The American College of Physicians, representing 70,000 specialists in internal medicine, appreciates this opportunity to appear before you today to discuss Medicare policies and procedures that are seen as administratively burdensome to physicians. I am Edgar Jackson, Jr., MD, FACP, a practicing physician in Cleveland, Ohio and a member of ACP’s Clinical Practice Subcommittee. I am Clinical Professor of Medicine at Case Western Reserve University and was recently elected to the Institute of Medicine.

Our comments focus specifically on two areas of particular concern to ACP members—utilization review and peer review organizations. I will touch briefly on specific problems related to nursing home care. Because internists provide a large portion of the medical care provided to the nation's elderly, Medicare's administrative environment has a great impact on ACP's membership. We hope to identify problems and to suggest pathways to solutions.

INTRODUCTION

The issue of administrative overload has for some time been a priority concern for number of physician organizations, especially those whose membership is comprised of primary care physicians. The level of distress continues to grow among physicians who see administrative requirements of the system overtaking precious time for patient care and draining practice resources and their own energies. It is a time of crisis for primary care. The need for specialists who provide continuous and comprehensive care continues to grow and the supply diminishes.

The College became acutely aware of the power of this issue as it addressed the problem of increasing numbers of uninsured and underinsured Americans. As College members sought solutions to the crisis of access to care in this country, they realized that simply expanding the current system with its administrative waste and burdens could exacerbate current problems rather than solve them. This conclusion was based in part on the belief that excessive administrative burdens and loss of clinical autonomy play a role in physicians' decisions to retire early and to limit the number of new Medicare patients. They also
discourage medical students from entering careers in internal medicine.

A survey of College members conducted last year found that only 39 percent would choose internal medicine again, and 40 percent would discourage medical students from choosing the specialty. Over a third would take a substantial reduction in income in return for clinical autonomy and reduced paperwork burdens.

This Committee well knows that a solid foundation of primary care providers is key to a rational health care delivery system. Your work to address the administrative requirements of Medicare could have a great impact on health care delivery overall and in future schemes to expand the system to include millions of Americans who are not now full participants. It has implications for health care costs, the quality of patient care and our ability to attract physicians to primary care specialties.

In preparing this statement, we contacted a sample of College members from across the country who are busy physicians in private practice with a substantial number of Medicare patients. They were selected, in addition, because of their thoughtfulness on health policy issues. All of them recognize a legitimate need for federal regulation and oversight but believe that there are ways to streamline and improve HCFA's administrative processes.

Two consistent themes emerged from these discussions. One is that the current system of utilization review needs significant improvement and that the peer review system needs fundamental restructuring. An additional overall perspective woven throughout their comments was that communications between physicians and the government must improve in order to solve both short-term problems and develop long-term reforms. Problem-solving is impeded as long as physicians perceive their relationships with HCFA as adversarial.

UTILIZATION REVIEW

The College has stressed the importance of utilization review reform before the various committees of Congress and the Physician Payment Review Commission. Most physicians see the process of claims review, pre-admission certification, retrospective reviews and medical necessity reviews as onerous, time-consuming, inefficient and cumbersome. The specific problems cited most often were:

--the number of inquiries, sometimes handled by unqualified or improperly trained individuals, for each carrier review.

--the frequency of claims denied without adequate explanations for the decision. Several
physicians reported that resubmitted forms, without changes, were frequently approved on the second go-around. This led some to conclude that the process was arbitrary at best, harassing at worst.

--the lack of timeliness by carriers in informing physicians of coding and reimbursement changes, requiring physicians to correct unintended overbilling with each individual patient. My own experience bears this out when it took three to four months to get a response to an inquiry regarding the allowed fee for a specific procedure. The hours that were spent correcting these bills could have been avoided.

--difficulty in simply reaching the carrier over the telephone to get a question answered. This problem includes busy phone lines, dealing with nameless, out-of-town bureaucrats and not even being able to leave a recorded message.

One extreme example of utilization review gone amuck, at least from this organization's perspective, was a HCFA pilot project in Georgia to "determine the effectiveness of subcontracted medical review and the impact of more effectiveness." While problems for physicians in Georgia were exacerbated by a concurrent change in carrier, the actions taken by the subcontractor "HealthCare Compare" did lasting damage to HCFA's relationship with the physician community. Damage that is not limited to Georgia since the saga of HealthCare Compare was told and retold over those years at ACP regional scientific sessions, ACP Governors' meetings, AMA House of Delegates meetings, and similar gatherings. Briefly, thousands of claims were denied, downcoded and deemed medically unnecessary. Because of a quirk in historical charge patterns in Georgia, the downcoding was often a three-story fall, from comprehensive visits to limited visits. At one point, the backlog of claims totaled 800,000.

The central question raised by ACP during this fiasco was whether there are proper safeguards in the system to assure that utilization review efforts do not become the tool for wholesale cost containment and budget savings as opposed to their proper role in assuring that appropriate services are delivered to beneficiaries.

As ACP testified to the Energy and Commerce Health Subcommittee at a field hearing in Georgia, some of the problems with the HealthCare Compare pilot project are emblematic of the problems increasingly being faced by internists around the country. Several of the lessons learned are: 1) mechanisms are needed to assure appropriate responsiveness to questions and concerns from the physician community; 2) efforts must be directed to find ways to reduce the substantial amount of time physicians spend responding to paperwork and documentation demands, and preparing appeals on denied or downcoded services.
A new approach to utilization review is needed. The current punitive approach does not serve physicians or patients and does not advance the policy goal of assuring appropriate services. One promising approach looks at patterns of practice rather than each individual physician-patient transaction.

We recognize a greater knowledge base is needed on clinical outcomes, effectiveness and guidelines to fully implement a new utilization review system based on physician profiling. We believe that there is strong evidence that physicians want to practice in the norm and when exposed to scientific findings that suggest different practice patterns, needed changes are made. The PPRC is currently examining the feasibility of using profiling to better monitor physician utilization. HCFA has also recognized of the need to move away from punitive, individual reviews to a system of improving medical practice by sharing information on patterns of care.

THE PEER REVIEW ORGANIZATION PROGRAM

The attached op-ed piece by one of ACP's active committee members, Dr. Robert A. Berenson, captures the flavor of very similar experiences and reactions of physicians around the country. He describes the hours of back-and-forth effort trying to admit to the hospital a seriously ill 93-year-old woman with Alzheimer's disease after a fall. Once admitted, the nurse called and asked why the CT scan was not ordered immediately. The tug-and-pull of the system was both time-consuming and humiliating for this doctor.

Another one of ACP's active members who was involved in the IOM's report on quality assurance recently assessed the current PRO program in a way that reflects the perspective of many ACP members. His view of the current system is that it is punitive in nature, lacks credibility of many of the current standards, and intrudes on individual patient-physician interactions. He added "...the wasteful duplication of external review among various organizations in appalling. Hospitals and their medical staffs must deal with separately developed standards and criteria established by the JCAHO, state Departments of Health, Medicare, Medicaid, HMOs, and traditional indemnity insurers. There is great need for agreement on a common system that can be tapped into by multiple organizations."

Dr. Wilensky's stated intention to "radically transform" the current Medicare PRO program should receive strong backing from the physician community and could help guide reform of the array of other PRO programs at state or institutional level. A new Medicare PRO program that uses large databases of clinical information such as the Uniform Clinical Data Set (UCDS) and computerized quality screens, updated with advances in medical care, could
very well provide the model for other programs.

Reports from physicians around the country about their PROs vary considerably. There is, however, almost universal support for restructuring the system even from those physicians who think the PRO in their state functions as well as it could within current regulations. Many report specific complaints that fall into several general areas:

--retrospective reviews of urgent or emergency room hospital admissions. It is distressing for physicians to be told months after a hospitalization that it was inappropriate. While not ideal, some sort of expedited authorization process in these cases would be preferred.

--the eight-to-ten month period taken by the PRO to review hospital charts makes recall of detail more difficult for physicians. While the PRO takes months to review a chart, the physician is given only days to respond. Some physicians are irked by the double standard.

--review screens are not always based on sound clinical data. Many physicians complain that they have had numerous citations but on appeal they were reversed. After the physician eventually talks to someone with the medical knowledge to understand the clinical circumstances of a particular case, the physician is exonerated. An internist from Chattanooga described it this way: It seems that the PRO assumes that a Medicare patient will be discharged from the hospital in a normal state as would a young person. The fact of the matter is that many elderly patients have conditions such as kidney failure and chronic anemia and are basically "sick as stink." Even though the discharge summary documents all of this carefully, you still receive the dreaded letter. The PRO assumes that these very sick patients should be treated and made perfect.

--the confidentiality of screening criteria frustrates physicians who want to avoid submitting a claim that will be denied. The aggravation and overhead costs of these denials are extremely frustrating to physicians.

The pressures of the system produce a high level of anxiety among all physicians, even those who have never been cited. The attached letter from the Medicare Part B carrier in Utah provides a dramatic illustration of how well-grounded this anxiety can be. A physician was informed that he had 30 days from the date of the letter to reimburse Medicare $8,871.86 as a result of a review that he was unaware was underway. The ACP leader who brought this case to our attention said he is "the epitome of the caring physician" and is the least deserving of this type of treatment than anyone he could think of. The hospital paid the sum to avoid interest charges and the doctor involved is busy reviewing charts from two to three years ago.
NURSING HOME CARE

In the context of a discussion of nursing home regulations, one physician concluded that we are riding a dinosaur when we need a race horse. It is her view that current nursing home regulations would make sense if nursing home residents were just fragile and simply unable to live alone. That may have been the case in 1955. She says that today's nursing home patients are very sick, could be treated in the hospital, but can be well cared for outside the hospital with as good outcomes and at less expense. But here's the rub. An automatic screen kicks out all but one visit each month. After an automatic claims denial for this subsequent visit, an appeal is usually successful but at a reimbursement level for a nursing home visit at about $20. The cost of appealing the decision is high enough to make it hardly worth the aggravation.

Several other physicians complained about the situation where a visit is made to the nursing home to meet the requirement for a mandatory visit every 90 days and the patient gets sick and needs to be seen within a month after the mandatory visit. Reimbursement is not allowed for a visit within 30 days. Once again, the physician can appeal but at a cost in dollars and time.

Finally, there appears to be a conflict between a HCFA regulation and a national carrier screen that is making it impossible not to contradict one or the other. While nursing home regulations require a visit at least every thirty days for the first 90 days of an admission or re-admission, a national carrier screen still in effect will kick out for review visits that are more frequent than every 30 days. ACP has discussed the contradiction with HCFA, and it appears to be a case of the left hand not knowing what the right hand is doing. HCFA staff and a state carrier office are reviewing the apparent conflict.

CONCLUSION

The formation of this committee by HCFA Administrator Gail Wilensky and Secretary Sullivan is an extremely positive signal that the federal government wants a partnership with the physician community. There are very few physicians who are not working in the best interest for their patients, yet many physicians feel they are treated as guilty parties. As the op-ed title "Meet Dr. Squeezed" and the accompanying illustration conveys, primary care physicians and their patients are suffering under the current system. While the problems we have identified may be difficult to solve and will require the cooperation of all branches of government and the private sector, finding solutions is nothing less than critical.