Patient Access to Internist-Subspecialists in Gatekeeper Health Plans

Recommendations of the American Society of Internal Medicine

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Executive Summary

This white paper documents the capability of subspecialists of internal medicine to provide both primary and specialized care to their patients in a managed care environment. Internal medicine subspecialists traditionally have served a dual role as first-contact and consultant physicians. This paper describes research, data, and current approaches to the issue of internal medicine subspecialists' scope of practice and presents the American Society of Internal Medicine's (ASIM) recommendations.

Internal medicine subspecialists face two separate, but related, scope-of-practice issues in managed care plans:

- Limits on their ability to provide primary care to all patients; and
- Limits on their ability to provide principal care to patients within their area of expertise.

ASIM defines "principal care" as

Integrated, accessible health care provided by medical subspecialists and neurologists that addresses the large majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management, developing a sustained physician-patient partnership and practicing within the context of family and community.

To prevent subspecialists from being restricted in their scope of practice, ASIM recommends four steps for MCOs:

1. Give internal medicine subspecialists and generalists the same opportunities to participate as primary care/gatekeeper physicians for any enrolled patient who wishes to choose them.

2. Permit internal medicine subspecialists to participate in MCOs as primary care physicians, principal care physicians, and/or consultants.

3. Allow internal medicine subspecialists listed as consultants to act as principal care physicians for patients with conditions in the subspecialist's area of expertise.

4. Accurately compare the cost of subspecialist and primary care physicians by using severity-adjusted economic profiles and other measures of physician performance.

This is one of four policy papers on "Reinventing Managed Care" published simultaneously by ASIM. The other papers, which are available upon request, address use of board certification in health plan credentialing of physicians, methods for assessing physician performance, and how to assure appropriate patient care under capitation arrangements.
Patient Access to Internist-Subspecialists in Gatekeeper Health Plans

Introduction

ASIM represents physicians who practice general internal medicine and each subspeciality of internal medicine. ASIM has prepared this paper to document the capability of subspecialists of internal medicine to provide both primary and specialized care to their patients within a managed care environment. Traditionally, subspecialists of internal medicine have served the dual role of first-contact and consultant physicians, but in recent years many managed care organizations (MCOs) have required subspecialists to limit their scope of practice to either primary care or consultative care. Internists who have specialized training in one branch of internal medicine often want to retain their traditional dual role, but find it difficult when managed care health plans enforce arbitrary restrictions on their scope of practice.

This arbitrary limit on scope of practice is a concern for internists. In a membership survey conducted in November 1994, ASIM asked internists to describe issues and problems they had with managed care plans' administrative policies. Of the 154 respondents, 27 percent indicated that they have experienced problems with managed care plans that prohibit them from providing primary care services to their patients. Subspecialists of internal medicine rated scope of practice as the second most important issue, after capitation. Eighty-five percent of subspecialists noted that scope-of-practice limitations were either “very important” or “important” issues. Subspecialists indicated that they participated in an average of six MCOs. Survey respondents also expressed their concerns about scope of practice:

Several internists in my group practice joined a managed care plan, but I was excluded because I was considered a 'specialist' (I am a rheumatologist). I feel this exclusion is harmful to my patients. I provide primary care to a large segment of my rheumatology patients and I want to continue to provide both primary and subspecialty care, but fear that other plans will exclude me.

—Internist in Montana

As a nephrologist, many times I had to refer a dialysis patient back to a primary care doctor for treatment of a minor problem. The patient is the loser in this case, because the patient has to spend unnecessary time seeing multiple physicians when one can do the job adequately. It is unfortunate, because I can and will provide primary care services to these patients if the managed care plans allow.

—Internist in Nevada

Internal medicine subspecialists face two separate, but related, scope-of-practice issues in MCOs:

- Limits on their ability to provide primary care to all patients; and
- Limits on their ability to provide principal care to patients within their area of expertise.

What Is Scope of Practice?

"Scope of practice" describes the breadth and type of medical services delivered by a physician. MCOs often force subspecialists to limit their scope of practice by requiring that they sign up either as a...
primary care, first-contact physician or as a consultant physician—but not both.

Most MCOs require their enrolled patients to select a primary care physician. The primary care physician—also described as the "gatekeeper"—is responsible for all aspects of the patient's medical care. The primary care physician determines when the patient needs to see a medical subspecialist for a particular problem. In most instances it is beneficial for patients to select a primary care physician, but this requirement sometimes causes problems. One of the biggest is the impact on existing patient-physician relationships. An internist describes how the primary care/gatekeeper requirement disrupted a long-standing relationship with a patient:

My patient was upset. Her family was upset. I was upset. But despite my appeals, cajoling and veiled threats, her insurance carrier was implacable. I had to choose between being listed as a primary care physician or an endocrinologist. My patient was an insulin-dependent diabetic. I had been her doctor for 10 years....Since her last pregnancy, she had been on an insulin pump. She was well-regulated because she and I had a relationship that worked....

Her employer subscribed to a preferred provider organization (PPO) that was being formed. The plan representatives approached me and asked whether I wanted to be on their panel as a subspecialist endocrinologist or as an internist. If I chose the former, I could see patients only on referral. If I picked the latter, I could accept no referrals ....They [health plan managers] are paying too little attention to the real world of internal medicine practice, in which a dual role—primary care internal medicine and a subspecialty proficiency—is often natural and desirable....The bottom line is this: Internists should be able to do what they are trained and competent to do, and what they wish to do...as long as they are qualified by training, experience, and competence. Their ability to do both shouldn't be interfered with by system managers and ill-equipped cost controllers who have little understanding of "what we [internists] are."

This physician's evident concern would probably increase after hearing these comments from managed care experts:

There hasn't been any scientific proof that gatekeepers save money.
—Managed care expert in Pennsylvania

Gatekeepers in systems we've studied are a complete failure. In one case, we found a gatekeeper HMO more expensive than an open-ended indemnity plan. 3
—Managed care executive of a national PPO network

Nonetheless, other analysts and studies suggest that gatekeepers do save money. But even as the merits of gatekeeper systems continue to be a subject of legitimate—and necessary—debate, it is important that health plans that use a gatekeeper system do not set arbitrary limits on who can serve as the primary care physician/gatekeeper. It is also important that health plans allow direct access to principal care provided by subspecialists when the subspecialist is the physician most qualified to provide ongoing care to a particular patient.
What Is Primary Care?

The Institute of Medicine (IOM) has defined primary care as

The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.4

ASIM supports the IOM definition of primary care with a caveat—the “majority of personal health care needs” should include a general list of primary care services, such as:

- Provision of comprehensive care that is not organ- or disease-specific;
- Periodic health maintenance exams;
- Health counseling;
- Immunizations and cancer screening;
- Terminal care;
- Diagnostic work-up for medical illnesses and necessary therapeutic intervention;
- Coordination of care for chronic illnesses;
- Arrangement of consultations for surgical and procedural interventions, and appropriate referrals for complex problems (as necessary); and
- Provision of urgent care.

Similarly, the Council on Graduate Medical Education (COGME) observed that:

Physicians who provide primary medical care...are trained, practice and receive continuing education in...health promotion and disease prevention, assessment and evaluation of common symptoms and physical signs, management of common acute and chronic medical conditions, [and] identification and appropriate referral for other needed medical services.5

Are Subspecialists Qualified To Provide Primary Care?

It is important to point out that primary care is an activity, not a person. Many public policy leaders and managed care executives have approached primary care as if it were exclusively provided by a particular subset of physicians.6 Although it is true that some physicians practice more primary care than others, it is incorrect to assume that internal medicine subspecialists do not provide primary care. Many do.

A study conducted in the 1970s by the Robert Wood Johnson Foundation and the University of Southern California analyzed the medical services provided by physicians in 24 different medical specialties, including many of the subspecialties of internal medicine. The study noted that for a significant percentage of their patient population, internal medicine subspecialists provided regular patient care, assumed continuing responsibility for their patients, and met most of their patients' medical needs. Although the study did not try to define this as "primary care," it fits the IOM criteria. The study indicated that the following subspecialties delivered a significant percentage of primary care:

...It is incorrect to assume that internal medicine subspecialists do not provide primary care. Many do.
...Because they were trained first in general internal medicine, internists who receive training in a particular subspecialty still have the requisite "core" training to provide comprehensive primary care to their patients.

Cardiology, 58.2 percent;
Rheumatology, 52.9 percent;
Endocrinology, 45.7 percent;
Pulmonology, 43.8 percent;
Gastroenterology, 42.3 percent; and
Allergy, 32.9 percent

(The other subspecialties of internal medicine were not studied.) The study also estimated that 20 percent of patients received primary care from subspecialists, and concluded:

These data document a widely held but previously unsubstantiated belief: conventional labels do not always correspond with actual practice. Many specialists also serve as general physicians, and some primary-care physicians deliver general medical care to fewer patients than is commonly supposed.

The study clearly demonstrates that subspecialists of internal medicine provide a substantial portion of the primary care delivered in the U.S. They offer a unique combination of skills that will always be needed. These skills include:

- Diagnosing and treating adult patients with complex, multisystem problems;
- Interpreting sophisticated diagnostic tests;
- Managing and coordinating care; and
- Preventive counseling.

Public policy leaders and managed care executives should encourage the availability of internists and internal medicine subspecialists to meet the primary care needs of the adult population, especially those of the elderly and people with complex, multisystem problems.

All internists complete at least three years of intensive postgraduate training in a residency program, working closely with experienced, teaching internists. Internists who complete three years of training in adult medical care and who choose not to receive further subspecialty training are often described as "general" internists, or generalists, despite their training in the specialty of internal medicine. Other internists complete at least two additional years of training to qualify as subspecialists in one of the several branches of internal medicine, such as gastroenterology or rheumatology. But because they were trained first in general internal medicine, internists who receive training in a particular subspecialty still have the requisite "core" training to provide comprehensive primary care to their patients. A well-publicized study looked at how different specialties prepared residents in the broad competencies required for primary care practice; it found that internal medicine exceeded the generalist training requirements and that it provided lengthy, well-defined continuity-of-care experiences.

The National Ambulatory Medical Care Survey and the Robert Wood Johnson study have demonstrated that internists typically spend more time with patients, and see a greater proportion of older and sicker patients than other physicians who provide primary care. Internists emphasize listening to patients, explaining test results, communicating the diagnosis to the patient, explaining treatment alternatives, and counseling on preventive measures—such as smoking cessation.
and dietary changes—that can improve health and reduce illness and premature death.\textsuperscript{12}

Like all other physicians who provide primary care services, internist-subspecialists should have current primary care skills, not just previous training. But since many subspecialists currently are providing primary care to a substantial portion of patients, health plans should not automatically assume that subspecialists lack current skills in primary care.

**Why Should Subspecialists Be Allowed To Provide Primary Care?**

Many managed care plans do not allow subspecialists to provide both primary, first-contact care and specialized, consultative care. Earlier this year ASIM conducted a survey of 210 health maintenance organizations (HMOs) nationwide. The majority of responses came from independent practice association-model HMOs. Eighty-eight percent of the 62 survey respondents indicated that they used a gatekeeper system that required patients to select a primary care physician.\textsuperscript{13} Under this system, patients could go to a subspecialist designated as a consultant only if referred by the primary care physician.

ASIM contends that subspecialists should be permitted to serve as primary care, gatekeeper physicians for any patient enrolled in a managed care plan who wishes to select an internist-subspecialist as primary care physician. A primary care physician designation should not preclude a subspecialist from also being listed by the health plan as a specialist-consultant who can receive referrals from gatekeeper physicians. Subspecialists are trained in general internal medicine and should not be penalized for additional training and experience in their subspecialty. If subspecialists can satisfy an MCO’s credentialing requirements for primary care physicians and want to serve in primary care, they should be allowed to do so. They might be primary care physicians for some patients, consultants for others, and providers of a continuum of primary and subspecialty care to another segment. Subspecialists who accept the role of a primary care physician must be willing to provide the full range of primary care services.

Health plans should be flexible in allowing physicians to assume the role that best helps the individual patient. The traditionally-recognized dual role of subspecialty practice best serves the longitudinal medical needs of patients. It is not acceptable or desirable for a health plan to make the physician and the patient choose between the two roles.

ASIM’s HMO survey found that many health plans have a positive view of the role of subspecialists as primary care physicians for all patients. Fifty-five percent of respondents stated that internal medicine subspecialists can designate themselves as both consultants and primary care gatekeepers in their plans. Forty-three percent stated that the subspecialist could function in one role or the other, but not both. Only 2 percent of respondents said that all subspecialists must be listed only as consultants in their plan.\textsuperscript{14}

Some have suggested that to be eligible to serve as primary care physicians, subspecialists should be required to show that much of their practices is in general
Internists in each subspecialty of internal medicine feel strongly that they should be allowed to act as principal care physicians. The thinking is that subspecialists with a significant proportion of primary care patients (e.g., 50 percent) are better prepared to deliver primary care than others with a smaller percentage of primary care patients. ASIM opposes such a requirement. Objective criteria on training, continuing medical education, and demonstration of competence—applied equitably to generalists and subspecialists—provide a more reasonable basis for eligibility.

When considering the concept of primary care, some have suggested that subspecialists should demonstrate that they have clinical experience and expertise in treating organ systems outside those typically seen within their subspecialty. "Re-training" is a popular public policy theme, but ASIM believes that because many subspecialists are already fully trained as internists and most have ongoing experience in providing primary care to their patients, they do not need retraining in primary care. Subspecialists, however, should meet the MCO's credentialing criteria for its primary care panel. If, for example, a health plan requires that a primary care physician be able to provide pelvic examinations on female patients, office dermatology and other aspects of comprehensive, first-contact care, then the subspecialist should be able to demonstrate competence in those procedures.

What Is Principal Care?

ASIM defines "principal care" as:

Integrated, accessible health care provided by medical subspecialists and neurologists that addresses the large majority of the personal health care needs of patients with chronic conditions requiring the subspecialist's expertise, and for whom the subspecialist assumes care management, developing a sustained physician-patient partnership and practicing within the context of family and community.

Principal care describes the capability of the internal medicine subspecialist to serve as a first-contact physician for patients in his or her area of expertise. Internists with specialized training in one branch of internal medicine often want to serve in this role, but managed care plans often limit their scope of practice to either primary or consultative care.

Why Should Subspecialists Be Allowed To Provide Principal Care?

Many managed care plans do not allow subspecialists trained to provide principal care to serve as first-contact, continuous-care physicians for patients with chronic diseases. ASIM maintains that MCOs should permit subspecialists to serve as principal care physicians for patients with conditions that fall within their area of expertise; MCOs and physicians should jointly determine which subspecialists should be allowed to act as principal care physicians.

Internists in each subspecialty of internal medicine feel strongly that they should be allowed to act as principal care physicians. For example, physicians in the subspecialty of allergy and immunology are committed to serve as principal care physicians for patients with diseases such as chronic asthma, primary immune deficiency disorders, chronic and severe upper respiratory disorders such as chronic sinusitis, and chronic and severe...
cutaneous disorders such as chronic severe urticaria and atopic dermatitis. Gastroenterologists might provide care management for patients with inflammatory bowel disease and chronic liver diseases. Nephrologists traditionally have served as principal care physicians for patients with end-stage renal disease and chronic renal insufficiency.

Subspecialists argue that direct patient access to a subspecialist—either through the principal care model or other mechanisms such as the point-of-service (POS) model*—is consistent with the increased emphasis on preventive care to improve medical outcomes and decrease costs. The example of nephrologists shows that direct access to nephrology care for the patient with chronic, progressive renal insufficiency yields dividends in quality care, improved outcome and cost containment. Nephrology care must be available for the duration of the patient's need, and not be limited by time or by number of visits. Nephrologists are better trained to address the unique technology related to dialysis and the special medications related to renal transplantation for the end-stage renal disease patient, as well as the multisystem complications and the drug dosing and interaction issues related to all levels of renal insufficiency.

In its survey of HMOs, ASIM found that many health plan executives and medical directors view the principal care model positively. Fifty percent of respondents using the gatekeeper system indicated that they would allow patients with certain disease conditions direct access to subspecialists if the subspecialists could prove that they are more cost-effective providers of primary care than generalists for these patients. Seventy-four percent indicated that they would allow subspecialists to designate themselves as both primary care physicians and consultants if they were more cost-effective than primary care physicians.15

Here are some supportive comments from HMO executives:

We would consider the principal care concept, understanding that the subspecialists would be primary care providers only for certain disease-specific critical pathways.

—Managed care medical director, Ohio

For certain disease conditions such as HIV [human immunodeficiency virus], AIDS [acquired immune deficiency syndrome], or ESRD [end-stage renal disease] a subspecialist may be designated as a principal care provider.16

—Managed care executive, Illinois

There's a subset of patients with complex illnesses who should be managed by specialists. For example, a person with advanced rheumatoid arthritis would probably be better and more cost-effectively managed by a rheumatologist.17

—Managed care medical director, Minnesota

Even though many internal medicine subspecialists are well qualified by training and experience to provide comprehensive primary care, principal care for patients with conditions in their area of expertise, and subspecialty consultant services, many MCOs restrict their ability to serve in each of those roles. Many MCOs require subspecialists to choose one of these roles to be their exclusive type of practice.

* The POS model allows patients direct access to a subspecialist at the cost of a slightly higher coinsurance and deductible.
How Are Health Plans Now Limiting Scope of Practice?

The arbitrary scope-of-practice restrictions imposed by MCOs affect physicians in two major ways:

- They prohibit subspecialists from providing primary care to any patient if they want to be listed on the consultant-specialist panel of physicians. Subspecialists whose practices are part subspecialty and part general internal medicine, therefore, have to give up their general internal medicine practice if they choose to be listed as a subspecialist with the plan.

- The limitation on subspecialists’ scope of practice prevents them from serving as principal care physicians for patients with chronic diseases within their area of expertise.

Patients may not notice how their physician is listed in the MCO’s physician directory, but the listing is significant. In both scenarios, the patient’s physician directory would list the subspecialist as a consultant. However, in the first scenario, the subspecialist may be willing—but not able under health plan protocols—to treat any patient in his or her panel for general internal medicine concerns, including patients who do not have specific medical conditions within the subspecialist’s area of expertise. Similarly, in the second scenario, the subspecialist may be willing—but not able by health plan protocols—to treat patients with certain chronic disease conditions within his or her subspecialty panel for their principal care needs. Some health plans restrict their subspecialists’ scope of practice by preventing them from providing primary care; others prevent their subspecialists from providing principal care; and still others prevent subspecialists from providing both primary and principal care.

Some health plans’ policies on the scope of practice issue are bizarre. A health plan in the Washington, D.C., area offers several health insurance products. One of its products allows physicians who are Board certified in both internal medicine and a subspecialty of internal medicine to provide primary care and subspecialty care to patients on their primary care panel, but not to see subspecialty referrals from other physicians. However, the health plan has the opposite policy for another insurance product—under its protocols, the physician cannot treat his or her own patients in the subspecialty area, but is allowed to receive subspecialty referrals from other physicians. Although these policies are conflicting, they wouldn’t create problems if the provider networks were mutually exclusive—but they are not. Some physicians participate with both, which creates confusion for them, their staff and their patients. Patients become incensed when they switch from one insurance product to the other and find that they can no longer seek medical treatment the same way as before.

What Will Scope-of-Practice Limitations Do to Patient Care?

1. Scope-of-practice limitations often interrupt continuity of care and the patient-physician relationship, which are essential elements of high-quality medical care. An example is the previously-cited case of the diabetic patient who had seen the
same endocrinologist for 10 years for both primary and subspecialty care only to find that she no longer could see that physician without the permission of her primary care gatekeeper.

2. **Scope-of-practice limitations** could result in a patient receiving care for a chronic condition from a generalist when a more qualified, principal care subspecialist is available. This may result in lower quality care for the patient. The following comments from ASIM members illustrate this:

We are endocrinologists; most of our patients are endocrine patients (particularly diabetics), who use us as both their subspecialist and general internist. Unfortunately, many of the managed care plans that have asked us to join them insist that we be listed as either general internists or endocrinologists. These plans utilize a gatekeeper system, which makes it necessary for patients to see another physician before they can be referred to us. The system merely shifts the patient's care from an endocrinologist to a physician who has had less training in this area and who likely has less of an interest in endocrine diseases. In light of the DCCT [National Institutes of Health Diabetes Control and Complications Trial], which shows that tight control over blood sugars prevents diabetes complications, and considering how much time it takes to achieve the level of knowledge necessary to manage diabetics effectively, the position of the insurance company is somewhere between ludicrous and dangerous. The new primary care physician has a vested interest in not sending the patient out for referral and yet he or she is very unlikely to be qualified to get into the management of diabetes at the level needed to achieve tight control. We are left with either remaining endocrinologists and seeing our practice erode or becoming primary care physicians for all patients. Both of these options have significant negative aspects for us and our patients.

—Internal medicine practice in Ohio, January 1995 letter

I am a general internist. I have cared for managed care patients whose care would best have been continued with the patients' established nephrologist and endocrinologist.

—Arizona internist responding to an ASIM survey

Very few family practitioners or internists do the generalist care of oncology. In fact, once the patient has cancer and is referred to me, the patient never returns to the primary care physician.

—Internist subspecializing in oncology, responding to a survey by the Internal Medicine Center to Advance Research and Education, December 1993

3. **Scope-of-practice limitations will exacerbate the problem of access to primary care, since internal medicine subspecialists now provide a significant amount of primary care.** If subspecialists no longer can serve as primary care physicians for some patients, the current shortage in primary care will worsen. This especially will be a problem in underserved areas where a subspecialist may be the only source of primary care and subspecialty care.

4. **Scope-of-practice limitations expose the patient to unnecessary hassles, inconvenience and red tape if they have to get a gate-
keeper physician's permission to see the subspecialist most qualified to serve as their principal care physician. Patients, their primary care physician and the subspecialist are all frustrated by the hassle factor of referral restrictions.

5. Exclusion of subspecialists from the managed care plan's panel of primary care physicians (or forcing subspecialists to give up their subspecialty to be qualified to serve on the primary care panel) could result in "de facto" discrimination against patients with more complex and costly health conditions. Because subspecialists often see sicker patients, health plans effectively can keep those patients out by not allowing their physicians to sign up as primary care physicians.

6. A subspecialist may be able to provide principal care more cost-effectively for selected patients than a generalist. Therefore, limitations on scope of practice may lead to higher costs for the health plan, which ultimately are passed on to enrollees and their employers. For patients with certain conditions, subspecialists may actually be more frugal in ordering tests than generalists, who may have to rely more on testing to make a diagnosis and to manage the patient's condition than a subspecialist would.

Some MCOs argue that subspecialists provide more expensive primary care—or principal care—than other physicians. ASIM does not believe that there are data that convincingly compare the costs of primary care and principal care provided by subspecialists with those of the care provided by generalists. Most of the studies on this subject have suffered from not applying adequate severity adjustments to the utilization data to take into account the pool of sicker patients typically seen by subspecialists. ASIM expects that further research will show that subspecialists can provide primary care as cost-effectively as generalists, and perhaps more cost-effectively for patients with disease conditions that fall within their training and expertise.

Since restrictions on scope of practice inconvenience patients, interfere with their ability to choose the physician best qualified to treat their medical conditions, and prevent subspecialists from providing primary and principal care services that fall within their training and clinical experience, why do health plans restrict the scope of practice of subspecialists?

Why Are Health Plans Restricting Subspecialists' Scope of Practice?

To find out why managed care plans limit the scope of practice for internists able to treat patients in a subspecialty of internal medicine, ASIM included scope-of-practice questions in its 1995 survey of HMOs. Executives from plans that restrict subspecialists from being listed as both primary care providers and consultants stated that the five major impediments are:

- Concern that subspecialists would self-refer patients for consultant services if they were allowed to provide primary care (25 percent);
- Adverse selection problems for the physician and for the health plan (22 percent);
- Concern that subspecialists would self-refer patients for consultant services if they were allowed to provide primary care (25 percent);
- Adverse selection problems for the physician and for the health plan (22 percent);
Concern that subspecialists are more expensive than generalist physicians (16 percent); 

Concern that it is administratively burdensome for the plan to allow subspecialists to provide primary care (16 percent); and similarly

Concern that utilization review would be more difficult if subspecialists were allowed to provide primary care (11 percent).

However, if the plan uses capitation to pay its physicians, the problem of excessive self-referrals and adverse selection is moot if the capitation payment is calculated correctly. For instance, the plan could allow a gastroenterologist enrolled as both a primary care physician and a gastroenterologist to provide gastroenterology care, since it would be included under the capitation payment. An additional strategy for managing self-referral by subspecialists is to pay fee-for-service for evaluation and management services and to capitate procedure codes. This creates an incentive to provide preventive medicine and removes the incentive to overuse costly complex medical technology. Finally, health plans can use profiling to determine if a subspecialist differs from other internists in patterns of referral, utilization of tests, or other aspects of clinical decision-making. Such profiles should be adjusted for patient severity, as explained in ASIM’s white paper, “Reinventing Managed Care: Assessing Physician Performance in a Managed Care Plan.”

Furthermore, health plans that pay physicians by capitation can deal with the problem of adverse selection by:

• Adjusting the capitation rates for the health status and prior utilization of the patients signed up with the primary care or principal care physician;

• Creating “carve outs” from the capitated rate for certain high-cost conditions and procedures; and

• Incorporating the other recommendations made by ASIM in its white paper, “Reinventing Managed Care: Assuring Appropriate Patient Care under Capitation Arrangements.”

The concern that allowing subspecialists to provide primary care will increase the administrative burden and make utilization review more complex is shortsighted, as is the assumption that subspecialists are more expensive providers of care in all circumstances. Simply because the primary care/gatekeeper system presupposes that physicians’ scope of practice can be limited in an arbitrary cookie-cutter fashion does not mean that such limitations are in the best interest of cost-effective patient care. In fact, these restrictions may increase the cost of care in some circumstances. Loosening the arbitrary restrictions should reduce the administrative burden, not increase it. MCOs should recognize that physicians should be able to provide care based upon their range of training and experience rather than arbitrary distinctions between primary care/generalists and subspecialists.

Another concern expressed in the comments section of the survey was that subspecialists are not qualified to provide primary care; ASIM maintains that this is not a valid generalization—this paper already has documented the extensive primary care training that all internists undergo.
Recommendations

**ASIM** recommends that MCOs:

1. **Give internal medicine subspecialists and generalists the same opportunities to participate as primary care/gate-keeper physicians for any enrolled patient who wishes to choose them,** provided that they meet the same or equivalent credentialing criteria—such as demonstrated competence in all aspects of primary care.

2. **Permit internal medicine subspecialists to participate with managed care plans as primary care physicians, principal care physicians and/or consultants,** based on their preference if they meet the requisite credentialing criteria for each role.

3. **Allow internal medicine subspecialists listed as consultants with a health plan to act as principal care physicians for patients with conditions in their area of expertise.** Health plans should consult with representatives of the internal medicine subspecialties on specific disease conditions that would qualify for principal care. Plans should not require patients to obtain authorization from a gatekeeper physician to receive services from their principal care physician.

4. **Evaluate the cost of subspecialist and primary care physicians by using severity-adjusted economic profiles and other measures of physician performance,** rather than arbitrarily limiting subspecialists' scope of practice because of cost-effectiveness concerns.
Conclusion

Physicians who specialize in internal medicine, both generalists and subspecialists, have the capability to provide both primary and specialized care to their patients within the managed care environment. Many subspecialists provide general primary care to their patients. Traditionally, they also have acted as principal care physicians, addressing most of the personal health care needs of patients with chronic conditions within their area of expertise. ASIM recommends that MCOs allow subspecialists of internal medicine to participate with plans as primary care physicians, consultants or both, and that those who are listed as consultants be allowed to act as principal care physicians.

MCOs should eliminate arbitrary restrictions on internists' scope of practice, because such restrictions are not in the best interests of patients. It makes no sense to deny patients the ability to select the primary care physician of their choice simply because an internist has additional training in a subspecialty. Nor does it make sense to deny patients with certain disease conditions direct access to the subspecialist who is most qualified to treat their specific conditions and meet the majority of their personal health care needs. MCOs can legitimately require, as part of their credentialing process, that subspecialists show the same current skills in providing primary care as other physicians who are accepted into their primary care panel. They can also use severity-adjusted profiling to identify any physician, whether a subspecialist or a generalist, who has patterns of utilization that are out of line with those of their colleagues. However, they should not arbitrarily limit the ability of subspecialists to fill the distinct roles for which they are trained:

- **Primary care physicians** who have training and experience in general internal medicine;

- **Principal care physicians** who have unique skills in meeting the health care needs of patients with certain conditions that fall within their subspecialty training; and

- **Consultants** to other physicians for problems that require the specialized training of an internal medicine subspecialist.

The recommendations in this paper, if accepted by MCOs, would allow patients access to the physician who best meets their own individual needs without diminishing in any way the incentives for cost control inherent in managed care.
Endnotes


8. Ibid., p. 1366.


15. Ibid., p. 6.

16. Ibid., p. 7.

17. Azevedo, op. cit.

18. ASIM. "Managed Care Survey of HMOs." Washington, DC, 1995, pp. 4-5.