pendulum has swung back in their direction.

But those physicians who remain unaffiliated with a larger group are swimming against the tide. Consolidation among independent physicians into business entities is still in its early phases. Each week independent physicians call us and ask one or more of the following questions:

1. Managed care is transforming our practice. How can we stay independent and continue to practice in this market?
2. We've seen that we are indispensable for delivering care and that capital seems to be available from multiple sources to help us organize and grow. How can we get access to some of this capital without giving up our autonomy?
3. How do we accept capital from a partner and yet retain ownership of our practice and our assets?
4. How can we find an independent adviser, someone who has our interests in mind and will offer us unbiased opinions?

Physicians who have questions about how to consolidate their practices into a larger entity that would be more capable of winning managed care contracts are invited to call our toll-free number, 888/242-2788. We will answer your question or direct you to someone who can.

Remaining solo or in a small group practice is no longer an option for physicians who expect to practice for 10 or more years. To thrive means winning managed care contracts, and to do that, physicians will need the leverage inherent in a larger organization of physicians.

A Signal for More Consolidation?

On the issue of consolidation, the Federal Trade Commission reportedly is considering issuing a policy this summer that would make it easier for physicians to band together, to coordinate prices, and to form networks to compete with large insurers and HMOs. The FTC is said to be concerned about large managed care organizations (MCOs) controlling a significant share of the health care market. Many astute observers say the FTC is simply trying to measure the reaction to such an idea. State insurance regulators would certainly oppose the move, as they now oppose congressional efforts to allow physician networks. The FTC also wants large insurers and MCOs to think twice before initiating mergers, the observers say. In any case, the FTC signal is likely to spur even more consolidation among physicians.



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and Medigap policies could be eliminated. Finally, investors say the market potential for Medicare-risk HMO growth is staggering (see map, Managed Medicare Market Size).

Medicare-risk HMO growth is especially fast in mature managed care markets, where seniors have been exposed to HMOs. If your practice is in such a market and you are not a participating physician in the right HMO network, you could lose much of your patient base in one enrollment period. In Portland, Ore., for example, nearly 60% of seniors joined HMOs in a recent two-year period.

Several factors affect the success of an HMO in the Medicare-risk market, including:

- The reputation of the HMO in the local community and the effectiveness and credibility of its marketing plan.
- The capitation rate, HCFA's Average Adjusted Per Capita Cost (AAPCC) in the market. Rates vary from \$177 per patient per month (PMPM) to \$678. The higher the rate, the more likely the HMO is to expand.
- The existing managed care infrastructure that permits the HMO to keep utilization low through primary care networks, case management, referral management, and provider contracting.
- How well the HMO's benefit plan is accepted in the community.
- The financial resources of the HMO. To start a Medicare-risk HMO, a managed care organization may need \$10 million to absorb losses for two or three years, to have sufficient marketing clout to enroll a base population of 5,000 to 10,000 members, and to offer competitive benefits.

Investor Interest

Recognizing an opportunity, entrepreneurs, investors, and for-profit HMOs have shown increased interest in Medicare-risk HMOs in recent years. They sense that both Democrats and Republicans will turn to HMOs as the only practical way to control Medicare inflation rates, which until now have been uncontrollable. The potential for profit, especially in those markets with an AAPCC of \$400 PMPM is significant. By way of explanation, the AAPCC is what HCFA pays a health plan for taking the risk to provide care for the

population. Rates are based on the average historic cost of delivering health care to the population in that region (see figure, Market Penetration for Top 10 Per Capita Rate Counties).

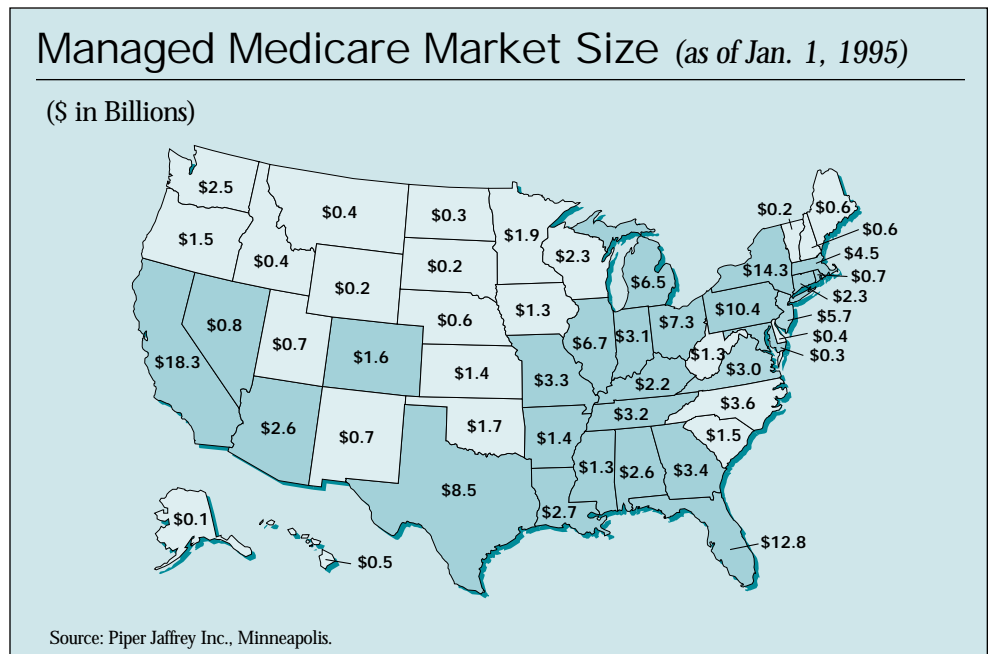
Just as investors recognize an opportunity, so do seniors. Nearly one-third of all California Medicare beneficiaries belong to senior-care HMOs. In Tucson, Ariz., Riverside, Calif., and Portland, Ore., HMOs have captured more than 40% of the market. Small wonder. In Tucson alone, these HMOs may offer free hospital stays, free annual physician exams, free laboratory tests, and free mammograms. In addition, eyeglasses cost \$26; the co-payment for a doctor's appointment is \$5 or \$10; and a three-month supply of any one of 300 prescription drugs costs \$7.

Better Benefits for Retirees

Until recently, employers did not view managed care as a viable option for their health care programs for retirees even though the cost of retiree medical benefits has grown far faster than that for active employees. In response, Towers Perrin, health care consultants in New York, launched the Medicare HMO Initiative

principal with Towers Perrin, and a former chairman of the New York Business Group on Health, a coalition of employers. The initiative showed that Medicare-risk HMOs could offer significant advantages to employers seeking affordable, quality health care for retirees. In addition, the retirees, who had seen deep cuts in health benefits in recent years, found richer benefits in the Medicare-risk HMOs, fewer out-of-pocket costs, freedom from paperwork, and protection from physician fees exceeding reasonable and customary limits, Martingale said. Through the point-of-service (POS) concept, Medicare recipients can use doctors outside the network. As they would with any Medigap or supplemental policy, beneficiaries continue to pay Medicare Part B premiums.

For employers, Medicare HMOs provide seamless managed care coverage—and potentially significant cost savings—when employees move from active to retired status. The Medicare-risk products may save companies as much \$1,000 a year for each retiree. In some locations with high reimbursement rates and efficient HMOs, an employer may pay no premium at all. In a hypothetical compa-



ny with 5,000 active employees and 2,500 Medicare-eligible retirees, annual cost savings could total \$200,000 and the

last year. This group-purchasing effort involved a coalition of more than 70 large employers and 2 million retirees in 50 markets, according to Joseph J. Martingale, a

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Market Penetration for Top 10 Per Capita Rate Counties (as of Jan. 1, 1995)

Rank	State	County	Eligible Enrollees	Actual Enrollees	Penetration Rate	Parts A&B Combined Per Capita Rate
1	NY	Bronx	150,418	13,211	8.8%	\$678.90
2	NY	Richmond	56,124	9,476	17.5	673.82
3	NY	New York City	211,907	11,510	5.4	653.79
4	LA	St. Bernard	10,518	165	1.6	649.50
5	NY	Kings	300,546	29,931	10.0	646.88
6	PA	Philadelphia	263,859	25,236	9.6	625.81
7	LA	Plaquemines	2,842	37	1.3	624.17
8	FL	Dade	294,088	87,827	29.9	615.57
9	NY	Queens	290,370	29,980	10.3	592.89
10	MI	Wayne	311,524	3,129	1.0	567.67

Source: Health Care Financing Administration, Washington.

The Pros and Cons of Medicaid HMOs

Practicing physicians are unusually wary of Medicaid patients, and for good reason. In most states, the Medicaid bureaucracy is frustrating if not infuriating. Medicaid payment rates are notoriously low, and patients often don't keep their appointments and don't follow instructions. So many Medicaid patients are so demanding—and even abusive—that other patients may feel uneasy in their presence.

Yet physicians' attitudes are changing, partly due to economic pressures. In any given practice, 50% of patients may have commercial insurance, 35% may have Medicare, and 15% may be on Medicaid. While practice revenue from other sources declines, doctors can no longer overlook Medicaid, particularly if reimbursement for those patients is higher than in the past. If you're serving a capitated HMO population, the monthly check may be substantial.

Moreover, the potential size of the Medicaid HMO market (34 million) is similar to that of the Medicare market (37 million). Yet, more Medicaid patients are enrolled in HMOs, and enrollment is growing faster. Some 11 million recipients, or 32% of the total, were enrolled in managed care plans in 1995, compared with 8

million, or 24%, in 1994, and 4.8 million, or 14%, in 1994. Only about 10% of Medicare patients are in HMOs.

Growth has been fueled by federal and state efforts to control health costs and to find more predictable payment systems. Seeking flexibility to enroll participants in managed care plans, many states have requested waivers from the federal Health Care Financing Administration (HCFA), which sets Medicaid rules on eligibility, delivery, and administration. Until recently, this bureaucracy has slowed Medicaid HMO growth.

Since 1993, eight states have been granted federal Medicaid waivers, Florida, Hawaii, Kentucky, Ohio, Oregon, Rhode Island, Tennessee, and South Carolina. Eleven others have waiver applications pending, Delaware, Illinois, Louisiana, Massachusetts, Minnesota, Missouri, Montana, New Jersey, Texas, Utah, and Vermont.

In many states, Medicaid patients represent 20% of the population. Yet, these patients typically seek care in emergency rooms and make up a large part of the patient flow to public hospitals and academic medical centers. The shift of Medicaid patients to HMOs, which deal mainly with

community hospitals and physicians, threatens public institutions.

Three states have moved most of their Medicaid populations to managed care. Since 1986, Arizona has shifted all Medicaid recipients to managed care. Since 1993, Tennessee has done so as well, with considerably more controversy. California has been proceeding county by county.

Lessons from Arizona

In Arizona, county governments faced a financial crisis in the late 1970s that was driven by rising health costs and exacerbated by a state law that limited budget increases. In 1982, the Arizona legislature approved an experimental Medicaid project, the Arizona Health Care Cost Containment System, or AHCCCS, the first statewide, prepaid Medicaid system. The start up was rocky, and many entrepreneurs, physician groups, and hospitals stumbled badly. Since then, however, the program has been fine-tuned and now covers 500,000 residents. Medicaid patients go to private doctors and hospitals. Phoenix Memorial Hospital created the nation's first pre-paid Medicaid health plan, now accredited by the National Committee for Quality Assurance, health

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annual accounting expense under a new financial accounting standard, known as FAS 106, could be trimmed by \$1.6 million. FAS 106 requires employers to recognize the cost of future retiree health benefits on current balance sheets.

To be sure, planning, marketing, and managing a Medicare-risk HMO remains a difficult business. HMOs must establish new utilization review programs, provide custom training and staffing, and hire new medical directors and concurrent review nurses. To be profitable, an HMO must cultivate “healthy” seniors by inviting potential enrollees to informational lunches, teas, or seminars, and market to employers, which would enroll their retirees into risk plans. Marketing to shut-ins or residents of nursing homes could be disastrous. Seniors use five times as many hospital beds as the

commercial population, and they spend five times longer on the phone with customer-service representatives than non-elderly enrollees. On average, HMOs must plan to spend \$1,000 to acquire each Medicare enrollee, but only \$50 for each member of its commercial plan.

Significant Implications

Shifting beneficiaries from the traditional fee-for-service Medicare plan to Medicare-risk HMOs has serious implications:

1. It would capitate a large segment of the population, which may mean providers could generate a profit initially, but as seniors age, they use more medical resources.
2. It would require a tremendous capital investment for infrastructure, primary care physicians, utilization and case management programs, and information systems.

3. It could lead to a dominance of for-profit HMOs, which could get the needed capital from the public markets.

4. It would easily make managed care systems the dominant form of health delivery in all markets.

Those organizations that capture the Medicare markets would become the market leaders for commercial populations. Such managed care dominance would lead to reduced hospital utilization, hospital closures, and eroding patient care bases for academic health centers.

One final note: Spurred by the success of commercial points of service (POS) plans, HCFA also is pursuing the development of Medicare-risk POS plans. Allowing Medicare-risk POS plans to enter the market would only speed the shift to managed care. ■

plan accreditation agency in Washington. In 10 years, the plan, Phoenix Health Plan, has widened its network to include 165 primary care doctors and 204 specialists. It has more than 40,000 members.

Under the program, Medicaid HMOs have learned to focus on prevention of illness and case-managed programs to promote prenatal care, asthma, mammography, and immunization. In 1991, the program saved \$52 million, including \$37 million for the federal government. In a report issued in October, the U.S. General Accounting Office said, “Since 1982, Arizona, has operated a statewide Medicaid program that mandates enrollment in managed care and pays health plans a capitated fee for each beneficiary served. Although the program had problems in its early years, it has successfully contained health care costs while maintaining beneficiaries’ access to mainstream medical care.” In the report, the GAO encourages other states to follow Arizona’s lead.

These conditions make managed Medicaid work, the GAO says:

- Freedom from some federal managed care regulations,
- Use of market forces to contain costs and improve quality,
- Controls to protect beneficiaries from

inadequate care, and

- Investment in data collection and analysis. Among doctors and health care executives, success in Medicaid HMOs requires fundamental shifts in focus.

Trouble in Tennessee

Like Arizona, Tennessee has had trouble in the early years of its experiment with Medicaid HMOs. The TennCare program has created chaos, including bureaucratic obstacles to care, forcing generic drugs on physicians, and a reduction of physicians’ fees. In addition, academic and public hospitals have shut down beds and laid off staff. Among the problems Tennessee has found in marketing to, treating, and following Medicaid populations are these:

- Enrolling primary care physicians to treat Medicaid patients is difficult, because a substantial number of doctors simply refuse to see such patients. Fees are low, and patients often are noncompliant. Recruiting patients is troublesome because they don’t change habits easily after years of getting care in emergency rooms.
- Accustomed to doctor shopping, some Medicaid patients are limited to one doctor and 10 visits a year.
- Many Medicaid patients are transient and either illiterate or don’t speak

English.

- For many, concerns about food and shelter come before preventive care.
- Hospital physicians don’t know how to function under capitation.
- Medicaid patients often don’t have telephones or transportation.
- Disabled Medicaid patients, 30% of all enrollees, account for 70% of the costs.
- Cuts in Medicaid funding are an increasing possibility, and physicians must decide if they can provide an adequate standard of care given the low reimbursement rate.
- Since Medicaid plans are subject to abuse, federal and state governments strictly regulate Medicaid-risk contracts. To reach Medicaid recipients effectively, a doctor must operate in a difficult environment laden with ethical dilemmas and regulatory uncertainties.
- To gain patients, health plans give marketing representatives commissions and send them to recruit in unemployment offices, food stamp offices, and door to door in poor neighborhoods.

Despite all these problems, the competition for Medicaid patients is intense, because of the large populations involved, the opportunities to cut costs systematically, and guaranteed government payments. ■

Putting Physician Groups at the Center of Care



Paul Keckley, PhD, is the author of *The Modern Handbook of Healthcare Research* (American Hospital Publishing, 1988), *99 Questions You Should Ask Your Doctor and Why* (Rutledge Hill Press), and co-author of *Integration Issues in Physician/Hospital Affiliations* (Medical Group Management Association).

He holds a BS degree in Political Science and Organic Chemistry from David Lipscomb College and a Masters degree and a PhD in Marketing degree from Ohio State University. In addition, he has completed a graduate fellowship in economics at Oxford University in England. As president of PhyCor Management Corp., he manages independent practice associations (IPAs). PhyCor Management is affiliated with PhyCor Inc., one of the nation's largest practice management companies. The PhyCor companies manage multi-specialty clinics and IPAs with 7,000 physicians in 41 states.

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Q: How do you view the current practice environment, and what are physicians' best options?

A: We believe physicians' options are to practice independently or to be a cost center controlled by someone else. In our view, the best model for physicians to perform well in the economics of managed care is in a primary-care-anchored multi-specialty group setting.

In our markets, we will build one of those, align it with a partner hospital and with one or more health plans, and create a virtual network as opposed to our having our hospital and our plan in a network controlled by the physician organization, or as opposed to a model where the physician organiza-

tion—the group practice—is owned by or controlled by a hospital or health plan. In this way, what you have, from a strategy standpoint, is doctors looking at joining a hospital-controlled group, a plan-controlled group, or becoming part of an independent group. That's their options right now in the simplest terms, and we think that independent medical groups that are aligned with key hospitals and plans is the better option for physicians, professionally, economically, and strategically.

Q: So these independent physician groups could contract with multiple hospitals?

A: Well, in some markets it may make sense to do that and in other markets we have designated partner hospitals. We have aligned our groups with hospitals, and in these markets, we basically said if our incentives are aligned with those of the hospital, and our ambition in terms of market strategy is consistent, there's no reason for the hospital to feel it has to buy the practices and there's no reason for the medical group to believe it needs to own a hospital.

That is the issue in the marketplace for doctors. If you strip away all of the little terms and structures that are being used to describe where doctors can find a home right now, they basically have a home in a group setting. They all know it. How you get there, whether you go through PHO doors or IPA doors or any other set of doors, those are all intermediate places. But then the doctor has to determine, is my future in that group best served as a group built and controlled by the hospital, built and controlled by an HMO, or built and controlled by the physicians?

Q: And your answer is that the best home is built and controlled by the physicians.

A: Absolutely. The physician is ultimately the key player in managing care. It's the decisions the physician makes that

determine not just the cost effectiveness of the care but the outcome of the care. And we believe that physicians will make good judgments about cost, access, and quality if they're provided with

- First, the tools to do so, which are information systems and medical education;
- Second, if they operate in a structure where they're incentivized to perform as a group;
- Third, if they operate as a key component of a local delivery network where hospitals or plans are partners with that medical group.

But that's decidedly different as a strategy than a strategy where the hospital says, the only way for us to build this system is to acquire practices and grow our own group. That's the reason that four out of five hospitals that are doing that are losing money on it, and that's the reason that doctors in hospital-owned groups tend not to be successful in managing care. You cannot take a hospital infrastructure and extend it to the medical practice. It just doesn't work. The information system vendors tend to be different players; the mechanics of running a practice are not an extension of out-patient services at a hospital, they're completely different; and I think what we're doing very aggressively in markets is challenging our physicians to select a hospital partner, align the incentives with that hospital, find one plan or many plans that wish to contract with that entity, and then become first in the market to demonstrate outcomes, improve access, and not just reduce cost and length of stay.

Q: PhyCor is now in multiple markets, perhaps as many as 70. Do you find wide geographic differences?

A: Huge differences, yes. I think our philosophy from day one has been that every market is distinct so you develop a strategy which is community specific. We don't have a cookie cutter in any market. We have principles that we try to use in

evaluating a market and we have a set of criteria that we use to assess whether that physician organization could become the dominant independent physician organization in the market. But beyond that, structurally, financially, strategically, we have to look at every market as a new market.

Q: *Do you feel this trend toward physician consolidation is inevitable?*

A: Absolutely. The medical profession *per se* is the last large cottage industry in health care. When you look at the data saying that currently there are only 750 groups of doctors that are over 25 in size,

“We think in most communities the ability to be first in the market to accept full-risk capitation is a strategic advantage, and we encourage our groups to participate in contracts which in some cases they’ve been reluctant to participate in.”

and you see 687,000 doctors out there in a hundred thousand different practice settings, you’ve got huge opportunity for reducing operating expenses, increasing the business success of that enterprise. My goodness, every day we’re getting dozens of calls from a three-doctor practice in a certain place, or an eight-doctor practice somewhere else, saying, ‘What do I do? How do I get to the next step?’

Q: *Do you find that the mood of doctors has fundamentally changed? They’ve gone through this grieving process and they’re now at the stage that they want to negotiate. They’ve accepted that managed care is here and they’re at the stage where they want to move forward now.*

A: Well, I think in most markets that’s true. We do encounter physician cartels, efforts by networks. Typically these are physicians in mid-to-late career who have

small solo or single-specialty practices who came together to keep managed care out of their market. And they’re not interested in moving forward. But for every one of those, we’ll probably meet with five groups that are saying, ‘How do we make ourselves prominent in managed care?’

Q: *Is one of your strategies to prepare these groups for capitation?*

A: Absolutely. Absolutely. What we are very clear about in our visioning with physician groups is that we see significant opportunity in capitation for physicians. We think in most communities the ability

to be first in the market to accept full-risk capitation is a strategic advantage, and we encourage our groups to participate in contracts which in some cases they’ve been reluctant to participate in.

Q: *How many markets are you in now and how many physicians are affiliated with you?*

A: We’re now operating in 52 markets. In 33 of those markets, we have multi-specialty groups where we have acquired the assets of the group. We have about 2,100 doctors in those 33 markets, and those doctors are in professional corporations. We don’t employ physicians in our markets. That’s not our philosophy. In 21 markets—two markets overlap—we operate IPA organizations with 8,000 doctors in them. In these IPA markets, we are doing two things:

- First, we are assisting the physicians in assuming capitated risk and we are stabilizing or anchoring the IPA with primary care group development.
- Second, we’re building those primary care multi-specialty groups inside the IPAs.

Q: *So you serve an MSO function, too?*

A: Yes.

Q: *Life must be pretty exciting for you these days?*

A: I would say we are getting more phone calls on a daily basis than even we anticipated. It’s phenomenal. Our success historically has been in two key areas. One is, we have always been a company which believed that the physician is a professional who with the right tools would make good decisions, and our relationships with our doctors are very sound. And second, we’re an operating company. We focus on blocking and tackling. We don’t make a lot of noise. You won’t see PhyCor on a sign at any of our operations. We’re a behind-the-scenes operator which gives physicians the tools to do what they feel needs to be done. And I can tell you, since 1988 when this thing started, we haven’t deviated from either of those principles. We stay very focused. We are not a company which wants to go out and own our own hospitals. We don’t desire to go out and have our own HMOs. We think those groups in the industry play an important role. And quite honestly, it’s everything we can do to use our capital and our people to just build strong physician organizations. We don’t think we have the intellectual capital to build hospitals and to go out and build HMOs. We think those are areas of expertise which we can partner with at the market level. So we’re staying very focused. ■

How Outcomes Are Used to Assess Physician Performance

By David Aquilina and Patty Ball

Interest in measuring and managing outcomes in health care is exploding. Academic researchers and consultants, health care associations and accreditation agencies, physician specialty societies, pharmaceutical companies, and medical device manufacturers are advancing an array of outcomes measures and promoting a variety of outcomes tools. In response, entrepreneurial firms are developing software systems and services to support diverse outcomes initiatives.

In the midst of this development, confusion about divergent outcomes definitions has left physicians and health care managers perplexed. In general, outcomes are understood to be the consequences of medical interventions. However, specific approaches to defining and measuring outcomes vary considerably. Purchasers, health plans, physicians, and patients take different approaches to outcomes. Purchasers are keenly interested in the value they are getting for their health care dollars. Health plans tend to focus on the appropriateness of care and the efficiency of providers. Physicians typically look at effectiveness based on clinical results. Patients are primarily concerned about the effect of medical conditions and medical care on their quality of life.

For physicians, it is important to understand the spectrum of outcomes systems. Increasingly, physicians' clinical decisions, and resulting utilization and cost patterns, are the focus of various outcomes measurement and management tools. Purchasers and managed care organizations are using outcomes systems to assess physician performance and determine their compensation. Physicians who understand outcomes can position themselves strategically for success in the rapidly changing health care market.

Physicians should understand that the

three main approaches to outcomes have their own methodologies and systems. These three are:

1. Outcomes indicators;
2. Clinical outcomes; and
3. Patient-reported outcomes.

Outcomes Indicators

Outcomes indicators are not direct measures of outcomes but assess aspects of the process of medical care that are considered prerequisites of good outcomes. Thus, these indicators focus on whether care is appropriate. In turn, if patients receive appropriate care, it is assumed that their outcomes will be good. For instance, the percentage of women in a health plan who receive mammograms within a specified time is one typical indicator. The assumption is that if women receive appropriate care, such as routine mammograms according to accepted screening guidelines, they would have better outcomes since any malignancies would be detected and treated early.

Such indicators are featured in the Health Plan Employer Data and Information Set (HEDIS), which the National Committee for Quality Assurance (NCQA), an HMO accrediting agency in Washington, has promulgated as the standard for managed care reporting to purchasers. Consequently, managed care plans, health insurers, and provider organizations are using administrative data (primarily, health insurance enrollment and claims data) to produce reports summarizing health plan performance on these indicators. Increasingly, such measures are being

applied not only at the plan level to assess overall system performance but at the individual provider level to profile physicians.

Clinical Outcomes

There are two basic types of clinical outcomes measures. The first centers on adverse inpatient hospital outcomes, such as morbidity and mortality. These measures present negative outcomes rates with adjustments for hospital case mix and differences in patient severity. The Health Care Financing Administration has used this approach with Medicare data to compare hospitals' outcomes.

The second measures positive outcomes. This is the focus of formal clinical trials. It is also the approach most familiar to practicing physicians. For example, if a patient has high blood pressure, a positive outcome is defined as improvement in the patient's

condition, and the physician measures it clinically as a reduction in the patient's blood pressure reading. Or, consider an allergist who has recommended a new type of inhaler for an asthma patient. Clinically, the inhaler yields a positive outcome if there is an improvement in expiratory volume and flow, measured with spirometry data. In sum, this approach to clinical outcomes centers on assessing what works for the patient based on quantitative clinical data from physical measurements and test results.

Patient-Reported Outcomes

Patient-reported outcomes place primary emphasis on the experience of the patient. This approach makes patients' perspectives and preferences the focal point of outcomes measurement and is often used to complement clinical outcomes.

Outcomes are measured by tracking changes over time in key dimensions of



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health and functional status as reported by the patient. The basic constructs quantify patients' general health perception, overall well-being (including mental and emotional health) and functional status (including the impact of health on the ability to perform daily physical and social functions). In patient-reported outcomes, the essential questions center on whether medical services result in improved patient health and functional status.

Widely accepted, validated instruments, such as the Health Status Questionnaire from the Health Outcomes Institute, in Minneapolis and the Short Form 36 (SF-36) from the Medical Outcomes Trust in Boston, are the main instruments used in patient-reported outcomes. Disease-specific instruments for chronic conditions, such as asthma and diabetes, combine patient-reported data with distilled clinical outcomes data.

Several physician group practices and managed care organizations are using patient-reported outcomes. NCQA plans to incorporate some selected patient-reported outcomes in HEDIS requirements to be released by year-end. This move by NCQA will accelerate the adoption of the patient-reported approach.

Implications for Physicians

Each of the main approaches provides valuable information for measuring and managing outcomes. Yet, each provides but one piece of the overall outcomes puzzle. The complete picture comes into view only when all the pieces are brought together. Accordingly, many health care organizations recognize the importance of integration and are developing health care information systems to combine clinical and patient-reported outcomes with utilization and cost data.

As systems solutions advance, many purchaser and managed care organizations are already using outcomes to make contracting decisions. U.S. Healthcare, the large managed care organization in Blue Bell, Pa., that is being acquired by Aetna, uses a combination of outcomes indicators and patient-reported information to profile physicians in its report cards. Blue Cross Blue Shield of Minnesota analyzed clinical outcomes to select cardiac surgeons for its network.

Other organizations have asserted that contracting decisions will be based on outcomes measures but have not yet clearly

defined which ones they will use. As outcomes measures, tools and programs continue to evolve, physicians and physician organizations are in a unique position to influence outcomes initiatives by shaping the systems that will be used to assess their performance.

An Opportunity for Physicians

Patient-reported outcomes provide particular advantages for practicing physicians. It may seem that every clinical decision a physician makes today is subject to external utilization controls or review. Moreover,

Using patient reported outcomes to keep the patient at the center of the process of care can help ensure that protocols appropriately assist, but do not supplant, physicians' clinical decision making.

with the extensive expansion of negotiated reimbursement arrangements with managed care, especially capitation, every clinical decision has a financial dimension.

Physicians have traditionally served as the patients' advocate. Today, physicians must balance the needs of their patients with the requirements of external utilization controls and new disease management programs, as well as the business pressures of managed care payment policies. Physicians who use patient-reported outcomes to demonstrate quality and satisfaction may be able to preserve the physician-patient relationship by retaining and emphasizing a focus on the patient.

Managed care organizations are moving rapidly to implement treatment guidelines and protocols to standardize the medical management of patients with chronic diseases. Using widely accepted instruments to measure outcomes based on changes in patient-reported health and functional status enables physicians to document and demonstrate how the services they provide affect patients' health. Using patient-reported outcomes to keep the patient at the center of the process of care can help ensure that protocols appropriately assist, but do not supplant, physicians' clinical decision making.

Physicians find that patient-reported outcomes data are useful in treating individual patients at the point of care. In particular, patient-reported outcomes help improve

communication with patients based on summaries of their general well-being and overall health and functional status. Since the patient-reported data can be collected and analyzed prior to patients' appointments, office visit time can be more productive.

Tracking patient-reported health and functional status systematically augments clinical decision making by adding new information that contributes to improved diagnosis and treatment. Understanding the patient's perspective on their health aids primary care physicians in accurate diagnosis and gives specialists a fuller picture of each

patient. Finally, use of patient-reported outcomes during patients' office visits improves patient satisfaction.

Conclusion

If physicians begin now to measure outcomes, they will enhance their ability to market to, and negotiate with, managed care plans. In emerging managed care markets, simply demonstrating a commitment to measuring and managing outcomes will provide a distinct competitive advantage. In mature managed care markets, the ability to bring your own outcomes data to the table strengthens your position. Understanding the differences in the various outcomes systems and their approaches can assure that you are gathering the right kind of information. Possessing relevant, patient-centered outcomes information can enable you to satisfy the needs of patients, purchasers, and health plans.

For more information, contact Mark Billmeyer, Velocity Healthcare Informatics Inc., 800/844-5648, extension 42.

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Medicare Growth and Projections

From 1985 to 1991, HMOs experienced little net gain in Medicare enrollment, according to InterStudy Publications, a research organization in Minneapolis that has followed the growth of HMOs for 17 years. But since 1991, Medicare HMOs have had double-digit growth annually.

Two possible scenarios for Medicare HMO enrollment growth are shown in Table 1. The

lower estimates (dark green bars) use the commonly reported Medicare managed care enrollment rate of 2% per month. The higher estimates (light green bars) assume Medicare beneficiaries will be encouraged to seek coverage from a managed care organization, that managed Medicare plans will be available, and that growth would reach 2.3% per year, InterStudy said. Annual enrollment growth in Medicare-

risk plans reached 27% last year (Table 2).

As of July 1, 1995, the top-10 HMOs ranked by Medicare enrollment (Table 3), gained 305,175 Medicare enrollees, representing 74.5% of the industry gain. The HMOs affiliated with national managed care firms, such as PacifiCare, United HealthCare, and Kaiser Foundation Health Plans, dominate this list of top gainers.

Medicare Managed Care Contract Report

As of April 1, 1996

	Number of plans	Enrollment
Medicare-risk plans	202	3,465,916
Cost plans	28	176,461
Demonstration plans (Social HMOs)	6	20,788
Health care prepayment plans (HCPPs)	53	488,184
Total	289	4,151,349

Source: InterStudy Publications, Minneapolis, 1996.

Definitions

- Medicare-risk HMOs: These HMOs contract with the federal Health Care Financing Administration (HCFA) to care for the Medicare population in its area at a capitated rate. The capitation rate is based on HCFA's Average Adjusted Per Capita Cost (AAPCC) in the market. Rates vary from \$177 per patient per month to \$678.
- Cost plans. These HMOs are prepaid based on the number of enrollees and can be reimbursed for costs up to 100 percent of AAPCC.
- Demonstration plans (Social HMOs): These plans operate under a demonstration project run by HCFA.
- Health care prepayment plans (HCPPs): These plans are cost based and provide beneficiaries only with certain Medicare Part B benefits.

Source: InterStudy Publications, Minneapolis, 1996.

Changes March 1 to April 1, 1996

Four risk contracts signed

- Principal Health Care of Florida, Jacksonville
- IHC Care Inc., Salt Lake City
- United HealthCare of Georgia, Atlanta
- Medical Service Corp. of Eastern Washington, Spokane

One cost contract signed

- Scott and White Health Plan, Temple, Texas

Two plans expanded service areas

- U.S. Healthcare of Delaware-Maryland, Blue Bell, Pa.
- Healthcare Corp. of the Mid-Atlantic Region, Baltimore

Enrollment Statistics

Total enrollment	New members	Percentage change
March	4,071,121	—
April	4,151,349	2%
Risk enrollment		
March	3,375,804	—
April	3,465,916	2.7%

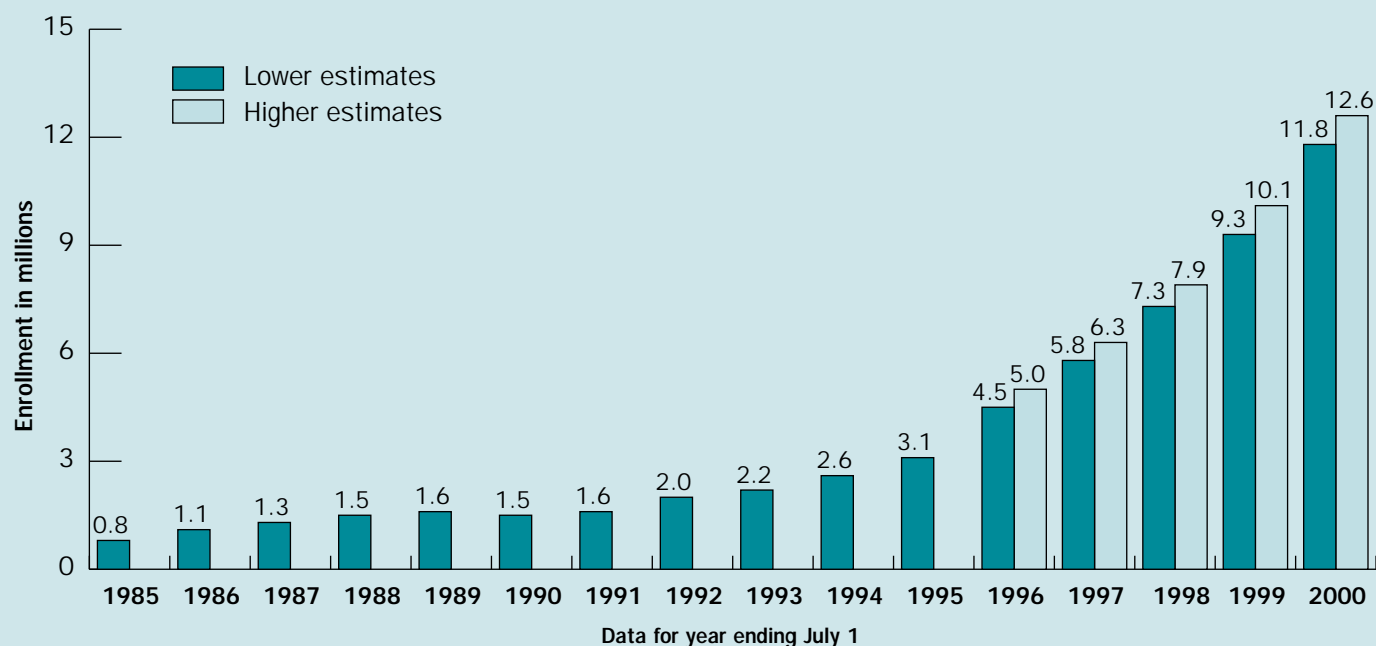
Source: InterStudy Publications, Minneapolis, 1996.

Pending Applications

	New	Expansions
Risk plans	52	37
Cost plans	8	1

Source: Operations and Oversight Team, Office of Managed Care, Health Care Financing Administration, Washington, April 1, 1996.

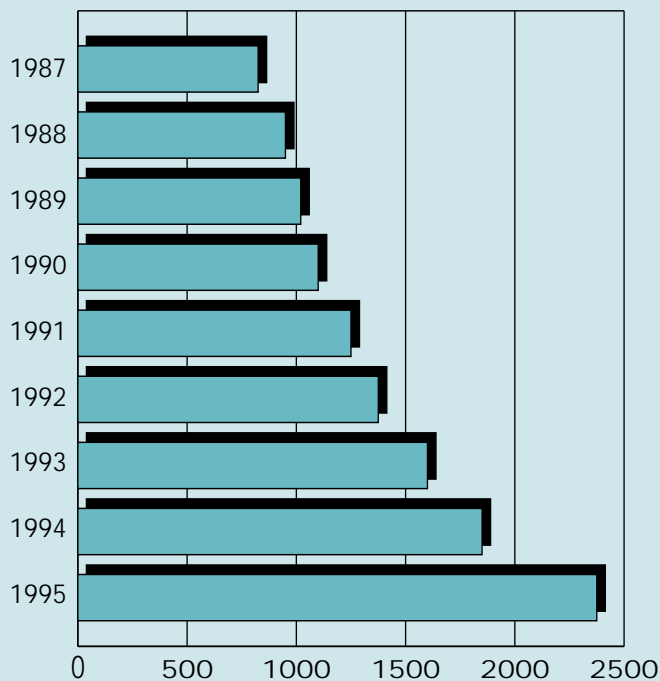
Table 1: Managed Medicare Enrollment Growth, 1985 to 2000



Source: InterStudy Publishing, Minneapolis, 1996.

Table 2: Medicare Rate of Growth Risk Enrollment, 1987 to 1995

Enrollment in as of January 1995



Source: InterStudy Publishing, Minneapolis, 1996.

Table 3: Top 10 HMOs Ranked by Medicare Enrollment As of July 1, 1995

HMO Name	Primary Service State	Medicare Enrollment	Annual Change
1. PacificCare of California	California	332,150	53,357
2. Kaiser Foundation Health Plan, Inc.- No. CA Region	California	255,242	13,627
3. FHP, Inc. (California)	California	206,872	-7,457
4. Kaiser Foundation Health Plan, Inc.- So. CA Region	California	178,054	11,254
5. Humana Medical Plan, Inc. (South Florida)	Florida	104,800	-3,200
6. Health Net	California	76,528	17,039
7. MEDICA	Minnesota	75,910	-1,595
8. Humana Medical Plan, Inc. (Tampa)	Florida	62,200	-1,500
9. Aetna Health Plans of California, Inc	California	53,055	53,055
10. Av-Med Health Plan	Oregon	50,089	28,724

Seeking to Benefit from Managed Medicare? Here's What You'll Need

By Brooks G. O'Neill

For physician groups, health plans, and managed care organizations (MCOs), a significant opportunity exists in providing care to the Medicare population. By delivering increased benefits with limited out-of-pocket cost, managed care represents an attractive alternative to the traditional Medicare fee-for-service benefits. Moreover, the federal government is interested because managed care has a proven history of delivering cost-efficient, quality health care.

skills and build infrastructure to address the operating issues created when marketing and delivering a Medicare product. Unlike the commercial health care market, where sophisticated buyers purchase health care for employees, the Medicare market consists of individuals buying benefits for themselves. Many of these seniors lack the knowledge to evaluate competing plans objectively and to make selections appropriately.

issue is being scrutinized closely by federal legislators. Any reduction in the AAPCC rate could adversely affect the profitability of a Medicare product because supplemental premiums and benefits may not be adjusted quickly enough to offset a decline in per-member revenue

Expanding a Medicare product into a new geographic area requires health plans to establish a non-Medicare book of business.

The demographics of this market alone are compelling. According to the U.S. Bureau of Data Management, there were more than 36 million Medicare beneficiaries as of Jan. 1, 1995, and this population is expected to increase to more than 39 million by the year 2000. At the same time, only 10% of this population is currently enrolled in managed care. The remaining beneficiaries, therefore, represent a potential target market of 32 million new members, of which 24 million (74%) already live in areas served by managed care, according to the Kaiser Family Foundation, a health policy research organization in Menlo Park, Calif.

Operating Issues

The current Medicare reform proposals indicate that beneficiaries will be given financial incentives to make more cost-conscious health care purchases. As such, it is probable that these beneficiaries will choose the form of coverage that best meets their needs, as Piper Jaffray stated in its report last year, *Managed Medicare—The Senior Carve-Out*.

The market's attractiveness notwithstanding, MCOs need to develop new

Therefore, MCOs need to implement retail marketing programs, in which one-on-one contact with a beneficiary can help answer a purchaser's questions. Retail sales requires additional marketing personnel, a focus on creating a branded identity (which can then be transplanted between markets), and an understanding of the senior sales cycle.

A Medicare product also requires additional investment in internal infrastructure to support the increased level of inquiries beneficiaries may have regarding managed care's restrictions and benefits. These beneficiaries also generate more claims than commercial enrollees, meaning more system resources are needed for claims processing and payments. Finally, because Medicare is a federal program, regulatory requirements create additional demands on data systems and staff. HCFA requires monthly reports, for example, on the level of Medicare enrollment and disenrollment.

An issue for MCOs participating in Medicare-risk contracting is the possibility of future changes in the monthly average adjusted per-capita cost (AAPCC). Although it is currently unclear whether this payment rate would be revised, the

The 50/50 Rule

One important consideration for physicians considering Medicare-risk contracting is the so-called 50/50 rule. This rule sets the maximum Medicare enrollment for a risk-contracting MCO at 50% of the total non-Medicare enrollment in the geographic area covered by the contract. Consequently, expanding a Medicare product into a new geographic area requires health plans to establish a non-Medicare book of business.

Physicians serving this market may find that patients have strong relationships with their doctors. As a result, the extent of the provider network is an important factor that distinguishes one Medicare HMO from another. In this market, many managed Medicare products are marketed to beneficiaries for little or no premium. When price is no longer a factor, other characteristics, such as benefit levels, quality of service, and proximity of providers, become more important.

One final caution. Medicare enrollees incur health care costs that are about four times higher than non-Medicare enrollees. Therefore, MCOs in this market need strong medical management. Delivery systems must have enough depth to ensure that referral for unaffiliated medical services is limited. In addition, Medicare beneficiaries may present more severe and complex health conditions, requiring different provider mixes and advanced clinical protocols. ■

For more information, contact, Piper Jaffray Inc., in Minneapolis, at 612/342-6000.

Outcomes Study Asks: How Much Time Should You Spend with Each Patient?

New results from an ongoing study on patient outcomes show that cost-containment efforts, such as increasing doctors' practice volumes or decreasing the amount of time physicians spend with patients, may backfire. Such efforts may compromise certain key aspects of the quality of interpersonal care. These aspects of quality lead directly to patients changing doctors, said researchers from the Primary Care Outcomes Research Institute at the New England Medical Center, in Boston.

Seeking to limit costs, many HMOs have productivity targets that state doctors should spend 40 minutes in a first-visit with a patient and 20 minutes for other patients. Some managed care plans encourage doctors to limit the time spent with patients to as little as eight minutes. Yet research by Sherrie H. Kaplan, PhD, MPH, and associates at the New England Medical Center shows that 20 minutes is the minimum time for a productive encounter between patient and doctor. Currently, health system planners are arguing over 15 to 20 minutes, said one researcher. "The battle over more than that is over."

"If future research supports the results of this study, then special attention must be paid to supporting increased interpersonal

Study (MOS). Started in 1986, the MOS is a long-term analysis of patient-centered health outcomes.

"The study indicates that a physician who sees too many patients per hour may not be able to serve the interests of the

them in medical care decision making.

Three factors were associated with higher participatory decision-making style:

1. Training in primary care,
2. Training in interviewing skills, and
3. Lower-volume medical practices and

Some managed care plans encourage doctors to limit the time spent with patients to as little as eight minutes. Currently, health system planners are arguing over 15 to 20 minutes, said one researcher. "The battle over more than that is over."

patient well," said Sheldon Greenfield, MD, co-director of the outcomes research institute. "HMOs and other managed care providers may find unintended negative consequences of efforts to increase efficiency beyond a certain point."

The study found that physicians who were rated lowest for having a style that fostered participatory decision making between patients and doctors had one-third of their patients change to other doctors in the following year. Conversely, physicians who were rated highest for participatory style had only 15% of their patients change

high levels of personal satisfaction with professional autonomy.

Joseph Dorsey, MD, corporate medical director at Harvard Pilgrim Health Care, in Brookline, New England's largest HMO, said an average visit of 20 minutes is uneconomical. "That's not to say that the average shouldn't be around 20 minutes," he added. Obviously, some patients may need only five minutes, such as those with minor illnesses. But other patients, particularly those new to a practice or those with chronic illnesses, will need more time, Dorsey said.

Physicians getting squeezed for time may want to learn to turn over as much work as possible to nurse practitioners and physician assistants, says Richard Liliedahl, MD, a health care consultant with Milliman & Robertson Inc., in Seattle. A family practice physician for 18 years before joining M&R, Liliedahl also served as medical director for two HMOs, Group Health Cooperative of Puget Sound and FHP Inc. "These other types of providers deliver totally appropriate care and at lower cost," he says. In addition, NPs and PAs can handle 85% of a doctor's patient workload, he says. It takes years of experience to learn to make a patient feel as though he or she has had enough time in a doctor's office, he adds.

The results of the outcomes study were published in the *Annals of Internal Medicine* (March 1). ■

The research shows that physicians who got their patients involved in diagnostic and treatment decisions had fewer patients change to other doctors in the following year.

involvement and high quality—not just high quantity—interpersonal care," said Kaplan, co-director of the outcomes research institute.

The research also shows that patients are more than twice as likely to remain with physicians who involve them in care decisions. The study examined a representative cross-section of some 8,000 patients in Boston, Chicago, and Los Angeles who are participating in the Medical Outcomes

to other doctors, researchers said. Physicians who got their patients involved in diagnostic and treatment decisions—by talking to patients, offering them choices among treatment options, and encouraging a sense of control and responsibility—were identified as have a participatory decision-making style. Patients of doctors in solo practice, multi-specialty groups, and HMOs in selected urban areas were asked to characterize their doctors' inclination to include

Capitation Can Empower Physicians

By James T. Darnell

Many physicians oppose capitation, saying patient quality is compromised. They believe capitation's inherent financial incentives lead them to provide minimal care while practice overhead costs remain uncontrolled. As a result, many physicians in capitated plans think they have a conflict of interest.

This kind of thinking only prolongs the agony of trying to make a traditional fee-for-service practice work while managed care continues to gain marketshare. Those who are prepared for managed care in their

emphasis on doing the right thing because capitated practices are tied financially to their patients' health, not to their illness. When a doctor is paid a set fee regardless of the level of illness among patients, he or she is forced to separate those patients who abuse physician care from those who need medical attention. Primary care physicians in capitated markets are often surprised by the number of patients who do not need to see a physician and who can be cared for with alternative health services.

Any discussion of capitation leads

appropriately without numerous operational and political conflicts.

A recent example was cited in the cover story of *Hospitals and Health Networks* (March 20). The article explained how executives of a health system had carefully selected a large panel of physicians and spent \$25 million developing a capitated system. But when the system began to lose money, the executives blamed the participating physicians for the losses, struggles in making the system manageable, and reductions in productivity.

When one speaks with the physicians involved in this case, however, one gets a very different story. These doctors had been led to believe that they would be secure and managed properly. They had been told they would be allowed to improve practice efficiency and to become more effective under many prepaid managed care plans. All they had to do was to allow their practices to be reorganized by a hospital-funded management company and administered by the hospital's health system executives. These physicians weren't given the opportunity to lead the organizational efforts of the delivery system.

When practicing physicians work with their colleagues to make utilization decisions and educate their patients to understand how managed care works, capitation can be a healthy experience for physicians, patients, and medical practices. But physicians must be willing to take a leadership role in their communities so that both health plans and medical centers can build alliances that work for the best interests of the community. Practice management organizations that develop managed care plans in their communities must be led by physicians, not by health systems. Physicians become empowered through capitation when they can control their relationships with payers, work toward reducing their medical and operational costs, control utilization, and educate their patients in preventive care. ■

For more information, contact the Alliance of Healthcare Advisors Inc., Lafayette, Calif., 888/242-2778.

Capitation can empower physicians to develop a healthier patient base while allowing the practice to become more efficient in scheduling and tracking costs.

markets usually find ways to manipulate the market to their advantage, allowing them to serve patients appropriately. Unfortunately, it's mainly hospitals and health systems that have heard this message and are organizing physicians and their compensation systems in preparation for more sophisticated levels of managed care.

So why are physicians missing the point on how managed care and prepaid plans can empower them to practice medicine appropriately and install controls in their practice operations?

Taking Stock

Capitation forces physicians to scrutinize the volume of services rendered, the utilization of those services, and the cost of delivering appropriate care. As primary care physicians organize into groups and begin to understand cost control, they become more efficient and effective. Efficiency is doing things right; effectiveness is doing the right thing. Fee-for-service allows for equal emphasis on effectiveness and efficiency motivated by individual physician initiative. In fact, fee-for-service plans make it possible to do many things correctly, but not necessarily to do the right things.

Conversely, capitation provides the necessary incentives for physicians to put more

inevitably to the question of under-utilization. But the logic of capitation does not tolerate denying care inappropriately. Connecting physician reimbursement with a patient's good health means many more people may be involved in scrutinizing service utilization. Since most major decisions under capitation are made by panels of practicing physicians, doctors work in a collaborative case management environment with checks and balances that work against inappropriate utilization.

The result is that capitation can empower physicians to develop a healthier patient base while allowing the practice to become more efficient in scheduling and tracking costs. In addition, prepaid revenue stabilizes income streams.

Identifying Flaws

To be sure, capitation is not without its flaws. In the hands of non-physician-directed organizations, capitation has been used to manipulate market forces and to control the delivery of health care with little regard to patients' needs. In some saturated managed care markets, in which physicians have surrendered control to health systems seeking vertically integrated programs, research has shown that physicians are unable to practice medicine

Study Shows Effectiveness of Specialty Cardiac Care

Cardiologists do significantly better than general or family practitioners in adhering to recent guidelines for diagnosing and treating congestive heart failure, according to researchers at the San Francisco Veterans' Administration Medical Center and the University of California at San Francisco.

In a presentation to the American College of Cardiology, the researchers reported on a nationwide survey of 934 physicians to determine how they diagnose and treat heart failure, Business Wire reported. The survey included 316 general and family practitioners, 292 internal medicine specialists, and 327 cardiologists.

All of the physician groups adhered well to the diagnosis and treatment guidelines released in June 1994 by the federal Agency for Health Care Policy and Research (AHCPR), in Rockville, Md., says study leader Barry Massie, MD. "But there were real differences that potentially could add up to enormous clinical and economic impact."

Massie recommends that cardiologists

play a role in caring for people with severe heart failure, such as patients who already have been hospitalized for the condition. "I also think it's reasonable that any newly diagnosed heart failure patient might benefit from a consultation with a specialist," he says. Many internists and family practitioners will not need a cardiologist's opinion, he adds, "but I don't think a consultation should be disallowed by managed care."

For diagnosing heart failure, AHCPR recommends that doctors use some specific measure of the heart's function, such as echocardiography—a technique that employs sound waves to create an image of the heart and its valves. "That's important because one out of every three patients you think might have heart failure actually does not," Massie says. In the survey, Massie and colleagues found that 87% of cardiologists, 77% of internists, and 63% of family and general practitioners followed this guideline.

Another AHCPR guideline recommends that all patients with heart failure be treated

with ACE (angiotensin-converting enzyme) inhibitors. Numerous trials have shown that these drugs help prevent progression to symptomatic heart failure in people who have no symptoms when diagnosed. Massie points out, "In those with symptomatic heart failure, we know ACE inhibitors help prevent deaths and hospitalizations." Among surveyed doctors, 75% of cardiologists, 62% of internists, and 53% of general and family practitioners gave ACE inhibitors to patients without symptoms when diagnosed. For patients who had symptoms when diagnosed with mild or moderate heart failure, the drugs were prescribed by 87% of cardiologists, 77% of internists, and 63% of general and family practitioners.

Commentary: HMO executives believe the best way to cut costs is to use primary care gatekeepers. Yet there is mounting evidence that having a knowledgeable specialist diagnose and treat patients with heart disease saves money and improves outcomes. This study is but one showing that specialists can provide the best and most cost-effective care. ■

Hospitals Adjust To Managed Care

A survey of 1,700 hospitals by the American Hospital Association (AHA) shows that profit margins have increased slightly since 1990, according to the *Contra Costa Times*, in Walnut Creek, Calif. Cost cutting helped the hospitals that answered the survey to post a 5.2% profit margin for the year ending in November 1995, up from the 4.8% for the same period in 1990, said the AHA.

In a survey of 1994 financial data reported by 357 California hospitals, the median profit margin for that year was 3.7%, lagging a nationwide median for that year of 4.1%, according to information gathered by HCIA, a health care researchers in Baltimore.

AHA statistics show revenue growth has dropped from about 10% a year in 1991 to 5.3% last year. At the same time, the rate of growth in expenses also has slowed, from 11% in 1990 to 5.4% last year.

Comment: Hospitals may be losing money on inpatient care, but by drawing on other revenue sources and cutting costs, profit margins are up, except in California. ■

Paradoxes Among the Physician Work Force

The number of physicians in the United States is continuing to grow at a faster rate than the general population and a higher percentage are becoming specialists rather than badly needed general physicians, a new report concludes.

The trends reflect "a paradoxical decline in the supply of generalist physicians in smaller rural communities (where they are sorely needed) despite the growing physician surplus," say authors Marc Rivo of PCA Health Plans of Florida and David Kindig of the University of Wisconsin School of Medicine. Their report on the physician work force was published in *The New England Journal of Medicine* on April 4 and may explain why some physicians are complaining that they are having trouble finding work.

Among the conclusions of the survey:

- The number of doctors involved in patient care will have nearly doubled from 1970 to 2000.
- The percentage of general practice or family practice physicians is continuing to decline and fell from 51% in 1965 to 35% in 1992.
- Many doctors believe they have not been trained adequately in key skills, such as preventive care, cost-effective care, and being able to identify community resources for patients.
- Training of doctors is disproportionately high in five states: New York, Massachusetts, Connecticut, Pennsylvania, and Rhode Island.

The United States will have more doctors than it needs, but also, "the increasing participation of non-physician professionals in work previously performed only by physicians will make the projected surplus even greater," the researchers said.

Comment: Some observers believe one way to cut costs effectively is to have an equal mix of specialists and primary care physicians and that physicians should be in primary-care driven organizations. If these observations are correct and if, as the journal article says, the current mix of specialists to primary care physicians is 65% to 35%, then managed care has the right conditions for long-term success. ■

Plan Can't Drop N.H. Doctor

In a decision thought to be the first in the nation, the New Hampshire Supreme Court has ruled that a health insurer cannot drop a physician from a health plan without cause. In 1994, Healthsource New Hampshire, a managed care plan with 122,000 subscribers, canceled a contract it had with Paul Harper, MD, a surgeon in Derry.

Comment: The court said the public has a substantial interest in the relationship between health plans and doctors. Unfortunately, the decision has no effect beyond New Hampshire. ■

Canadian M.D.s Are Moving to U.S.

Saying their health system limits freedom, Canadian physicians are moving to the United States in record numbers, according to *The Boston Globe*. In 1994, some 410 doctors quit practicing in Canada and most moved to the United States, the Canadian Medical Association said. The rate of departure has risen in recent years, from 241 doctors in 1990. Of the 96 graduates of the University of Toronto's family medical program last year, 34 started practicing in the United States.

The numbers may seem small by U.S. standards, but Canada has only 55,000 medical doctors and 30 million residents.

Comment: The irony is striking: The doctors are leaving due to deep dissatisfaction and distrust of what they say is an increasingly intrusive, bureaucratic, and cash-starved medical system. Yet these doctors think its better here? ■

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