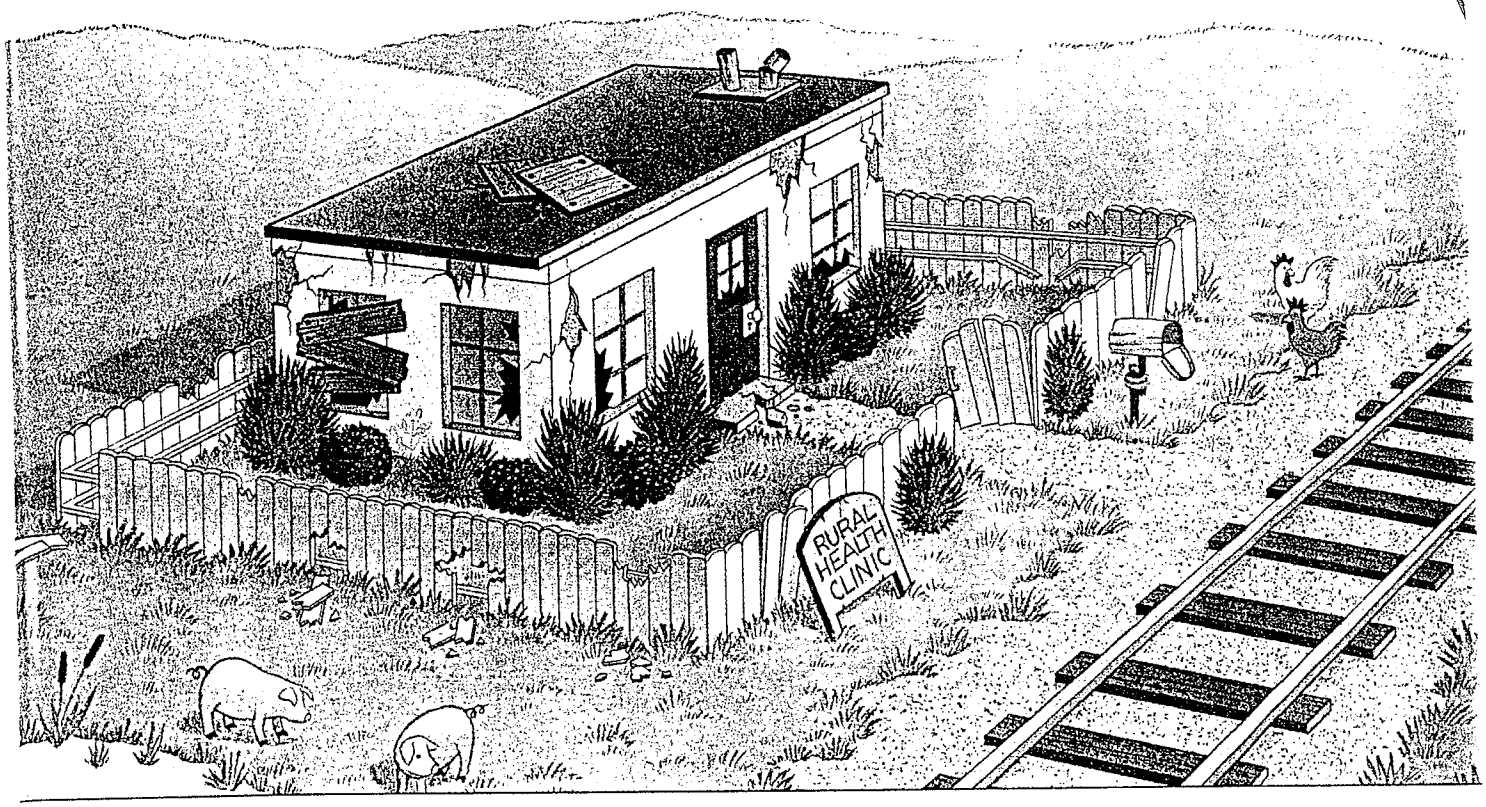


# The gravy train doesn't stop here anymore

*For years, a legal loophole gave rural hospitals an unfair advantage over local private doctors. Now that's history.*

**By Harold Connett**

Often disparaged as a federal gravy train rolling through pastoral America, the rural health clinics (RHC) program was hauled back to Washington last year after two decades of delivering primary care to the elderly and the poor in underserved communities.

The occasion wasn't a 20th anniversary celebration, but rather a critical appraisal of a rapidly growing Medicare and Medicaid reimbursement program that was spiraling out of control and fostering unfair competition between hospitals and other providers.

The author is a freelance writer in Atlanta.

Los Banos, Calif., FP John Mevi explains the inequity: "I'm paid $16.81 for seeing a Medi-Cal patient. The hospital-owned clinic right across the street, because it's officially a 'rural health clinic,' gets $125" (see page 148).

This year, as the program begins its third decade, it will be retrofitted with legislative and regulatory reforms designed to put it back on track and curb the abuses that Mevi and others have complained about, shortcomings confirmed in a November 1996 General Accounting Office report. Rural-health experts predict that few if any clinics will close; instead, private physicians like

Illustration by Rob Roper

Mevi, who have seen their practices erode under the old system, will benefit from a more equitable playing field.

Public Law 95-210, which authorized the establishment of the RHC program, was enacted in 1977 when most rural clinics were run by physician assistants and nurse practitioners. Unable to attract doctors, they were generally unable to qualify for Mediplan coverage and struggled to remain solvent. The RHC law changed that, authorizing Medicare and Medicaid reimbursement to non-physician providers—if their clinic was located in an area defined as rural and as either a medically underserved area (MUA) or a health-professional-shortage area (HPSA).

"If they would pay me $25 instead of $16, *I* could see those patients. Instead, they pay an RHC $125."

**FP John Mevi**

Photo courtesy of John Mevi, M.D.

As an added enticement to draw providers into the program, the clinics were reimbursed based on the actual cost of services (rather than according to less generous Mediplan fee schedules). That allowed them to at least break even.

But despite these and other federal incentives, the RHC program languished throughout the 1980s. Although the Health Care Financing Administration publicized the program widely, not until the late 1980s, after HCFA switched most hospitals from a cost-based reimbursement system to DRGs (diagnosis-related groups), did RHCs begin to attract the attention of rural hospitals. The reason: RHCs were exempted from DRGs; their reimbursement remained cost-based.

Rural hospital administrators came to realize not only that the RHC program was ill-defined, but that the program's very vagueness masked a wealth of fiscal benefits.

For example, few rules and regulations had ever been drawn up for RHCs owned by hospitals. Unlike independent (often doctor-owned) clinics, they were exempt from an annually adjusted cap on per-visit costs—currently just under $58—and they didn't have to comply with the same cost-reporting requirements as independent clinics. A hospital located in a medically underserved area or health-professional-shortage area thus could escape the fiscal constraints of DRGs by converting its outpatient clinics to RHCs and shifting much of its own overhead costs to them.

"RHCs became a convenient dumping ground for administrative costs; just move them into this outpatient area that had previously been in an inpatient area," notes William Finerfrock, executive director of the National Association of Rural Health Clinics. "There had been no incentive to do that under DRGs or the old fee schedule. Wherever a cost was applied, it was still a hospital cost and reimbursement was regulated."

Several hospitals dove head-first through this loophole. Finerfrock recalls hearing anecdotes that hospitals sent administrative secretaries to "work" at RHCs during lunch hour "so their salaries could be thrown into the RHC's overhead."

Word spread, and the number of RHCs soared from 57 in 1990 to 1,267 in 1995, comprising most of the 30 percent annual growth in RHCs. "In the past couple of years, as more hospitals came to recognize the advantages, they converted outpatient clinics and ordinary practices into RHCs," says Keith Mueller, immediate past president of the National Rural Health Association. "Unfortunately, many

of them gamed the system, and now everyone has to pay the price."

Among the first to pay were physicians like John Mevi, whose independent clinics or medical offices had to compete with hospital-sponsored—and much more highly reimbursed—RHCs. He saw his mostly Medi-Cal patient load slide from about 25 percent to its current 15 percent in part, he says, because he cannot afford to see those patients at the current California rate of $16.81.

### Unregulated, RHCs became less rural, more profitable

Just how far the RHC program had run off track was documented in the late 1996 GAO report, presented in February 1997 before a House of Representatives subcommittee. The GAO found that, contrary to the program's original purpose, RHCs have been increasingly certified in areas that look more like crowded suburban Chicago than desolate West Texas.

"In converting their clinics and practices to RHCs, many hospitals gamed the system. Now everyone has to pay the price."

Keith Mueller, President, National Rural Health Association

Photo courtesy of Keith Mueller

Although the U.S. Census Bureau defines a rural area as a geographic entity with a population of fewer than 2,500, under the RHC program, cities and towns with populations as high as 50,000 are considered rural because they haven't been designated as urbanized by the Census Bureau. And yet, GAO officials estimate that half the counties designated medically underserved areas would not qualify as rural, using 1990 census data. (The definition of rural area is so vague and outdated that the Census Bureau plans to revise it later this year; the MUA listings haven't been systematically reviewed since 1981.)

GAO officials lay the blame for the proliferation of RHCs on the program's easily met eligibility criteria (that is, it's easy to qualify as "rural" or "underserved") and on the outdated MUA and HPSA listings. At the same time, the law that created rural health clinics makes no provision for clinic decertification. Hence the quip: "Once an RHC, always an RHC."

Just as RHCs have proliferated, so have their billings, the GAO discovered. By conducting postpayment reviews of clinics, it found that inadequate cost controls (specifically, no reimbursement cap) have allowed RHCs to bill for and receive much higher Medicare and Medicaid reimbursements than providers on a Medicare fee schedule, often 300 percent more than doctor-owned RHCs.

That amounted to an estimated $295 million in additional Mediplan payments in 1996. In one case, a clinic was receiving $214 per patient visit, compared with the average $37 for providers on the Medicare schedule.

The GAO also found that independent clinics had claimed excessive reimbursement for salaries and overhead. One clinic claimed $270,000 in compensation for each of its four primary-care physicians. Nearly one in four RHCs paid their doctors more than the $127,000 national mean for physician compensation.

By late 1996 the GAO report and growing complaints from private physicians had put RHC officials in the hot seat. "Everybody recognized that the examples

**Atrovent®** In allergic and nonallergic perennial rhinitis
**(ipratropium bromide) Nasal Spray 0.03%**
**Brief Summary of Prescribing Information**
**INDICATIONS AND USAGE** ATROVENT® (ipratropium bromide) Nasal Spray 0.03% is indicated for the symptomatic relief of rhinorrhea associated with allergic and nonallergic perennial rhinitis in adults and children age 12 years and older. ATROVENT Nasal Spray 0.03% does not relieve nasal congestion, sneezing or postnasal drip associated with allergic or nonallergic perennial rhinitis.
**CONTRAINDICATIONS** ATROVENT® (ipratropium bromide) Nasal Spray 0.03% is contraindicated in patients with a history of hypersensitivity to atropine or its derivatives, or to any of the other ingredients.
**WARNINGS** Immediate hypersensitivity reactions may occur after administration of ipratropium bromide, as demonstrated by rare cases of urticaria, angioedema, rash, bronchospasm and oropharyngeal edema.
**PRECAUTIONS General** ATROVENT® (ipratropium bromide) Nasal Spray 0.03% should be used with caution in patients with narrow-angle glaucoma, prostatic hypertrophy or bladder neck obstruction, particularly if they are receiving an anticholinergic by another route. Cases of precipitation or worsening of narrow-angle glaucoma and acute eye pain have been reported with direct eye contact of ipratropium bromide administered by oral inhalation.
**Information for Patients** Patients should be advised that temporary blurring of vision, precipitation or worsening of narrow-angle glaucoma or eye pain may result if ATROVENT Nasal Spray 0.03% comes into direct contact with the eyes. Patients should be instructed to avoid spraying ATROVENT Nasal Spray 0.03% in or around their eyes. Patients who experience eye pain, blurred vision, excessive nasal dryness or episodes of nasal bleeding should be instructed to contact their doctor. Patients should be reminded to carefully read and follow the accompanying PATIENT'S INSTRUCTIONS FOR USE.
**Drug Interactions** No controlled clinical trials were conducted to investigate drug-drug interactions. ATROVENT Nasal Spray 0.03% is minimally absorbed into the systemic circulation; nonetheless, there is some potential for an additive interaction with other concomitantly administered anticholinergic medications, including ATROVENT for oral inhalation.
**Carcinogenesis, Mutagenesis, Impairment of Fertility** Two-year oral carcinogenicity studies in rats and mice have revealed no carcinogenic activity at doses up to 6 mg/kg/day. This dose corresponds, in rats and mice respectively, to about 200 and 100 times the maximum recommended human daily dose (MRHD) on a mg/m² basis of ATROVENT Nasal Spray 0.03%. Results of various mutagenicity studies (Ames test, mouse dominant lethal test, mouse micronucleus test and chromosome aberration of bone marrow in Chinese hamsters) were negative.
Fertility of male or female rats at oral doses up to 50 mg/kg/day (about 1,660 times the MRHD on a mg/m² basis) was unaffected by ipratropium bromide administration. At doses above 90 mg/kg/day (about 3,000 times the MRHD on a mg/m² basis), a decreased conception rate was observed.
**Pregnancy** *TERATOGENIC EFFECTS Pregnancy Category B.* Oral reproduction studies were performed at doses of 10 mg/kg/day in mice, 100 mg/kg/day in rats and 125 mg/kg/day in rabbits. These doses correspond, in each species respectively, to about 160, 3,000 and 8,000 times the MRHD of ATROVENT Nasal Spray 0.03% in perennial rhinitis (252 mcg/day) on a mg/m² basis. Inhalation reproduction studies in rats and rabbits at doses of 1.5 and 1.8 mg/kg/day (about 50 and 120 times the MRHD on a mg/m² basis for each species, respectively) have demonstrated no evidence of teratogenic effects as a result of ipratropium bromide. At oral doses above 90 mg/kg/day in rats (about 3000 times the MRHD on a mg/m² basis) embryotoxicity was observed as increased resorption. This effect is not considered relevant to human use due to the large doses at which it was observed and the difference in route of administration. However, no adequate or well controlled studies have been conducted in pregnant women. Because animal reproduction studies are not always predictive of human response, ATROVENT Nasal Spray 0.03% should be used during pregnancy only if clearly needed.
**Nursing Mothers** It is known that some ipratropium bromide is systemically absorbed following nasal administration; however the portion which may be excreted in human milk is unknown. Although lipid-insoluble quaternary bases pass into breast milk, the minimal systemic absorption makes it unlikely that ipratropium bromide would reach the infant in an amount sufficient to cause a clinical effect. However, because many drugs are excreted in human milk, caution should be exercised when ATROVENT Nasal Spray 0.03% is administered to a nursing woman.
**Pediatric Use** Safety and effectiveness of ATROVENT Nasal Spray 0.03% in patients below the age of 12 years have not been established.
**ADVERSE REACTIONS** Adverse reaction information on ATROVENT® (ipratropium bromide) Nasal Spray 0.03% in patients with perennial rhinitis was derived from four multicenter, vehicle-controlled clinical trials involving 703 patients (356 patients on ATROVENT and 347 patients on vehicle), and a 1-year, open-label, follow-up trial. In three of the trials, patients received ATROVENT Nasal Spray 0.03% three times daily, for 8 weeks. In the other trial, ATROVENT Nasal Spray 0.03% was given to patients two times daily for 4 weeks. Of the 285 patients who entered the open-label, follow-up trial, 232 were treated for 3 months, 200 for 6 months, and 159 up to 1 year. The majority (>86%) of patients treated for 1 year were maintained on 42 mcg per nostril, two or three times daily, of ATROVENT (ipratropium bromide) Nasal Spray 0.03%.
The following table shows adverse events, and the frequency that these adverse events led to the discontinuation of treatment, reported for patients who received ATROVENT Nasal Spray 0.03% at the recommended dose of 42 mcg per nostril, or vehicle two or three times daily for 4 or 8 weeks. Only adverse events reported with an incidence of at least 2.0% in the ATROVENT group and higher in the ATROVENT group than in the vehicle group are shown.

| | % of Patients Reporting Events[1] | | | |
|---|---|---|---|---|
| | ATROVENT Nasal Spray 0.03% (n=356) | | Vehicle Control (n=347) | |
| | Incidence% | Discontinued% | Incidence% | Discontinued % |
| Headache | 9.8 | 0.6 | 9.2 | 0 |
| Upper respiratory tract infection | 9.8 | 1.4 | 7.2 | 1.4 |
| Epistaxis[1] | 9.0 | 0.3 | 4.6 | 0.3 |
| Rhinitis* | | | | |
| Nasal dryness | 5.1 | 0 | 0.9 | 0.3 |
| Nasal irritation[2] | 2.0 | 0 | 1.7 | 0.6 |
| Other nasal symptoms[3] | 3.1 | 1.1 | 1.7 | 0.3 |
| Pharyngitis | 8.1 | 0.3 | 4.6 | 0 |
| Nausea | 2.2 | 0.3 | 0.9 | 0 |

[1] Epistaxis reported by 7.0% of ATROVENT patients and 2.3% of vehicle patients, blood-tinged mucus by 2.0% of ATROVENT patients and 2.3% of vehicle patients.
[2] Nasal irritation includes reports of nasal itching, nasal burning, nasal irritation and ulcerative rhinitis.
[3] Other nasal symptoms include reports of nasal congestion, increased rhinorrhea, increased rhinitis, posterior nasal drip, sneezing, nasal polyps and nasal edema.
[1] This table includes adverse events which occurred at an incidence rate of at least 2.0% in the ATROVENT group and more frequently in the ATROVENT group than in the vehicle group.
* All events are listed by their WHO term; rhinitis has been presented by descriptive terms for clarification.
ATROVENT Nasal Spray 0.03% was well tolerated by most patients. The most frequently reported nasal adverse events were transient episodes of nasal dryness or epistaxis. These adverse events were mild or moderate in nature, none was considered serious, none resulted in hospitalization and most resolved spontaneously or following a dose reduction. Treatment for nasal dryness and epistaxis was required infrequently (2% or less) and consisted of local application of pressure or a moisturizing agent (e.g., petroleum jelly or saline nasal spray). Patient discontinuation for epistaxis or nasal dryness was infrequent in both the controlled (0.3% or less) and 1-year, open-label (2% or less) trials. There was no evidence of nasal rebound (i.e., a clinically significant increase in rhinorrhea, posterior nasal drip, sneezing or nasal congestion severity compared to baseline) upon discontinuation of double-blind therapy in these trials.
Adverse events reported by less than 2% of the patients receiving ATROVENT Nasal Spray 0.03% during the controlled clinical trials or during the open-label follow-up trial, which are potentially related to the local or systemic anticholinergic effects of Atrovent include: dry mouth/throat, dizziness, ocular irritation, blurred vision, conjunctivitis, hoarseness, cough and taste perversion. Additional anticholinergic effects noted with other ATROVENT dosage forms (ATROVENT® Inhalation Solution, ATROVENT® Inhalation Aerosol, and ATROVENT® Nasal Spray 0.06%) include: precipitation or worsening of narrow angle glaucoma, urinary retention, prostatic disorders, tachycardia, constipation, and bowel obstruction.
There were infrequent reports of skin rash in both the controlled and uncontrolled clinical studies. Other allergic-type reactions such as angioedema of the throat, tongue, lips and face, urticaria, laryngospasm and anaphylactic reactions have been reported with other ipratropium bromide products.
No controlled trial was conducted to address the relative incidence of adverse events of BID versus TID therapy.
**HOW SUPPLIED** ATROVENT® (ipratropium bromide) Nasal Spray 0.03% is supplied as 30 ml of solution in a high density polyethylene (HDPE) bottle fitted with a metered nasal spray pump, a safety clip to prevent accidental discharge of the spray, and a clear plastic dust cap. The 30 ml bottle of ATROVENT Nasal Spray is designed to deliver 345 sprays of 0.07 ml each (21 mcg ipratropium bromide), or 28 days of therapy at the maximum recommended dose (two sprays per nostril three times a day).
Store tightly closed between 59°F (15°C) and 86°F (30°C). Avoid freezing. Keep out of reach of children. Avoid spraying in or around the eyes.
Consult package insert before prescribing.
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brought forward created a dangerous environment for us," admits Finerfrock of the National Association of RHCs. "If we didn't resolve these problems in good faith, we very well could have seen the RHC program go away."

## The inequities draw legislative attention

Some RHC supporters criticized the GAO report, contending that it overstated the proliferation of clinics and exaggerated the salaries paid to RHC doctors. Nevertheless, the rural-health provisions contained in the Balanced Budget Act of 1997 were enacted in August with widespread support.

Although RHC abuses and shortcomings had been substantial, few lawmakers considered eliminating the program, says Marcia Sayer, a staff member for the subcommittee, which is headed by Rep. Christopher Shays, R-Conn. "It was the congressman's view that HCFA and HRSA (Health Resources and Services Administration) weren't minding the store to the extent they should," she says. "We think the Budget Act did some very good things to address the issues raised in the GAO report."

The package of reforms contains four major provisions, most of which took effect at the first of this year:

***Capping costs.*** The new law subjects hospital-based RHCs to the same cost-reimbursement cap as independent (doctor-owned) clinics. The only exception is those owned by hospitals with fewer than 50 beds. Rural-health lobbyists fought hard to exempt the smaller hospitals, says Keith Mueller of the National Rural Health Association, because they

> "People who take advantage of the system are supposed to get caught in surveys and audits. When those things don't get done, you open the door for abuse."
>
> **Sam Tessen, Executive Director Texas Rural Health Association**

Photo courtesy of Sam Tessen

often need full reimbursement and cost-shifting leeway to stay open.

HCFA says it never established cost limits for provider-based clinics for two reasons: Few clinics owned by hospitals were certified when the program began. And it was easier to reimburse them the same way Medicare paid for their other outpatient services. The National Association of RHCs supported the new cap after doctor-owned clinics complained of having to compete against hospital RHCs set up in the same towns.

"We took the position that there should be equity," Executive Director William Finerfrock says. "A rural health clinic should be a rural health clinic, and if the physician in that town can deliver care within the cap, then it seems reasonable to assume a hospital can, too."

***Triennial review.*** The secretary of Health and Human Services is now authorized to recertify clinics every three years. The purpose is to assure that areas designated as medically underserved communities have remained underserved. Clinics that no longer meet the RHC criteria will be decertified—unless the secretary determines that they are essential to the delivery of primary-care services in the area.

Under the original act, HCFA had no authority to discontinue cost-based subsidies, even if clinics were located in areas that were no longer underserved. "HRSA didn't seem to be moving any time quickly to [deal with the problem of outdated MUAs], so the only option we had was to change the statute," Finerfrock says. The three-year period was chosen because health-professional-shortage areas are reviewed and updated on that schedule.

***Midlevel providers.*** One of the objectives of the original RHC program was to bring physician assistants and nurse practitioners into underserved areas. Texas, for example, had no midlevel providers in rural areas prior to the RHC program, according to Sam Tessen, a former rural clinic operator in the town of Nixon.

While the program has succeeded in recruiting non-physician health workers, clinics have been able to obtain waivers when they were unable to attract them, according to NRHA's Mueller. The new law retains the waiver only for clinics already providing services under Medicare. New clinics are required to hire at least


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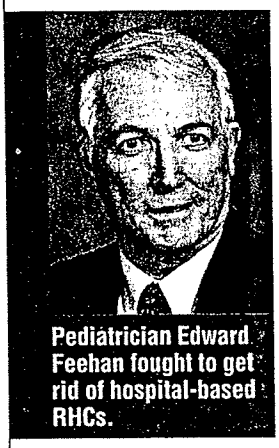
## Physicians in California fight rural health clinics



Pediatrician Edward Feehan fought to get rid of hospital-based RHCs.

To John Mevi, a longtime family practitioner in the city of Los Banos in California's Merced County, the federal safety-net scheme known as the rural health clinics program represents unfair competition, pure and simple. A soloist, Mevi receives $16.81 for seeing a Medi-Cal patient. The hospital-owned clinic across the street, an RHC, can charge $125.

"The clinic is 20 yards from my office, yet it receives a considerably better fee than I do," he says. "It's a significant difference, and hard to explain."

On the other side of Merced County, an agriculturally rich area east of San Jose, pediatrician Edward Feehan has been trying to explain how localities haphazardly designated "medical-shortage areas" have been able to profit. An activist, Feehan self-published a book on the shortage-area designation process in 1994, and sent it to Washington. He's even gone so far as to quit the California Medical Association to protest its passivity on the issue.

"He's gutsy to be so outspoken, because he can't be making friends out of this," says Marcia Sayer, a staff member of the House Subcommittee on Human Resources, which reviewed Feehan's finding for background information.

Feehan's crusade against federally subsidized health care in Merced County eventually paid off. After visits by national media and federal inspectors, all but one of the county's shortage designations were removed.

"We were getting buried here," says Feehan. "We had subsidized competition all around us. The shortage designation areas and federally subsidized clinics of one kind or another were being milked to the hilt."

Like Mevi, Feehan grew alarmed at the number of hospital-based RHCs that were being established in the county, even though the area had become less and less rural. As a pediatrician with more than three-quarters of his patients on welfare, Feehan says his practice was "decimated" by the competition from pediatricians who contracted with the clinics.

"RHCs get paid 8.4 times as much as we do for seeing welfare patients," he says. "When I first came here, I was the second pediatrician in the area. Now there are probably 15."

Much of the competition has come from the county hospital, now privately owned, which set up three RHCs in the city of Merced. "They are well-managed and very successful," Mevi says. "They own or rent brand new buildings everywhere."

The local medical society generally opposed the proliferation of subsidized clinics in Merced County but with little effect, Mevi notes, adding that many of its members worked in them. Mevi also points out that powerful farming interests in Merced support RHCs, because the clinics provide low-cost medical care to migrant workers.

The situation has caused Mevi to jettison most of his Medicaid patients, and to restrict his practice to mostly Medicare and insured patients. Thus, his practice hasn't been affected as much as Feehan's has. Nonetheless, Mevi finds the current system incomprehensible; he'd prefer a more logical alternative that would give Medicare and Medicaid patients a choice of providers. "It seems to me a very inefficient way to spend money. The Catch-22 is if they would pay me $25 instead of $16 per visit, I could see these patients. Instead, they pay an RHC $125."

To some RHCs, the physicians' comments sound like sour grapes. But Sayer is sympathetic. Not only do RHCs receive higher reimbursement, she points out, but until now community health centers have been able to use federal dollars to advertise and provide transportation for patients.

"The truth," Sayer says, "is that if private physicians are competing against cost-based reimbursement, they're at a disadvantage."

Photo courtesy of Edward Feehan, M.D.

one midlevel provider in addition to a physician.

***Performance standards.*** On the regulatory side, HCFA and HRSA are instituting changes that rural-health experts say are long overdue. Responding to the GAO finding that clinics are inadequately reviewed and audited, HCFA is implementing quality objectives similar to those it sets for other Medicare programs that RHCs will have to meet annually to remain in compliance.

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The agency also is reminding its fiscal intermediaries to apply tests of reasonableness for clinic charges, and to pay particular attention to salaries and overhead. In its position paper on RHCs, the National Rural Health Association noted that although annual surveys of RHCs were required under the original legislation, the surveys have not been conducted consistently. In Texas, clinics have operated for more than five years and never been surveyed after the initial certification study, says RHC operator Sam Tessen.

"People who take advantage of the system are supposed to get caught by surveys and audits. When those things don't get done, you open the door for abuse," Tessen notes. "But what people don't realize is that HCFA never issued a manual of rules for hospital-based RHCs, so with all they've done they haven't officially violated anything."

Regular reviews are difficult, HCFA says, considering the large number of RHCs. The Health Resources and Services Administration, meanwhile, is drafting proposed changes in shortage-designation criteria that would combine HPSAs and MUAs. This will simplify data-gathering requirements and use more relevant indicators of need. Most important, some current MUAs may not qualify as underserved areas under the new criteria, which will heavily weigh provider-to-patient ratios and levels of poverty.

## More reforms may be needed

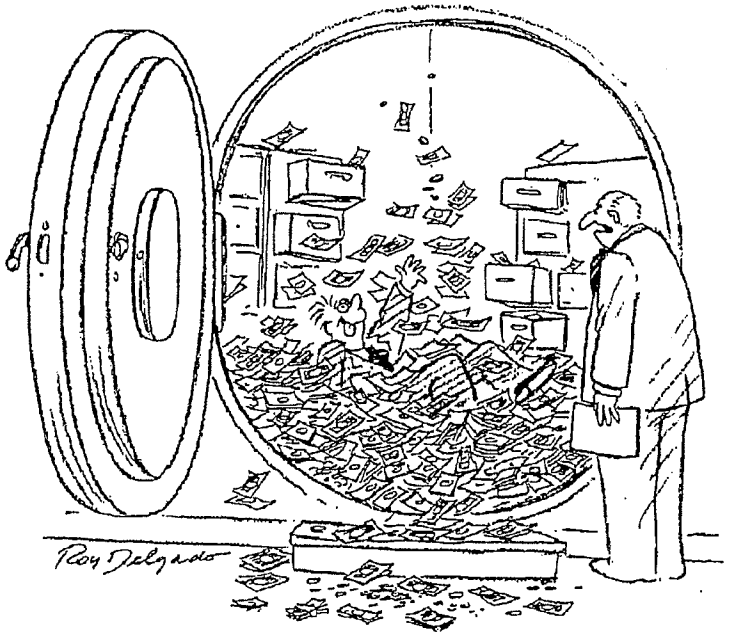
How will the new reforms affect rural health clinics? Both industry associations expect that a few clinics, especially hospital-based ones, will close or scale back. Congressional staffer Marcia Sayer is doubtful, but she says it's too soon to tell.

To be sure, when the GAO asked RHCs how important cost-based reimbursement was to their financial stability, newer clinics reported it necessary only in the first few years, until they established an adequate patient base. Established clinics reported that while cost-based reimbursement was preferable to Medicare fee schedules, it was not crucial to their financial viability.

Because of the continuing uncertainty about how closely HCFA will manage the RHC program, the subcommittee may hold another hearing on the subject, Sayer says. "We think there is still more that needs to be done."

California FP John Mevi doubts that the new law will have much impact in his town. The community hospital in Los Banos has fewer than 50 beds, so it's exempt from the cost-reimbursement cap. And while Los Banos and the neighboring town of Merced have already lost their MUA and HPSA designations, their RHCs remain. "Though the government has determined there is no shortage in these two cities, they continue to support and pay for the RHCs," Mevi says.

"I think the answer is to fold all these entitlements into a managed-care program," he explains. "Make these funds available, and let physicians who wish to care for these patients join the program. Then the patients can go to anyone they wish, and they'll get the continuity of care they deserve." ■




"I had the same desires when I was young, Beegley.
Now put that money back in the drawers and get back to your cage!"