Physician Attitudes and Behavior in Response to Changes in Medicare Reimbursement Policies

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Background. Rapidly changing Medicare reimbursement policies since 1983 have affected every primary care physician. This study has attempted to quantify the attitudes and behaviors of Ohio primary care physicians toward these changes.

Methods. In Ohio, 1758 primary care physicians were surveyed by a mailed questionnaire about their attitudes toward recent changes in Medicare reimbursement policies and the resulting changes in their practices.

Results. More than 80% of respondents termed most Medicare policies as "objectionable" or "very objectionable." Fifty percent were limiting the number of Medicare patients in their practices. Family physicians and physicians who perceived their income to have decreased and their staff workload to have increased were also more likely to limit the number of Medicare patients in their practices.

Conclusions. Ohio primary care physicians have a negative opinion of Medicare reimbursement policies and have limited their practices significantly as a result.

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Nearly every physician's practice today is affected by the changes in Medicare reimbursement policies that have been enacted in recent years. These changes came swiftly, and often were received negatively by physicians, particularly primary care physicians. Some have questioned whether physicians' negative attitudes toward the new Medicare reimbursement policies have resulted in limited access to health care for elderly patients.

The expressed purpose of the Medicare program when it became law in 1965 was to ensure that elderly citizens have equal access to quality health care.[1,2] For the first decade of Medicare's existence, its "usual, customary and reasonable" formula for physician reimbursement seemed to meet these goals. Under this formula, however, Medicare expenditures grew dramatically, making the program second only to Social Security for size and growth of a federal domestic program.[3] Growth in Medicare payments to physicians recently has far outstripped the growth in the economy as a whole. From 1975 to 1983, Medicare Part B costs increased three times faster than the gross national product.[3] These facts caused Congress to implement several new reimbursement policies. The 1983 Deficit Reduction Act asked physicians to choose to "participate" (accept Medicare assignment rates as payment in full) or continue to have their fees for Medicare patients "frozen." The Omnibus Budget Reconciliation Act of 1986 removed this "freeze" for nonparticipating physicians and in its place established the Maximum Allowable Actual Charges (MAAC) program. A thorough review of the history of the Medicare program is provided by Holahan and Zuckerman.[4]

Several authors have voiced concern that these new policies, which were implemented to reduce costs, may result in physicians limiting their care of Medicare patients. Some critics feel that the effect may go well beyond the physician's income and result in elderly patients losing long-established relationships with their physicians.[5] Others predict that a reduced number of physicians may be willing to treat Medicare patients.[6] According to a past president of the American Academy of Family Physicians, access to primary care for the elderly has been limited in some areas because family physicians perceive the present system as undervaluing their services.[7]

Medicare reimbursement policies are an emotional topic of editorials and letters. One writer terms these policies "harassment."[8] Another coined the term "MAAC attack" for physicians' negative feelings about the complex calculation of their Maximum Allowable Actual Charge.[5] Several physicians blame low Medicare reim-

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bursement rates for reducing the amount of office time spent with each Medicare patient.[9,10]

Few studies have determined whether these attitudes and behaviors are widespread among physicians, particularly among primary care physicians. Studies conducted before the 1983 changes in Medicare reimbursement policies predicted greater access to medical care for the elderly with a higher rate of reimbursement and less complicated reimbursement procedures.[11,12] In a 1987 American Medical Association survey, 22% of physicians were found to be making deliberate efforts to reduce Medicare patient loads (R. Reynolds, M. Gonzales, Effects of Medicare Fee Controls on Access to Care. Unpublished report, Center for Health Policy Research, American Medical Association, 1989).

A crisis of limited access to primary care may be emerging for our elderly population. This study was designed to determine the attitudes of primary care physicians toward present Medicare reimbursement policies, and to determine how their practices are changing in response to these policies. An understanding of primary care physicians' attitudes and behavior might lead to modifying the Medicare reimbursement system to contain costs as well as to assure Medicare beneficiaries of continued access to primary care.

Methods

Members of both the Ohio Academy of Family Physicians and the Ohio Society of Internal Medicine were selected as the study population. Mailing lists were provided by both organizations. All 803 members of the Ohio Society of Internal Medicine were surveyed, as well as a random sample of half of the 1910 members of the Ohio Academy of Family Physicians. Excluded from the study were respondents who were retired, academic, or military physicians; physicians on an institutional salary; and internists who practiced general internal medicine less than 50% of the time.

The survey instrument was constructed by the authors after the methods of Dillman[13] and Henry and Zivick.[14] It consisted of 15 Likert scale items to elicit opinions about various Medicare reimbursement policies. Physicians were asked to respond to nine statements about Medicare using a 6-point scale from "very strongly agree" to "very strongly disagree." Then they were asked to give their opinion on six specific Medicare policies using a 4-point scale of "very reasonable" to "very objectionable," along with a 5th category of "no knowledge." Three partially close-ended questions inquired about changes in practice patterns related to Medicare reimbursement policies. Physicians were asked to give multiple responses if applicable. Finally, there were seven questions seeking demographic information. The survey instrument was pilot-tested among 12 primary care physicians, and modifications were made with regard to their comments about bias, ambiguity, length, redundancy, and wording.

The survey instrument was mailed during the first 3 months of 1990 in three waves, according to the method of Dillman.[13] A cover letter signed by an officer of the appropriate specialty association was included to encourage response. The initial mailing was followed by a postcard reminder 3 weeks later. A second mailing of the survey instrument was sent to nonrespondents 2 weeks after the postcard reminder.

A power analysis was performed and revealed that 336 responses were necessary to assure a representative sample. The data from the returned surveys were analyzed using several methods. Frequencies for all responses were determined. A step-wise multiple regression was performed to determine the most important variables that affect physicians' limitations of Medicare practice. Two-by-two chi-square analyses were then used to compare level of income, size of Medicare practice, participation status, and specialty to practice changes, as well as to the opinion variables found to be most important by multiple regression analysis.

Results

Participant Characteristics

Of the 1758 physicians surveyed, 838 returned the survey for an overall response rate of 48%. Three hundred forty-five of 803 surveys mailed to internists were returned resulting in a response rate of 43%, and 493 of the 955 to family physicians were returned resulting in a 52% response rate. Of the 838 returned surveys, 172 were excluded from the study because the respondents were retired, academic, or military physicians; physicians on an institutional salary; or internists not practicing general medicine. The final sample size was 666.

Of the final study population, 61% were family physicians, and 39% were general internists, the majority of whom were board certified (78%). Other pertinent characteristics of the study population are summarized in Table 1.

Physician Opinion About Medicare Policies

The Likert scale responses of "strongly agree" and "very strongly agree" were grouped together to generate the frequencies reported. Forty-eight percent of the respond-

Table 1. Characteristics of Physician Respondents

Characteristic	Percentage	Number
Family practice	61	382
Internal medicine	39	261
Board certified	78	420
Income		
<$100,000	61	395
≥$100,000	39	252
Medicare practice		
<40%	59	389
≥40%	41	271
Participating (do accept assignment)	41	269
Nonparticipating (do not accept assignment)	59	390

ents agreed that caring for geriatric patients was enjoyable, but 52% reported that Medicare reimbursement policies had decreased their enjoyment of caring for the elderly. Sixty-five percent believed physicians' concerns about Medicare policies were not exaggerated.

With regard to the impact of Medicare's policy changes on the elderly, 6% of respondents agreed that Medicare allowed adequate access to medical care for the elderly. Only 9% believed that Medicare provided medical services at a reasonable cost to the elderly. Sixty-two percent believed that recent changes in Medicare reimbursement policies had created anxiety and confusion among their elderly patients.

With regard to their own practices, 65% of physician respondents believed that Medicare paperwork had been a more significant factor in the increased workloads of their clerical staff than other reimbursement plans. Sixty-three percent believed that Medicare policies had resulted in a decrease in their practice incomes. Thirty-nine percent believed that levels of Medicare reimbursement were too low to cover their overhead per patient.

A large majority of respondents found specific Medicare policies as "objectionable" or "very objectionable," as summarized in Table 2. Thirteen percent of respondents had no knowledge of civil monetary penalties. Peer review organizations were least likely to be considered "objectionable," while restrictions on reimbursement for concurrent care were most likely to be considered "objectionable."

Table 2. Percentage of Ohio Physicians Ranking Specific Medicare Policies as "Objectionable" or "Very Objectionable" (N = 666)

Medicare Policies	Percentage
Restrictions on concurrent care billing	93
"Medical necessity" letters	90
Civil monetary penalties	84
Incentives to participate	82
Maximum allowable actual charge (MAAC)	82
Peer review organizations	71

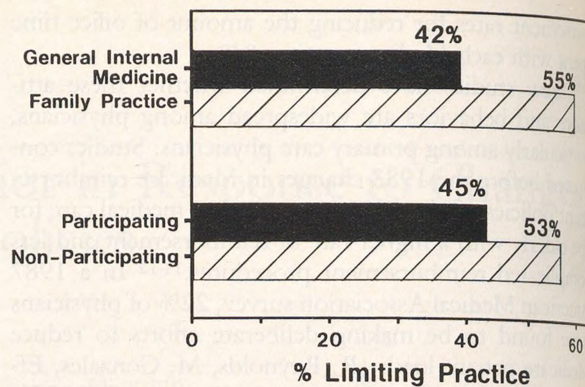

Figure 1. Practice limitation by specialty assignment status. Family physicians and "nonparticipating" physicians were more likely to limit their Medicare practices ($P < .05$).

Limitations on Medicare Practice

In response to questions about how physicians were changing their practices in response to Medicare reimbursement policies, 36% stated that they were making no changes. Nevertheless, 15% were accepting no new Medicare patients, 27% were taking less time with each Medicare patient, and 38% were limiting their nursing home practice. Overall, 50% reported that they were taking at least one of the above actions to change their Medicare practice.

Factors Influencing Practice Limitations

By multiple regression analysis, followed by two-by-two chi-square analyses, several subgroups were found to be more or less likely to limit their Medicare practices. These subgroup responses are summarized in Figures 1 through 4. Family physicians were more likely to restrict their Medicare practices than general internists (Figure 1). "Non-participating" physicians also were more likely to limit their practices than "participating" physicians (Figure 1). Those respondents who enjoyed geriatrics most strongly were less likely to limit their practices, while those whose enjoyment of geriatrics had markedly decreased as a result of Medicare reimbursement policies were more likely to limit their practices (Figure 2). Those respondents who perceived that Medicare reimbursement policies had had a strong impact on their practices by increasing their clerical workload, decreasing their income, or not covering their overhead per patient were more likely to limit their practices (Figure 3). Those

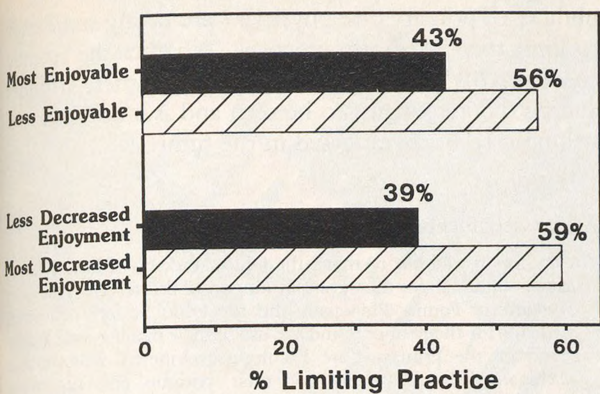

Figure 2. Practice limitation by enjoyment of geriatrics. Physicians who did not enjoy geriatrics or who perceived their enjoyment of geriatrics to be lessened by Medicare changes were more likely to limit their Medicare practices ($P < .05$).

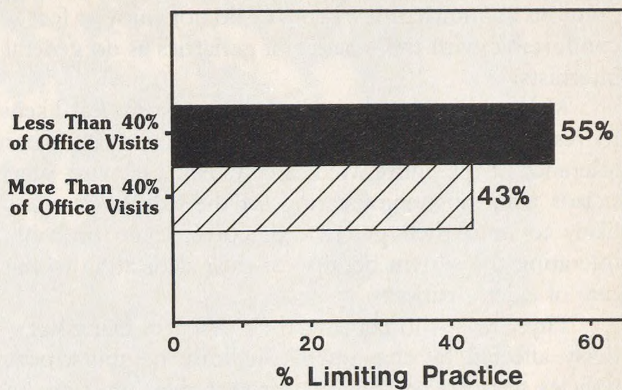

Figure 4. Practice limitation by size of Medicare practice. Physicians whose Medicare practice comprised less than 40% of their daily office visits were more likely to limit their Medicare practices ($P < .05$).

physicians with a smaller Medicare practice were more likely to limit their elderly care as well (Figure 4).

When compared with practice limitations, the variable of level of income (less than $100,000 per year vs $100,000 or more per year) was found not to be statistically significant by chi-square analysis.

Discussion

Although a large number of responses were generated by this survey, there are some important limitations. First, despite carefully following established methods of survey research,[13,14] the response rate was disappointing (48%). Reasons for this low response might include the length or perceived bias of the questionnaire, frequent surveys of the same population, apathy due to either a sense of impotence to change the system or the recent passage of the resource-based relative value scale (RBRVS). The higher response rate from family physicians might indicate that they feel more strongly about Medicare issues. Second, this study surveyed only Ohio primary care physicians and may not be generalizable nationwide because of variations in enforcement of Medicare policies by fiscal intermediaries.

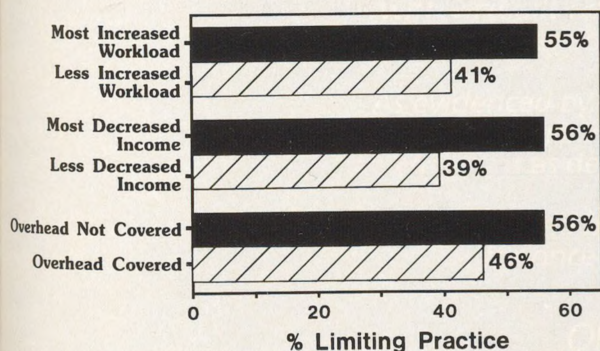

Figure 3. Practice limitation by impact on practice. Physicians who perceived a greater staff workload, decreased practice income, and inability to cover their overhead per patient because of changes in Medicare were more likely to limit their Medicare practices ($P < .05$).

Nevertheless, a number of conclusions can be drawn from this study. First, Ohio primary care physicians strongly believe that Medicare reimbursement policies are negatively affecting both their elderly patients and their practices. They see their patients as confused by a system that no longer provides access to medical services at a reasonable cost to the elderly as intended by the original Medicare legislation in 1965. They see their staff workloads increasing and their incomes decreasing as a result of Medicare's new policies. An overwhelming majority (more than 80%) viewed most specific Medicare policies as "objectionable" or "very objectionable."

One half of primary care physicians are taking some steps to limit their Medicare practice. Of physicians who are limiting their Medicare practice, the most frequent method of doing so has been to reduce nursing home care. Perhaps they believe that care of these patients can be easily passed to nursing home medical directors.

Family physicians are more frequently limiting their Medicare practices than general internists. There may be a number of reasons for this finding, including a broader patient base for family physicians so that less would be lost by limiting care of the elderly compared with general internists. This reason is supported by the finding that physicians with a smaller proportion of Medicare patients are more likely to limit their practices. Perhaps this finding also suggests that family physicians have stronger

opinions about Medicare issues or do not enjoy or feel as comfortable with the practice of geriatrics as do general internists.

Medicare "participating" physicians were less likely to restrict their practices, perhaps reflecting a greater tolerance of the entire Medicare system. Likewise, physicians who most enjoy caring for the elderly were less likely to limit their geriatric practices, again probably tolerating the system because of their dedication to the care of elderly patients.

Physicians who perceive their practices being negatively affected by changes in Medicare reimbursement policies seem to be trying to protect their practices by limiting the number of Medicare patients in their practices. If the workload is increasing and income is decreasing, natural business sense would dictate a move to more profitable markets. Our findings indicate that physicians are not an exception to this rule.

This study confirms the speculations and research of others. In attempting to quantify the attitudes and opinions of Ohio primary care physicians, this study found them to be at least as negative as the editorial literature previously cited indicates.[4,8–10] Furthermore, the fears that Medicare critics cited[4,6,7] are being realized: the majority of Ohio primary care physicians are reducing their care of the elderly. In fact, the frequency of physicians limiting their care is greater than found by the American Medical Association in their 1987 study: 50% compared with 22%. In addition, this study has identified some of the factors that result in these changes in practice patterns, such as decreased enjoyment of geriatrics, perceptions of increased staff workloads, decreased incomes, and per patient overhead not being covered by Medicare reimbursements.

This study has confirmed and quantified the negative attitudes and opinions that primary care physicians have about changes in Medicare reimbursement policies since 1983. The survey found that an alarmingly large number of primary care physicians are taking some steps to limit their Medicare practices. Whether the recently enacted RBRVS will significantly change these attitudes and behaviors remains to be seen and is a question that will need to be investigated in the future.

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