Reimbursement Issues in Urban Family Practice: Experience in New York City

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Family practice is alive but not so well in New York City. The area has too few family physicians to serve the population. A major reason for this is the reimbursement pattern of third party payers. Personal experience with direct payment from patients shows that less than one percent fail to pay. The self-pay/no-pay syndrome of the hospital clinics has not affected the private family physicians.

Table 1 shows the fee-for-service schedules for primary care of the most frequently used third party payers in New York City. Examples of the reimbursement issues of urban family physicians are taken from this table.

Reimbursement Issues

Low Fees

Fee schedules of third party payers are uniformly below the usual and customary fees of the area. Payments-in-full fee schedules for primary care may be less than the proportionate visit overhead expenses of conducting a private family practice. The worst examples are Worker's Compensation/No Fault Insurance, from which a board certified family physician receives $11.43 for routine office or hospital visits, or Medicaid, which pays $6.00 to $7.50 for that visit.

Inequity of Fees for Equal Service

Quality primary care is delivered by many categories of physicians. The principle of equal remuneration for the same service seems eminently fair. What acceptable reason can there be for a different fee? There is no difference in relevant training for delivery of primary care. The training of a super specialist takes longer, but the training does not result in superior ability to render primary care (if indeed as good). The training of a general internist and family physician is equal in postgraduate years, and both may be board certified. Internists claim that their caseload includes more sick patients. This is questionable; but if it is true, and their patients do take more time to treat, equitable adjustments can be achieved with additional remuneration for lengthy visits in all third party fee schedules.

Examples of unequal pay from third party payers for the same medical service abound. Worker's Compensation/No Fault Insurance in New York State have different fees for every primary care service for general practitioners, board certified family physicians, and various other specialists. Medicare maximum fee schedule in New York has different fees for all primary care

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Table 1. Fee-For-Service Schedule for Primary Care—New York City, 1980

	First Office Visit	Subsequent Office Visits	Extended Office Visit	First Hospital Visit	Subsequent Hospital Visit	Extended Hospital Visit	ECG in Office
Usual fees ($)	35.00	25.00	10.00	50.00	30.00	15.00	30.00
Worker's Compensation/No Fault Insurance							
GP*	18.25	11.43		18.25	11.43		All
S-FP**	34.23	11.43		34.23	11.43		34.60
Internist	45.64	11.43		45.64	11.43		
Blue Shield (various contracts)	3.00 and up†	3.00 and up†	?†	10.00 and up†	6.00 and up†	?†	20.00 and up†
Medicare (maximum fee)							
Nonspecialist	23.00	15.30	23.00	25.00	18.40	40.00	All
Specialist	38.30	23.00	30.70	38.30	23.00	76.70	30.00
Medicaid (maximum fee)							
GP	9.50	7.00	—	6.50	5.00	—	All
S-FP**	12.00-14.50††	7.20-7.50	—	10.00-12.50††	6.00-7.50††	—	
Pediatrician	14.50	8.50	—	10.00	6.00-7.50††	—	15.00
Internist	19.50‡	9.00	15.00-25.00	15.00	7.50	20.00-25.00	

*General practitioner
**Board certified family physicians
†Probably same maximum as Medicare
††Higher fee is for age over 16 years
‡Includes hematocrit, urine glucose and albumin, drawing blood samples, and report

services for specialists and nonspecialists (general practitioners). The Medicaid New York State maximum fee-for-service schedule has different fees for many primary care services for general practitioners, board certified family physicians, pediatricians, and internists.

Inadequate Reimbursement for Lengthy Visits

Since the service offered by physicians is related both to ability and time spent, it is clear that lengthy visits merit additional remuneration. This principle has been recognized by some policies of Blue Shield of Greater New York, but only for internists in the case of in-hospital medical services. Also Medicare in New York City has an extra fee for extended visits, initial or subsequent, either in the office or hospital. Caring and counseling functions and patient education are time consuming and considered indispensable by family physicians; these merit remuneration from all third party payers.

Lack of Coverage for Health Maintenance

Health maintenance is used here to include prevention by immunization and education and by screening for asymptomatic illness, which, if detected, can be improved by treatment. The improvement may be cure of a disease, enhanced subsequent quality of life, or improved morbidity or mortality statistics. Most third party payers do not compensate for health maintenance. Exceptions are some Blue Shield contracts that include a special office visit per year for a comprehensive

history and physical examination, with discussion of a plan of therapy, and Medicaid reimbursement for well-baby care and children's immunizations. But there are also examples of glaring inequities in the remuneration formulas of third party payers in screening and immunizations. Recommendations for increased screening in the group over 65 years of age by the American Cancer Society and the Canadian Task Force on the Periodic Health Examinations have not been incorporated into Medicare, which does not reimburse for screening unless a diagnosis is reported. For the over-65 age group influenza vaccine was recommended but not paid for unless the diagnosis warranted it. A congressional study conducted by the Federal Office of Technology Assessment recommended that Medicare dispense free pneumonia vaccine to everyone over 65 years of age, but federal laws did not pay for it unless warranted by diagnosis. These deficiencies were corrected in 1981. The same study reported that the cost of giving the vaccine would be largely offset by the money now spent to treat elderly people for pneumonia. In Medicaid there is no payment for any laboratory tests or Papanicolaou smear unless the diagnosis indicates the test was necessary.

Inequity of Reimbursement for Primary Care and Procedures

It is important to address this inequity because it may discourage physicians from practicing primary care where physicians are needed. Compare the payment for endoscopy to a primary care visit as an obvious example of inequality in remuneration formulas of third party payers. Another example is the author's office where remuneration for an electrocardiogram (done by a medical assistant, taking a few minutes of the physician's time to read and explain the interpretation to the family) is approximately equal to remuneration for an average visit.

Static Reimbursement Formulas

The New York State Worker's Compensation fee-for-service schedule was unchanged from 1973 to October 1, 1980. The Medicaid maximum fee-for-service schedule was unchanged from 1972 to July 1, 1980. Blue Shield of Greater New York bases Medicare reimbursement formulas on the actual claims of the greater portion of the previous calendar year and makes adjustments on July 1. Therefore, the fee schedule for July 1, 1980, to June 30, 1981, is based on claims of 1979. All of these third party payers need to improve their frequency of updating reimbursement formulas, which, with the increased use of computers, is not an impossible task.

Use of Universal Health Claim Form

At this time the physician must complete a variety of lengthy health forms. The greatest offender is the Medicaid form. There is a federal mandate to develop a universal health claim form, but none has been accepted in New York State.

Promptness of Payments by Third Party Payers

This problem relates mostly to Medicaid, from whom payments frequently take over six months. In cases of lengthy hospitalizations, however, Medicare will not infrequently take three to four months to pay the physician, scarcely an incentive for the physician to accept assignment. One month seems a reasonable interval for all third party payers to complete the payment.

Need for Revision of Medicaid Payment Formula

Constructive change in the reimbursement formula for the health care of medicaid patients must be adequate to bring to reality the concept of providing patients of limited income access to providers of their choice. Present low fees, prolonged intervals before payment, and unmanageable paper work systematically undermine the idea of Medicaid. Even the most highly motivated physicians in private practice cannot survive under the present system. Dedicated medical students and residents expect to be able to deliver health care to all socioeconomic groups. The inability to deliver private medical care to the Medicaid segment of the population is frustrating to this future generation of physicians. At the same time it is a disservice to patients to deny them true free choice of physicians. Making the Medicaid program work demands a comprehensive overhaul.