

Revitalizing Internal Medicine: Recommendations for Resolving Payment and Practice Hassle Issues

**Policy Paper of the
American College of Physicians
Medical Service Committee
July 2003**

Revitalizing Internal Medicine: Recommendations for Resolving Payment and Practice Hassle Issues

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How to cite this paper:

American College of Physicians. Revitalizing Internal Medicine: Recommendations for Resolving Payment and Practice Hassle Issues. Philadelphia: American College of Physicians; 2003: Public Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

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Executive Summary

The American College of Physicians (ACP) is concerned that the practice environment for those in medical practice has become so encumbered with regulation and practice hassles, at a time when reimbursement for care provided by internal medicine physicians is declining, that physicians are finding it increasingly difficult to provide care for their patients. The ACP is also concerned that socioeconomic factors of the practice of medicine are forcing medical students to choose careers outside of internal medicine. These factors include the following: student debt, earnings expectations, hassles of practice, liability, and practice costs. This paper will address payment to internists and practice hassles in internal medicine practice. Specifically, this paper offers recommendations to properly fund the Medicare physician fee schedule, rationalize the Medicare physician payment system, and reduce insurance hassles that unnecessarily limit physicians' ability to provide patient care. The ACP is very concerned that, if public policy makers and the health care delivery system do not address these issues in the near future, patient access to fundamental health care services will suffer, with long-lasting consequences for future generations of Americans.

ACP Recommendations

Recommendations To Properly Fund the Medicare Physician Fee Schedule

1. The Medicare physician fee schedule payment rate (conversion factor) should be restored to the 2001 level until a suitable replacement to the existing payment update formula is developed and implemented, as recommended below.
2. Consistent with the recommendation of the Medicare Payment Advisory Commission (MedPAC), the current flawed Medicare physician payment update formula, known as the Sustainable Growth Rate (SGR) system, which erroneously links updates to changes in the nation's gross domestic product, should be replaced with a new method that will allow for predictable increases based on inflation in the costs of providing services.
3. The Medicare funding that was lost due to previous errors in the SGR system should be immediately restored.

Recommendations To Rationalize the Medicare Physician Payment System Further

1. The Centers for Medicare and Medicaid Services (CMS) should recognize that they did not fully implement the Evaluation and Management (E/M) recommendations of the Relative Value Scale Update Committee (RUC) during the first 5-year review of the Medicare physician fee schedule (1997) and did not review the issue during the second 5-year review of the Medicare physician fee schedule (2002).

2. **The CMS should review the relative value of E/M services during the next 5-year review of the Medicare physician fee schedule (2007).**
3. **The CMS should fund an independent analysis of the extent by which the top-down practice expense allocation methodology perpetuates historical inequities in physician payment.**
4. **The CMS should develop and implement a method to correct the Medicare physician fee schedule problems that are identified by the independent analysis of the top-down practice expense allocation methodology.**
5. **Medicare and other payers should provide reimbursement for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual E/M service.**
6. **Changes in coding and the relative value units (RVUs) that reflect new medical technologies and new Medicare benefits should not be subjected to Medicare budget neutrality adjustments and should be specifically identified in the conversion factor update formula.**
7. **Congress should establish a process to authorize coverage of appropriate and cost-effective preventive care and screening services in an ongoing fashion, based on expert evaluation of, and consensus on, the medical evidence of their effectiveness. Medicare payment levels to physicians for covered preventive benefits must be adequate to assure that beneficiaries have access to such services.¹**
8. **Congress should authorize coverage for physician-directed geriatric assessments and care coordination of frail elderly patients, as defined in S. 775, the Geriatric Care Act of 2001.**
9. **Medicare should revise its reimbursement system so that outpatient volume increases associated with changes in Medicare Part A do not penalize reimbursement under Medicare Part B.**

1. In addition, ACP has extensive policy regarding Medicare reform, which can be found in the 2002 policy paper "Medicare in the 21st Century: A Prescription for Change from America's Internists."

Recommendations To Reduce Unnecessary Practice Hassles

1. **Claims Payment Issues. All payers in all health care payment systems:**
 - A) **Must pay clean claims promptly within 30 days of receipt of the clean claims and not delay payment for all services if one service on an otherwise clean claim needs additional information.**
 - B) **Must make “black box” coding edits for code bundling and claims editing available to physicians at no cost, for the purpose of education.**
 - C) **Should give practicing physicians the opportunity to review coding edits before implementation in claims processing systems.**
 - D) **Should not require that office visit claims be submitted with copies of the chart, unless there is ample suspicion of fraud.**
 - E) **Should not down-code services and procedures without appropriate individual medical review.**
 - F) **Should request for repayment of claims based on audits, not billing profiles. Billing profiles should be used to identify subjects for possible audits, not repayment without further investigation.**
 - G) **Must make detailed information on compensation arrangements readily available to physicians, including fee schedules; relative values and conversion factors of services; capitation arrangements; percent of premium; and other physician incentive plans, such as withholds and bonuses.**
 - H) **Must eliminate extending negotiated discounted fee schedules to other payers without the consent of the physician with whom the original agreement was made (e.g., eliminate silent preferred provider organization [PPO] arrangements).**
2. **All payers in all health care payment systems should eliminate the use of contract “all-products clauses,” which force physicians to participate in health insurance plans against their will.**
3. **All payers in all health care payment systems must maintain a 24-hour-a-day telephone line or other confidential electronic means of communication to provide information about specific coverage of and benefits available to any patient presenting for medical care or agree to pay for services provided when such a system is unavailable.**

4. Paperwork Reduction and Administrative Uniformity:

- A) One standard physician credentialing and recredentialing form should be used for health care plans and hospitals, with the input of practicing physicians in the development of the form. The universal credentialing form should be linked to an electronic database so the recredentialing form can be pre-populated with previously submitted data from the physician.**
 - B) Physicians should only have to be recredialed and required to undergo a site visit once every 3 years, unless quality issues indicate more immediate attention. Insurers should be able to share credentialing and site visit information upon approval of the physician.**
 - C) The health insurance industry should standardize the fields of information required so that there is a single uniform encounter form, single uniform durable medical equipment approval form, single formulary request form, single uniform referral form, etc. All health insurance industry forms should be uniform, with one form per task rather than a different form from every insurer for the same task. The development of the uniform forms should involve practicing physicians.²**
- 5. The health insurance and pharmaceutical industries should develop technology to make formulary databases accessible and easier to utilize and provide these databases in electronic formats that can be imported into practice systems. Practicing physicians should be involved in the design and pretesting of these technologies.³**
- 6. Health insurance carve-out entities, such as managed behavioral health organizations (MBHOs), should share their disease management protocols with primary care and other treating physicians. When a patient's health is managed and/or administered by a carve-out entity, the primary care and other treating physicians should be immediately notified and kept apprised of the patient's treatment, progress, and medications, so that the primary care and other treating physician can coordinate the patient's health care needs in an optimal fashion.**
- 7. Health insurance plans should allow consulting physicians or primary treating physicians to make referrals for tests, radiologic procedures, and therapy rather than requiring "gatekeeper" physicians to manage all referrals.**

2. In addition, ACP has extensive policy regarding physician credentialing and facility and medical records reviews, which can be found in the 1998 policy paper "Reinventing Managed Care: Reducing the Managed Care Hassle Factor."

3. In addition, ACP has extensive policy regarding formularies and pharmacy benefit management, which can be found in the 2001 policy paper "Ambulatory Care Formularies and Pharmacy Benefit Management by Managed Care Organizations."

I. Underfunding Problems with the Medicare Physician Fee Schedule

Medicare cut the physician fee schedule payments four times over the past 12 years, and cuts are projected for the next few years. In recent years, physicians and other practitioners have been inundated with expensive new federal requirements associated with the government's efforts to eliminate billing errors, improve quality, ensure patient safety, and provide culturally sensitive care. Yet, Medicare payments between 1991 and 2003 rose by an average of just 0.7% a year, far below the cost of inflation (which was approximately 3% a year on average in this time period), and dramatically below medical cost inflation (which was approximately 5% a year on average in this time period). Over this time period, medical cost inflation outgained Medicare payment rates to physicians by more than 64% (1, 2).

The ACP is concerned that the increasing gap between medical practice cost inflation and Medicare's payment updates is taking an increasing toll on physicians, forcing them to limit their practice, and Medicare patient access problems are occurring across the nation. Unfortunately, the problem is not exclusive to Medicare. Private payers often use the Medicare payment rates as a benchmark, so when the Medicare rates stay stagnant or go down, the private payer rates typically do the same. This is one of the reasons why physician participation in managed care programs has gone down in recent years (3).

Along with these payment cuts, there is clear evidence that patient access problems are on the rise. According to a 2002 study by the Center for Studying Health System Change:

- The percentage of seniors covered by Medicare who reported experiencing delays in receiving needed care, or who did not receive care at all, is on the rise.
- The percentage of privately insured people between the ages of 50 and 64 years (near elderly) who reported access problems increased.
- Both seniors covered by Medicare and older privately insured people are waiting longer for appointments with their physicians. More than one third of seniors covered by Medicare waited more than 3 weeks for a checkup. A similar percentage waited a week or more for an appointment for a specific illness.
- The proportion of physicians accepting new Medicare patients is falling (4).

The Balanced Budget Act of 1997 (BBA) attempted to slow the growth of Medicare spending and extend the life of the Medicare Trust Fund by drastically reducing payments to physicians and other health care providers, with cuts totaling \$112 billion (5). More than 5 years after passage of the BBA, the financial health of the nation's physicians has clearly deteriorated. A study conducted by the Massachusetts Medical Society showed that "physicians are working more for less." Presenting data from the Massachusetts Medical Society Physicians Practice Environment Index, median income (adjusted for inflation) dropped 13.9% over an 8-year period from 1992 to 2000. Further, physicians' median hours worked increased 6.7% from 49.5 hours per week to 52.8 hours per week over the same time period. The study also showed that the cost of running a practice had increased 60.9% from 1992 to 2000, further eroding physician income (6).

National data indicate that average physician income, after inflation, for primary care doctors dropped 6.4% from 1995 to 1999—at a time when wages were rising by 3.5% for other professional and technical workers. Specialists' incomes declined by 4%, while the incomes for all physicians declined by 5%. The report by the Center for Studying Health System Change notes that the greater decline in payments to primary care doctors is surprising, given that Medicare adopted policies designed to benefit primary care physicians over surgical specialists. They suggest that the effect of these policies may have been offset by managed care plans' retreat from a broader role for primary care doctors and toward providing enhanced access to specialists (7).

In addition, the costs of practicing medicine have skyrocketed over the past decade, while relative reimbursement is declining, making medicine a less appealing field for promising students. Results of the 2003 National Resident Matching Program residency match suggest a continuing decline in interest in internal medicine and family practice careers. Since 1999, there has been a 9.5% decline in U.S. medical students entering internal medicine, and over one half of that decline occurred this year. In addition to the sharp decline of interest in internal medicine careers by U.S. medical students, current trends also suggest that fewer than 50% of medical students entering internal medicine will pursue careers in general internal medicine, opting instead for subspecialty careers (8).

The BBA made a number of significant changes in the way that physicians were paid under Medicare fee-for-service, including replacing the volume performance standard with the SGR system. The SGR establishes a target growth rate for Medicare spending on physician services, then annually adjusts payments up or down, depending upon whether actual spending is below or above the target. The CMS's original method of estimating the SGR was flawed and resulted in a \$3 billion shortfall in payments to physicians during 1998 and 1999 (9). As the result of an intense Congressional lobbying effort by ACP, the American Medical Association, and 16 other medical organizations, the Balanced Budget Refinement Act of 1999 did produce some refinements to the SGR, primarily limiting oscillations in the annual update to the conversion factor and requiring the SGR be calculated on a calendar year basis. The Balanced Budget Refinement Act of 1999, however, did fail to reinstate the \$3 billion shortfall in 1998 and 1999 physician pay and failed to increase the SGR to account for rising physician costs due to technological advances and an aging population (10).

By 2001, defects in the SGR methodology forced the highly regarded congressional advisory body the MedPAC to conclude that the SGR was so inherently flawed that it would never “adequately account for changes in the cost of physician services” (11). The MedPAC grimly warned, “These problems with the SGR system can have serious consequences,” including physician payments so low they would “*potentially jeopardize beneficiary access to care . . .*” (4, emphasis added). The MedPAC was so concerned about the damage that continued use of the SGR would have on patients and physicians that it recommended that “*Congress replace the SGR system with an annual update based on factors influencing the unit costs of efficiently providing physician services*” (11, emphasis added).

The method of updating Medicare physician payments must be fixed, and ACP conceptually agrees with the MedPAC's goal of replacing the SGR with a more accurate and current update methodology, which is based on the true costs of providing physician services. Therefore, ACP recommends that:

1. **The Medicare physician fee schedule payment rate (conversion factor) should be restored to the 2001 level until a suitable replacement to the existing payment update formula is developed and implemented, as recommended below.**
2. **Consistent with the recommendation of the Medicare Payment Advisory Commission (MedPAC), the current flawed Medicare physician payment update formula, known as the Sustainable Growth Rate (SGR) system, which erroneously links updates to changes in the nation's gross domestic product, should be replaced with a new method that will allow for predictable increases based on inflation in the costs of providing services.**
3. **Medicare funding that was lost due to previous errors in the SGR system should be immediately restored.**

II. Need To Rationalize the Medicare Physician Payment System Further

The Medicare resource-based relative value scale (RBRVS) system was developed to respond to the criticism that Medicare's method of paying physicians, the "customary, prevailing, and reasonable" charge system, created a wide variation in payments among types of procedures, localities, and specialties that could not be attributed to costs of practice. According to the 1992 Physician Payment Review Commission, the advisory commission to Congress that was later renamed MedPAC, "Surgical and technical procedures became increasingly overvalued relative to visits and consultations. This contributed to marked disparity between incomes of primary care and other physicians" (12).

The Medicare payment system has been rationalized to some degree, primarily due to three pieces of legislation and one regulation: first, the Omnibus Budget Reconciliation Act of 1989, which created the Medicare RBRVS; second, 1994 legislation creating the resource-based practice expense component of the RBRVS; third, the BBA, , which created a single conversion factor for physician services; and, finally, the Medicare Physician Fee Schedule for Calendar Year 1997, Final Rule, published in the November 22, 1996 *Federal Register*, which increased the work RVUs for E/M services as a result of the first 5-year review of the Medicare physician fee schedule. However, recall that Medicare cut the physician fee schedule payments four times over the past 12 years. The Medicare payment cuts diminished the potential rationalization of Medicare payments that the Medicare RBRVS system promised (for more information, see the Appendix). The cuts in recent years have reduced the growth in Medicare payments so much that the payment updates don't even come close to keeping pace with inflation, let alone medical cost inflation (1).

In addition, many political compromises have been made along the way, muting the true potential payment rationalization envisioned by physicians, policy makers, and health services researchers, and, as described above, other political decisions were made that took money out of the Medicare physician fee schedule completely. Consequently, ACP is concerned that medical students are choosing careers other than internal medicine because the Medicare payment system and the private sector systems that echo it have not been completely rationalized and are underfunded. Therefore, in this paper, ACP makes several

recommendations to rationalize the Medicare RBRVS system and properly fund it.

A. E/M Recommendations Never Fully Realized

The January 1, 1997 increase to the work RVUs for E/M services were very modest compared to the recommendation of the American Medical Association RUC. At the time, ACP applauded Medicare for recognizing that E/M services had been long undervalued, compared to other services in the Medicare physician fee schedule, and for recognizing that the pre- and postservice work for E/M services increased over the 5-year period from 1992 to 1997. However, the Medicare change was much less dramatic than the recommendations of the multispecialty RUC panel. In addition, Medicare did not revisit the evaluation of E/M services in a second 5-year review of the Medicare physician fee schedule, which was implemented on January 1, 2002. Therefore, ACP recommends that:

- 1. The Centers for Medicare and Medicaid Services (CMS) should recognize that they did not fully implement the evaluation and management (E/M) recommendations of the Relative Value Scale Update Committee (RUC) during the first 5-year review of the Medicare physician fee schedule (1997) and did not review the issue during the second 5-year review of the Medicare physician fee schedule (2002).**
- 2. The CMS should review the relative value of E/M services during the next 5-year review of the Medicare physician fee schedule (2007).**

B. Practice Expense Methodology Locks In Historical Inequities

The ACP has previously expressed concern that the CMS's "top-down" approach to determining payments for physicians' practice expenses in the Medicare physician fee schedule has allowed traditional inequities in payments—which were created under the historical, charge-based methodology—to continue to exist. The top-down methodology is based on an assumption that aggregate specialty practice costs are a reasonable basis for establishing initial estimates of relative resource costs of physicians' services across specialties. It then allocates these aggregate specialty practice costs to specific procedures and cognitive services, such as office visits. The ACP continues to have concerns that, under the top-down methodology, many E/M services are undervalued, compared to inpatient procedures. The CMS is aware of studies by the Physician Payment Review Commission (13), Harvard University (14–16), and other analysts (17, 18) that support the ACP view that a resource-based methodology should have narrowed the ratio of the practice expenses of office visits to many inpatient surgical procedures by a greater extent than has occurred under the top-down approach.

The ACP is pleased that CMS acknowledged in the 1998 final rule (which created the top-down approach to determining payments for physicians' practice expenses) that the top-down methodology may allow inequities in payments that existed under the current historical, charge-based methodology to continue (19). In that notice, CMS simply stated that it would accept comments on this issue during the refinement

period for the resource-based practice expense methodology. However, ACP has found no evidence that Medicare officials have worked with physician specialty societies and other interested parties on developing a methodologic approach that would allow for correction of inequities that persist under the top-down methodology. In addition, in 1998, ACP recommended that CMS fund an independent analysis of the extent by which the top-down methodology perpetuates historical inequities in payment. Such an analysis would also explore alternative methodologic approaches and sources of data that could be used in making corrections to the practice expense system as it was implemented. Medicare had a 4-year transition period, ample time to undertake an extensive analysis of this research question that underpins the credibility of the entire Medicare physician fee schedule. Yet, such a study was never conducted. Improvements still must be made that will meet the original intent of eliminating historical inequities in payment that exist under the charge-based system and that are continued, to some extent, under the top-down approach. Therefore, ACP recommends that:

1. **The CMS should fund an independent analysis of the extent by which the top-down practice expense allocation methodology perpetuates historical inequities in physician payment.**
2. **The CMS should develop and implement a method to correct the Medicare physician fee schedule problems that are identified by the independent analysis of the top-down practice expense allocation methodology.**

C. E-Consults Not Reimbursed

The ACP recently published a policy paper titled “The Changing Face of Ambulatory Medicine—Reimbursing Physicians for Computer-Based Care.” The purpose of this paper was to shed light on how the revolution in the way that people communicate (by computers over the Internet) is changing the face of how medicine is practiced. Until recently, patients have had only two primary ways of actively communicating with their physicians—through a face-to-face office visit or through the hit-or-miss use of telephones. Yet, there is a wide spectrum of nonurgent patient conditions that could be effectively managed without the time and expense of an office visit, through a carefully structured e-consult system focused on established patients, which gathers all information necessary to render an informed medical decision, with the added benefits of automatically documenting the patient–physician encounter, while protecting patient confidentiality. This e-consult approach, within the framework of the established doctor–patient relationship, has many advantages over telephone contact, since physicians cannot always reach callers in timely fashion, while patients may not provide all of the information needed to render a medical decision.

Surveys cited in “The Changing Face of Ambulatory Medicine—Reimbursing Physicians for Computer-Based Care” show that both physicians and the public alike are using computers and the Internet more and more every day and that the major barrier to physicians’ using e-mail consultations to provide care to their established patients is the lack of reimbursement for this service by Medicare and many private payers. Some private-sector health insurers have displayed great initiative in bringing this technology to their enrollees, with recent pilots of the “webVisit” by organizations such as Blue Shield of California, Aetna, and ConnectiCare, showing outstanding results, saving nearly \$2 per member, per month, accompanied by a high level of physician and patient satisfaction (20). The paper urges CMS and other insurers to take note of the great potential that computer oversight of patients can have in terms of conserving and more effectively using precious funds and allowing physicians to better serve their patients, reserving office visits only for those patients who truly need face-to-face care. By paying for e-mail consultations with established patients, all parties will benefit: Physicians can spend more time serving their patients, yielding a happier and healthier patient population, while the government and private insurers save money by averting sometimes costly and unnecessary face-to-face office visits. Therefore, ACP recommends that:

Medicare and other payers should provide reimbursement for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual E/M service.

D. Budget Neutrality Penalizes Improved Technology

Another concern with the Medicare physician fee schedule is that it does not properly account for new technology and innovation in medical practice. The CMS applies a budget neutrality adjustment when new RVUs are introduced into the physician fee schedule, so that the overall budget is unchanged (21). This application to the creation of new codes in the Medicare fee schedule is perhaps the biggest reason the RBRVS did not fully accomplish what was intended. The budget neutrality provision essentially requires new technology to be paid for by reducing payment for existing technology. Changes in coding and, subsequently, the RVUs that reflect new technologies increase the total work associated with managing patients’ health. This is additive, not substitutive, work and should not be subjected to budget neutrality adjustments. The current budget neutrality limits essentially freeze the total amount of dollars (per patient) assigned to physician services at the level expended in 1992, the year that the Medicare RBRVS was introduced, even though the medical technology has improved and there are more methods available for caring for the aging Medicare population. Therefore, ACP recommends that:

Changes in coding and the relative value units (RVUs) that reflect new medical technologies and new Medicare benefits should not be subjected to Medicare budget neutrality adjustments and should be specifically identified in the conversion factor update formula.

E. Lack of Preventive Benefits

Medicare suffers from an outdated benefits package that denies patients access to preventive/screening services. Although Congress has added some preventive services, such as coverage for selected cancer screening tests on a piecemeal basis, the basic requirement for coverage is that the service must be for the diagnosis and treatment of disease on patients who present themselves with symptoms of disease. Screening tests on well beneficiaries generally are not covered benefits.

Medicare benefits must be updated to cover needed preventive care. However, the addition of Medicare benefits for preventive services should be based upon evidence of medical effectiveness. The ACP supports coverage of appropriate and cost-effective preventive care and screening services and geriatric assessments. A process should be established to authorize coverage for such services based on expert evaluation and consensus of medical evidence on their effectiveness. The ACP endorsed S.775, the Geriatric Care Act of 2001, which would enhance care for frail Medicare beneficiaries by increasing access to physicians who care for Medicare patients and providing coverage of care coordination and assessment services under the Medicare program. The term “care coordination and assessment services” is defined as “services that are furnished to a qualified frail elderly or at-risk by a care coordinator under a plan of care prescribed by such care coordinator for the purpose of care coordination and assessment,” which may include any of the following services:

- A. An initial and periodic health screening and assessment.
- B. The management of, and referral for, medical and other health services, including multidisciplinary care conferences and coordination with other providers.
- C. The monitoring and management of medications, particularly with respect to the management on behalf of a qualified frail elderly or at-risk individual on multiple medications prescribed for that individual.
- D. Patient and family caregiver education and counseling services.
- E. Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.
- F. Providing access for consultations by telephone with physicians and other appropriate health care professionals, including 24-hour availability of such professionals for emergency consultations.
- G. Coordination with the principal nonprofessional caregiver in the home.
- H. Managing and facilitating transitions among health care professionals and across settings of care.
- I. Activities that facilitate continuity of care and patient adherence to plans of care.
- J. Such other services for which payment would not otherwise be made under this title of the Social Security Act as the Secretary of the Department of Health and Human Services determines to be appropriate.

By providing comprehensive coverage for preventive services and treating beneficiaries early on, Medicare could save considerable amounts by avoiding paying for more serious illnesses and chronic conditions that might have been prevented.

- 1. Congress should establish a process to authorize coverage of appropriate and cost-effective preventive care and screening services in an ongoing fashion, based on expert evaluation of, and consensus on, the medical evidence of their effectiveness. Medicare payment levels to physicians for covered preventive benefits must be adequate to assure that beneficiaries have access to such services.⁴**
- 2. Congress should authorize coverage for physician-directed geriatric assessments and care coordination of frail elderly patients, as defined in S. 775, the Geriatric Care Act of 2001.**

F. Transition of Inpatient to Ambulatory Care Not Reflected in the Payment System

Another problem with the Medicare payment system is that this system is split into separate parts. Medicare Part A pays for inpatient care in hospitals, critical access hospitals, and skilled nursing facilities. It also covers hospice care and some home health care. Medicare Part B pays for physician services and outpatient hospital care. It also covers some other medical services that Part A does not cover, such as some of the services of physical and occupational therapists, and some home health care. Medicare Part A and Part B are funded differently, and they are not linked. Since 1983, Medicare Part A pays hospitals using a fixed price, prospective payment system, based on the classification of patients into Diagnosis Related Groups (DRGs). Use of the DRG system gives hospitals the incentive to discharge patients “quicker and sicker.” Medicare Part B utilization data shows an increased trend away from the hospital inpatient setting and towards more patient treatment in the outpatient office setting. As patients are discharged from the hospital sooner, an increase in volume and intensity of office services has resulted (22).

Another cause for the decrease in the hospital services, relative to outpatient services, is hospital use of severity of illness and intensity of service criteria to justify Medicare admissions to the hospital. These criteria, which have been required by Medicare since October 2000, discourage admission for patients with less severe conditions who are instead treated in an outpatient setting. Furthermore, Medicare mandates that a patient sign a Hospital Issued Notice of Noncoverage (HINN), if the patient does not meet criteria to be treated in the hospital. This puts the burden of payment on the patient, if the criteria are not met. This process has decreased hospital admissions and increased the volume and intensity of services provided in the outpatient setting (23).

4. In addition, ACP has extensive policy regarding Medicare reform, which can be found in the 2002 policy paper “Medicare in the 21st Century: A Prescription for Change from America’s Internists.”

The DRG system, severity of illness, and intensity of service criteria to justify Medicare admissions to the hospital create an overall cost savings for the Medicare program, as outpatient services are typically much less costly than hospital services. However, this Medicare cost-saving trend actually penalizes physicians. As was mentioned previously, Medicare Part A and Part B are not linked. As patient services are directed away from Part A to Part B through the DRG and admission criteria, the increased volume of Part B services are reimbursed under the Medicare RBRVS system, which has specifically been designed to penalize physicians for increased volume of services provided through the Medicare conversion factor update adjustment factor. The update adjustment factor is determined by comparing expenditures for Medicare physicians' services to an expenditure target. This target system is known as the sustainable growth rate (SGR). If expenditures exceed the target, the update adjustment factor is negative and the update is reduced. Expenditures will often exceed the target because the target does not account for how Medicare Part A services are transitioning to Part B services. Therefore, ACP recommends that:

Medicare should revise its reimbursement system so that outpatient volume increases associated with changes in Medicare Part A do not penalize reimbursement under Medicare Part B.

III. Practice Hassles Unnecessarily Limit Physicians' Ability To Provide Patient Care

Over the past 15 years, unprecedented insurance hassles have been introduced to the daily operations of the physician's offices. We defined the "hassle factor" in the landmark policy paper "America's Health Care System Strangling in Red Tape" (1990) as, "[t]he increasingly intrusive and often irrational administrative, regulatory review, and paperwork burdens being placed on patients and physicians by the Medicare program and other insurers."

Today, the hassle factor is worse than ever before. The ACP fears that the layer upon layer of bureaucratic requirements forced upon practicing physicians has not only taken its toll on the physicians practicing but has made medicine less palatable a profession for students interested in medicine. As was mentioned earlier in this paper, physician practice costs continue to rise far above changes in reimbursement, due primarily to ever-increasing bureaucratic hassles. Insurers may have sound reasons for their policies and procedures but often implement them in a manner that wastes physicians' time and creates discontinuities in patient care. Physicians are particularly concerned about how these policies fundamentally alter the traditional physician-patient relationship. The ACP's 1998 policy paper on the topic of hassles created by insurers found the following:

- Physicians are spending more time on insurance paperwork and less time seeing patients.
- Physicians believe that insurers question their professional judgment too often.
- Physicians have been forced to hire additional personnel to keep up with the abundant paperwork that insurance hassles create (24).

Five years later, the situation has not improved. The bureaucratic barriers created by the third-party payer reimbursement system in the United States have created an atmosphere where insurers and health care providers distrust each other. In order for the health care delivery system in the United States to improve, a more cooperative atmosphere and sense of trust must be fostered among all stakeholders. Insurers could start the process with prompt and courteous communications. Revising harsh and unclear letters informing physicians and patients of denial of insurance coverage for medical services is a good place to start.

In 2000, ACP undertook an effort to prioritize insurer hassle issues and share these concerns with insurers. The ACP shared these concerns with over 500 health insurers across the United States. The following is a description of ACP's top seven concerns and recommendations for solutions to reduce unnecessary paperwork and administrative hassles. We recognize that many individual insurers have made efforts to improve upon the areas discussed below; however, the job is far from complete and these recommendations are certainly not yet industry-wide standards.

A. Claims Payment Issues

Physicians are concerned that some insurers:

- Deliberately delay claims processing or lose claims to improve their cash flow at the expense of physicians.
- When appealed, overturn a high rate of claim denials in favor of the physician/patient signaling that payments should not have been denied initially.
- Use “black box” proprietary coding edits for code bundling and claims editing.
- Require that higher-level patient visit claims be submitted with copies of the chart.
- Inappropriately bundle or down-code claims.
- Request repayment based on billing profiles rather than audits.
- Do not share fee payment schedules and determination information with participating physicians.
- Take fee schedule discounts not approved by the physician's practice.

In order to improve perceived problems with claims payment issues, ACP recommends that all payers in all health care payment systems:

- a. Must pay clean claims promptly within 30 days of receipt of the clean claims and not delay payment for all services if one service on an otherwise clean claim needs additional information.**
- b. Must make “black box” coding edits for code bundling and claims editing available to physicians at no cost, for the purpose of education.**
- c. Should give practicing physicians the opportunity to review coding edits before implementation in claims processing systems.**
- d. Should not require that office visit claims be submitted with copies of the chart, unless there is ample suspicion of fraud.**
- e. Should not down-code services and procedures without appropriate individual medical review.**
- f. Should request for repayment of claims based on audits, not billing profiles. Billing profiles should be used to identify subjects for possible audits, not repayment without further investigation.**
- g. Must make detailed information on compensation arrangements readily available to physicians, including fee schedules, relative values and conversion factors of services, capitation arrangements, percent of premium, and other physician incentive plans, such as withholds and bonuses.**
- h. Must eliminate extending a negotiated discounted fee schedule to other payers without the consent of the physician with whom the original agreement was made (e.g., eliminate silent preferred provider organization [PPO] arrangements).**

B. Use of Contract “All-Products Clauses”

Some insurers include “all-products clauses” in their physician participation contracts. Essentially, the clause binds the physician to join the participating provider network for all insurance plans that the insurer currently operates and plans to implement. For example, a physician is asked by a patient to join the PPO plan that her employer offers. The physician agrees and asks to join the insurer’s network. The PPO then offers a participating provider contract with an all-products clause that binds the physician to participate with not only the PPO but all the other insurance plans that the PPO administrator offers. These all-product clauses force physicians to participate with insurance plans against their will. All-product clauses and policies restricting the ability of physicians to “close their patient panel” to certain insurance products and intercede into physicians’ ability to manage the volume of patients in their practice may effect quality of patient care and the financial viability of practices. In order to improve perceived problems with insurance contract issues, ACP recommends that:

All payers in all health care payment systems should eliminate the use of contract “all-products clauses,” which force physicians to participate in health insurance plans against their will.

C. Unavailable Real-Time Reliable Patient Insurance Eligibility Data

Physician offices desire easily accessible eligibility data to determine if a patient is currently enrolled in the health plan and to determine the patient’s copay. The physician office should have the ability to be connected to the insurer through the Internet so that data entry of the patient’s identification number would lead to eligibility information. Another problem with eligibility information is that some insurers will retroactively change a patient’s eligibility status from covered to noncovered. So, even if the insurer indicates that the patient is covered, payment for services rendered may still be denied at a later date. In order to improve perceived problems with insurance eligibility data issues, ACP recommends that:

All payers in all health care payment systems must maintain a 24-hour-a-day telephone line or other confidential electronic means of communication to provide information about specific coverage of and benefits available to any patient presenting for medical care or agree to pay for services provided when such a system is unavailable.

D. Paperwork Redundancy and Lack of Administrative Uniformity

There should be a single health insurance industry standard for credentialing, recredentialing, and site visits so that physicians would only have to be credentialled and required to undergo a site visit once every 3 years, unless quality issues indicate the need for more immediate attention. Insurers should be able to share this information upon approval of the physician. ACP is aware that the Council for Affordable Quality Healthcare has made tremendous progress towards making a universal credentialing form made available nationwide and encourages its further development. Industry should work with the physician community in standardizing the fields of information required so that there is one encounter form for all plans. All health insurance industry forms should be uniform, with one form per task rather than a different form from every insurer for the same task (i.e., a single durable medical equipment approval form, a single referral form, etc.). In order to reduce paperwork and create increased administrative uniformity, ACP recommends that:

- a. One standard physician credentialing and recredentialing form should be used for health care plans and hospitals, with the input of practicing physicians in the development of the form. The universal credentialing form should be linked to an electronic database so the recredentialing form can be prepopulated with previously submitted data from the physician.**
- b. Physicians should only have to be recredentialled and required to undergo a site visit once every 3 years, unless quality issues indicate more immediate attention. Insurers should be able to share credentialing and site visit information upon approval of the physician.**
- c. The health insurance industry should standardize the fields of information required so that there is a single uniform encounter form, single uniform durable medical equipment approval form, single formulary request form, single uniform referral form, etc. All health insurance industry forms should be uniform, with one form per task rather than a different form from every insurer for the same task. The development of the uniform forms should involve practicing physicians.⁵**

5. In addition, ACP has extensive policy regarding physician credentialing and facility and medical records reviews, which can be found in the 1998 policy paper "Reinventing Managed Care: Reducing the Managed Care Hassle Factor."

E. Prescription Drug Formulary Hassles

Physicians are concerned about formularies that are not consistent from plan to plan and are often changed, which makes adhering to them an impossibility. In addition, there are often inconsistent and burdensome requirements related to how often new written prescriptions are needed and how many drugs can be listed on a single form and irrational restrictions of quantities of drugs that can be ordered for patients with chronic conditions. Prescription writing could be electronic and formularies could be checked at the time that the prescription was written so that changes, if necessary, could be made by the physician. In order to improve perceived problems with drug formulary issues, ACP recommends that:

The health insurance and pharmaceutical industries should develop technology to make formulary databases accessible and easier to utilize and provide these databases in electronic formats that can be imported into practice systems. Practicing physicians should be involved in the design and pretesting of these technologies.⁶

F. Lack of Communication between Health Insurers, Health Insurance Carve-out Entities, and Physicians

Health insurance carve-out entities are organizations that manage patient care for a patient population for a specific condition under a capitation arrangement. The management of this service is “carved out” of the rest of the insurance program, meaning it is managed separately. Managed behavioral health organizations (MBHOs) are an example of a carve-out entity. These carve-out entities must share disease management protocols with primary care physicians and the other treating physicians. If, for example, a patient’s mental health care is managed and/or administered by an MBHO, with the patient’s permission, the primary care and other treating physicians should be immediately notified and kept apprised of the patient’s treatment, progress, and medications so that the physician can coordinate the patient’s health care needs in optimal fashion. The problem that currently occurs all too often is that a carve-out entity manages the patient’s care for a specific service, such as mental health, and the primary care physician is not informed of the care rendered. This can lead to a myriad of problems, such as the prescription of conflicting medications. In order to improve communication problems between health insurance carve-out entities and physicians, ACP recommends that:

Health insurance carve-out entities, such as managed behavioral health care organizations (MBHOs), should share their disease management protocols with primary care and other treating physicians. When a patient’s health is managed and/or administered by a carve-out entity, the primary care and other treating physicians should be immediately notified and kept apprised of the patient’s treatment, progress, and medications so that the primary care and other treating physician can coordinate the patient’s health care needs in an optimal fashion.

6. In addition, ACP has extensive policy regarding formularies and pharmacy benefit management, which can be found in the 2001 policy paper “Ambulatory Care Formularies and Pharmacy Benefit Management by Managed Care Organizations.”

G. Prohibition on Consulting Physicians Ordering Diagnostic Services

Physicians are concerned with health insurer policies that require “gatekeeper” physicians to make referrals for tests, radiologic procedures, and services requested by consulting physicians or primary treating physicians of other specialties rather than allowing the physician who needs the information gathered from the tests, radiologic procedures, and services. This is of particular concern when such services are outside the expertise of the designated “gatekeeper” physician. Referral restrictions should not unnecessarily shuttle a patient back and forth between physicians to get approval services that can be capably ordered by the consulting physician. Therefore, ACP recommends that:

Health insurance plans should allow consulting physicians or primary treating physicians to make referrals for tests, radiologic procedures, and therapy rather than requiring “gatekeeper” physicians to manage all referrals.

Conclusion

ACP believes that implementation of the recommendations stated in this paper will go a long way towards improving the practice environment for those in medical practice by reducing regulation and practice hassles and by improving reimbursement for care. Health care organizations in the United States have a duty to address the issues described in this paper so that physicians can become unencumbered from regulatory hassles and can focus on providing care for their patients. These recommendations should also serve to improve several of the socioeconomic factors of the practice of medicine that are currently forcing medical students to choose careers outside of internal medicine. ACP is very concerned that, if public policy makers and the health care delivery system do not address these issues—of properly funding the Medicare physician fee schedule, rationalizing the Medicare physician payment system, and reducing insurance hassles that unnecessarily limit physicians’ ability to provide patient care in the near future—patient access to fundamental health care services will suffer, with long-lasting consequences for future generations of Americans.

APPENDIX

While the charts below look like impressive increases in payment for E/M services relative to surgical services, remember that Medicare physician fee schedule payments have been cut four times over the past 12 years, so the absolute change in physician payment is not nearly what it would be if those cuts did not occur. In other words, the Medicare payment system gave more money to physicians providing increased payment to undervalued E/M with one hand, and then took much of the gain away again with the other hand through across-the-board cuts in recent years.

Comparison of 1992 versus 2003 Medicare Payment Rates for New and Established Outpatient Office Visits

CPT Code	1992 Payment \$	2003 Payment \$	Difference \$	Percent Change %	1992 Payment Adjusted for Inflation \$	Difference 2003 vs. Inflation \$	Percent Better than Inflation %
99201	\$25.73	\$34.95	\$9.22	35.83%	\$33.75	\$1.20	3.55%
99202	\$40.61	\$62.54	\$21.93	54.00%	\$53.27	\$9.27	17.40%
99203	\$54.87	\$92.70	\$37.83	68.94%	\$71.98	\$20.72	28.79%
99204	\$80.29	\$132.06	\$51.77	64.48%	\$105.32	\$26.74	25.39%
99205	\$99.82	\$168.48	\$68.66	68.78%	\$130.94	\$37.54	28.67%
99211	\$13.33	\$20.60	\$7.27	54.54%	\$17.48	\$3.12	17.85%
99212	\$22.32	\$36.42	\$14.10	63.17%	\$29.28	\$7.14	24.39%
99213	\$31.00	\$51.13	\$20.13	64.94%	\$40.66	\$10.47	25.75%
99214	\$47.12	\$79.82	\$32.70	69.40%	\$61.81	\$18.01	29.14%
99215	\$72.54	\$116.98	\$44.44	61.26%	\$95.16	\$21.82	22.93%

Sources: Consumer Price Index statistics from annual Statistical Abstracts of the United States and the Medicare physician fee schedules 1992 and 2003.

The chart on the following page demonstrates the change in payment from the year that the RBRVS was first implemented (1992) and the year it was finally implemented for heavily used physician services (2002). As the chart shows, office visits increased in value over 60% during this time period, while payment for surgery decreased. One measure that underscores this dramatic shift is the ratio of midlevel office visits to coronary artery bypass grafts. In 1992, a physician had to provide approximately 72 midlevel office visits to receive compensation equal to that for one coronary artery bypass graft. By 2002, the ratio dropped to 38 to 1 (25).

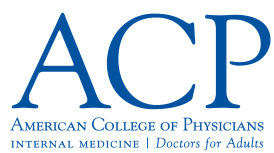
**Medicare Schedule of Physician Payment for Heavily Used Services,
1992 and 2002**

Code	Description	1992 Payment (\$)	2002 Payment (\$)	Change (%)
27130	Total hip replacement	1696.68	1452.31	-14.4
27236	Treatment of thigh fracture	1103.33	1113.85	1.0
27447	Total hip replacement	1815.73	1514.21	-16.6
33405	Replacement of aortic valve	1971.04	2047.06	3.9
33533	CABG, Single	1872.77	1827.34	-2.4
52601	Prostatectomy, TURP	801.69	769.96	-4.0
58150	Total hysterectomy	805.10	893.03	10.9
66821	Care after cataract laser surgery	326.75	213.94	-34.5
66984	Cataract surgery	940.57	669.32	-28.8
67210	Treatment of retinal lesion	519.27	603.08	16.1
43239	Upper GI endoscopy and biopsy	236.23	154.93	-34.4
45385	Colonoscopy to remove lesion	386.27	287.78	-25.5
52000	Cystourethroscopy	113.46	201.99	78.0
93510	Left heart catheterization	281.49	230.59	-18.1
35301	Carotid endarterectomy	1093.10	1061.36	-2.9
92982	Coronary artery dilation	892.52	584.26	-34.5
71020	Interpretation of chest film	10.54	11.22	6.5
76091	Interpretation of mammogram	20.15	43.44	115.6
93307	Interpretation echocardiogram	54.25	48.14	-11.3
93010	Electrocardiogram interpretation	10.85	9.05	-16.6
93015	Cardiac stress test	98.58	99.91	1.3
88305	Tissue examination	43.40	40.54	-6.6
99203	Office visit, new patient	54.87	91.95	67.6
99213	Office visit, established patient	31.00	50.32	62.3
99223	Initial hospital care	118.73	150.95	27.1
99233	Subsequent hospital care	60.45	76.38	26.4
99244	Office consultation	113.46	164.34	44.8
99254	Initial inpatient consultation	114.39	136.83	19.6
99255	Initial inpatient consultation	150.04	186.60	25.7
99285	Emergency department visit	126.17	144.80	14.8
99291	Critical care, first hour	127.41	198.37	55.7
99312	Subsequent nursing facility care	36.58	49.95	36.6

Source: *New England Journal of Medicine*. 2002;346:1927.

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