Diabetes Care Reimbursement Uncertain After Medicare Reform

Physicians remain skeptical of resource-based relative value scales.

A sweeping revision of the Medicare physician payment system that went into effect 1 January 1992 has raised the possibility of higher reimbursement levels for treating diabetes. However, some physicians fear that budgetary belt-tightening and the complexity of the new system will make the anticipated payment increase about as elusive as the "peace dividend" that was supposed to follow communism's fall. Kenneth Quickel, director of the Joslin Diabetes Center in Boston and chair of the American Diabetes Association's (ADA) government relations committee, says that it is too early to tell whether the reforms will have a significant impact on services for people with diabetes.

Under the Medicare reform—the most significant in the 26-yr history of the program—payments to most specialists will fall. The goal is to correct inequities in the old system that led to relatively high reimbursements for specialized procedures such as surgery but disproportionately low payment for primary care and prevention. The shift could have far-reaching implications, because private insurers often take their cue from the Medicare system. Medicare provides federal health insurance for >34 million elderly and disabled people.

In theory at least, the new system should increase reimbursement for many of the services physicians provide to patients with diabetes. "Its intent is to value upward the kinds of counseling and education services that are so important in the care of the diabetic," says Alan Nelson, incoming executive vice president of the American Society of Internal Medicine (ASIM). For a person with diabetes, appropriate counseling on nutrition, insulin adjustments, and other aspects of managing the disease are thought to significantly reduce the occurrence of complications. But minimal Medicare payments for that kind of preventive care have in the past made it more profitable to treat the complications of diabetes with expensive medical procedures.

ASIM and other groups that pushed for Medicare payment reform hope that it will ultimately improve patient access services like counseling and education that historically have been severely undervalued. But Nelson warns that pressure to trim the Medicare budget could undermine progress toward that goal. "There is incredible pressure to cut," he says.

Moreover, the new system does nothing to expand coverage for outpatient diabetes education. Current law does not specifically identify diabetes patient education programs as covered services under Medicare. Although payment is now provided for education in certain hospital outpatient departments and rural health clinics, Medicare reimbursement is inconsistent even in those settings. ADA has recently helped to draft a bill that would expand Medicare coverage for outpatient diabetes education and standardize coverage policies.

The new system aims to reimburse physicians for their service according to the actual work and overhead costs involved in providing them. Under the old system, established in 1965 by the original Medicare legislation, payments were based on the billing patterns of individual physicians—so-called "customary, prevailing, and reasonable" (CPR) charges. But critics called the CPR system inconsistent and distorted, because it retained outdated patterns that kept payments low for some physicians—particularly those in rural areas and those providing relatively low-tech services while allowing high payments for certain specialists who adopted new techniques and equipment or who had historically charged higher rates than others. Foremost among the medical services that the CPR system tended to undervalue were those sometimes referred to as "cognitive" or "evaluation and management" services such as office visits, consultations, counseling, and patient education.

Now, after years of research and debate, a formula-driven fee schedule is being phased in. By 1996, all Medicare payments will be derived from a "resource-based relative value scale" (RBRVS), which rates medical services according to the resources they require, such as physician work, time, and overhead costs. An enormous $6 million research project led by William Hsiao, an economist at the Harvard University School of Public Health in Boston produced the RBRVS for the Health Care Financing Administration (HCFA), which runs Medicare. Each of 7000 medical services was assigned a number that represents its value relative to other services. A simple equation converts that figure into a dollar amount. The equation includes a factor that adjusts for differences in overhead costs among locations, but geographical variation is much less than it was under the CPR system.

A new set of codes for categorizing medical services is being introduced along with the new fee schedule, and it includes an entirely new section of codes for evaluation and management services provided by physicians. This new coding system is one reason why reimburse-

ments for primary care and diabetes care should improve. But some physicians are not sure whether it is a blessing or a curse. "It's gotten so complex that in many cases it takes longer to figure out the billing and the code than it does to care for the patient," says Robert Ratner, chief of the Diabetes Center at George Washington University Medical School in Washington, D.C.

Jack Ginsburg, a senior analyst for the American College of Physicians (ACP), admits that "there is a lot of confusion about the new codes and about the new regulations." But Ginsburg says that a certain amount of confusion is probably inevitable with such comprehensive changes, and that the new coding system is a real improvement. "It is more complicated, but what we're pleased with is that it does give recognition for the services a physician actually provides during an office visit," he says. "We hope that the new payment system will encourage physicians to spend time with patients in counseling, evaluation, and diagnostic services that in the past have been undervalued." The goal is to eliminate financial incentives that, in the old system, favored high-tech procedures over preventive care.

Groups such as ACP and ASIM also hope that reforming the payment system will counteract the trend among young physicians to steer away from careers in primary care and opt for higher-paying specialties such as cardiology. The changes in Medicare payments will have far-reaching effects, says Ratner, because "Medicare has historically been the bellwether," leading the way for private health insurance companies such as Blue Cross and Blue Shield. Already, he says, private insurers are asking physicians to use the new coding system.

According to Ratner, several features of the new system should lead to higher reimbursement levels for diabetes care, but he is not sure that Medicare will agree with his reasoning. The new coding system takes into account several factors—including physician time, complexity of medical decisions, and presenting problem severity—in determining the level of reimbursement for services such as office visits and consultations. Importantly, the time factor includes time spent counseling the patient, as well as time spent performing medical procedures.

If a physician is "spending 40 minutes counseling the patient—talking about different options of nutrition or how to adjust your insulin when you exercise—that's legitimate counseling and *should* be reimbursed at a higher rate," Ratner says. In addition to the need to spend time counseling and educating patients with diabetes, Ratner cites the complexity and potential severity of the disease as factors that should lead to higher reimbursements for diabetes care. "This is a multi-system disorder that requires history and examination on multiple organ systems. . . , [which] tends to increase the complexity of the problem. . . . Presenting problem severity is [also] high, because the potential morbidity is high. What we don't know is whether or not [Medicare] will accept that," he says.

Ratner, a former chair of the ADA's government relations committee, says the principles behind the reforms are laudable, but he is pessimistic about the prospects for a significant increase in reimbursements for primary care. One reason is the controversial "conversion factor"—the number that converts the relative value units assigned to medical services into dollar amounts. The conversion factor that HCFA initially proposed last June would have cut overall Medicare payments by billions of dollars compared with the old CPR system. Groups that had worked closely with HCFA to develop the new fee schedule—such as ASIM, ACP, and the American Medical Association—felt betrayed by the proposal. "A good faith effort to provide a better and more fair system of valuing physician services was held hostage to the budget," says Nelson.

Physicians responded by flooding HCFA with >95,000 letters last summer, and the final regulations published in November set a conversion factor that is 13.2% higher than the agency's initial proposal. But the new figure still includes a 6.5% reduction that HCFA officials say is necessary to compensate for an expected increase in the volume and intensity of services for which physicians seek reimbursement. HCFA officials originally referred to the reduction as a "behavioral offset," but physicians objected strongly to the implication that they would compensate for lower fees by performing more of certain services, or that they would try to beat the system by "upcoding" services to higher reimbursement levels. HCFA now says that the adjustment "does not attribute blame" to physicians, but is based on studies indicating that, for whatever reasons, an increase in the volume of services can be expected.

In the view of some physicians, however, the intended gains in payments for cognitive services and primary care will not amount to much. "The fact is that they've put such a squeeze on the total dollars that there is very little benefit for primary-care specialists," says Kenneth Quickel, director of the Joslin Diabetes Center in Boston. Quickel says that the new fee schedule is "a step in the right direction," but will not dramatically affect services for diabetes patients.

Ginsburg says ACP is somewhat concerned that disgruntled physicians, frustrated by the administrative hassle of the new regulations, might decide not to accept new Medicare patients. But he says he has not seen evidence of that happening yet. "One of the things that we're reminding our members is that the payment reforms are being phased in over 4 yr, and the purpose of that transition period is to allow refinements and adjustments in the new system," says Ginsburg. "We are hopeful that overall the new system will increase [patient] access to needed preventive and counseling services."

A major concern of the ADA and

the Endocrine Society is that diabetes education is not included in the national fee schedule. As a result, reimbursement for diabetes education varies among the local carriers of Medicare policies. It is especially difficult to get reimbursement for diabetes education when it is provided by a non–physician practitioner, such as a nutritionist or a nurse educator.

A bill that addresses these problems—the Medicare Outpatient Diabetes Education Coverage Act (H.R. 3806)—was introduced in Congress in November. Quickel says the legislation would have "a tremendous effect" if it is enacted.

ADA and other groups are continuing to lobby HCFA, pushing for changes in the new regulations, which HCFA plans to revise for 1993. "This isn't the end of payment reform," says Nelson. "This is just the beginning."

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