January 10, 2018

James E. Mathews, PhD
Executive Director
Medicare Payment Advisory Commission
425 I Street, NW
Suite 701
Washington, DC 20001

Re: MedPAC discussion on "Rebalancing the physician fee schedule towards primary care services"

Dear Dr. Mathews:

On behalf of the 20 undersigned organizations, we write to express our concern with the November 2017 Medicare Payment Advisory Commission (MedPAC) discussion titled, "Rebalancing the physician fee schedule towards primary care services." We believe that many of the underlying assumptions in this November MedPAC meeting presentation are incorrect. Specifically, we question the problems that MedPAC describes with the way the physician fee schedule (PFS) pays for primary care, the concerns with income disparities between specialties, and the effectiveness of increasing payment to certain specialties as a means to address workforce issues.

Even if MedPAC continues to assert that payment for primary care should be increased, we do not believe that "rebalancing" of the PFS is appropriate or necessary. Instead, primary care clinicians should be paid for the value of the care that they provide. It is possible that this could result in increased payment for primary care. But to suggest that the increase must necessarily come at the expense of other providers shows a fundamental misunderstanding of the current and developing workforce shortages for specialties, the reasons that medical students select future career paths, and a disregard for the stress that has been placed on the entire Medicare system by, at best, stagnant reimbursements. We discuss these comments in more detail below.

November 2017 MedPAC meeting: Rebalancing the physician fee schedule towards primary care

The MedPAC presentation asserted that there are a number of problems with the way that the PFS pays for primary care services. MedPAC staff stated that because payment rates are based on estimates of the relative amounts of time and intensity of each service, and because primary care services are labor-intensive and less likely to decline in time compared to procedure-based services, procedure-based services then become overpriced relative to primary care services. MedPAC staff stated that this is because PFS payment rates are not updated frequently enough to reflect reductions in service time. Staff also stated that fee-for-service payment enables procedure-oriented specialties to more easily increase the volume of services provided compared to primary care. In addition, staff stated that the PFS is oriented toward services with a clear beginning and end, and therefore is not well-designed to support primary care, a major

component of which is ongoing, non-face-to-face care coordination. In addition, staff asserted that there are wide income disparities between primary care and radiology/procedural specialties that discourage new physicians from entering the primary care workforce. MedPAC presented two approaches to address these concerns:

(1) Increase physician fee schedule payments for primary care and psychiatric *services* provided by all specialties; or
(2) Increase payments for primary care and psychiatric services provided by *certain clinicians*.

The physician fee schedule does not require rebalancing

We challenge MedPAC's assumption that the PFS requires rebalancing because we believe that payment rates are in fact updated frequently and that primary care is not undervalued relative to other specialties.

Payment rate updates for non-primary care services

We strongly disagree that payment rates are not updated frequently and we are unclear as to why MedPAC would make this assertion. In 2006, the AMA/RUC established the Five-Year Review Identification Workgroup (5YR ID WG) in response to MedPAC's concerns that the RUC only addressed undervalued services as potentially misvalued and only once every five years.[1] The 5YR ID WG later transitioned to the Relativity Assessment Workgroup (RAW). Both the 5YR ID WG and the RAW worked in concert with efforts at the Centers for Medicare & Medicaid Services (CMS) to identify potentially misvalued codes using the following objective measures and screens:

- Site of Service Anomalies
- High Volume Growth
- CMS Fastest Growing
- High intra-service work per unit of time (IWPUT)
- Services Surveyed by One Specialty – Now Performed by a Different Specialty
- Harvard Valued, utilization over 30,000
- CMS/Other, utilization over 100,000
- Codes reported 75 percent or More Together
- Low Value/High Volume Codes
- Multi-Specialty Points of Comparison List
- CMS High Expenditure Procedural Codes
- Services with Stand-Alone PE Procedure Time
- Pre-Time Analysis
- Outlier Post-Operative Visits

---

[1] Medicare Payment Advisory Commission. Medicare Payment Policy, Reviewing the Work Relative Values of Physician Fee Schedule Services. *Report to the Congress Medicare Payment Policy*. 2006; 135 https://www.asipp.org/documents/MedicarePaymentPolicyMarch2006.pdf. Accessed December 23, 2017

- High Level Evaluation and Management (E/M) in Global Period
- 000-Day Global Services Reported with an E/M with Modifier 25
- Public Comment Requests
- Other Issues

These screens had no limits to the number of codes identified and required a relatively quick action for review. Since 2006, these screening criteria have resulted in the identification of 2,297 services for review (and sometimes re-review) as potentially misvalued. As shown in Table 1, of the 2,162 services for which the review was completed, the work values decreased for 775 services.

Table 1: CMS Requests and RUC Relativity Assessment Workgroup Code Review Status (September 2017)	
Total Number of Codes Identified*	**2,297**
• ***Codes Completed***	**2,162**
Work and PE Maintained	626
Work Increased	209
Work Decreased	**775**
Direct Practice Expense Revised (beyond work changes)	154
Deleted from CPT®	398
• ***Codes Under Review***	**135**
Referred to CPT® Editorial Panel	9
RUC to Review for *CPT 2019*	67
RUC future review after additional data obtained	59

**The total number of codes identified will not equal the number of codes from each screen as some codes have been identified in more than one screen.*

Primary care payment relative to other services

Over the past two decades, the reimbursement for E/M services, as well as other services that are provided by primary care physicians, has notably increased. For example:

- CMS has created new primary care services that have mainly shifted funds to primary care providers including Welcome to Medicare visit, annual wellness visits, transitional care management, chronic care management, and advance care planning. As shown in Table 2, the annual payment for these services starts at $382 million in 2011 and increases to $1.2 billion by 2016.

Table 2: Spending for select new E/M Services, 2011-2016 ($ millions)							
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**growth**
Welcome to Medicare visit	$31	$47	$53	$57	$64	$72	18%
Annual Wellness visits	$351	$421	$501	$593	$719	$829	19%
Transitional care management	$0	$0	$56	$105	$136	$178	47%
Chronic care management	$0	$0	$0	$0	$40	$96	138%
Advance care planning	$0	$0	$0	$0	$0	$52	-
Total	$382	$468	$610	$756	$960	$1,227	26%
% of total physician fee schedule	0.4%	0.5%	0.7%	0.9%	1.1%	1.3%	

Data sources: Medicare Physician/Supplier Procedure Summary files for 2011-2016

Note: Procedure codes included within each category are:

Welcome to Medicare visit: HCPCS G0402
Annual wellness visits: HCPCS G0438, G0439
Transitional care management: CPT 99495, 99496
Chronic care management: CPT 99490
Advance care planning: CPT 99497, 99498

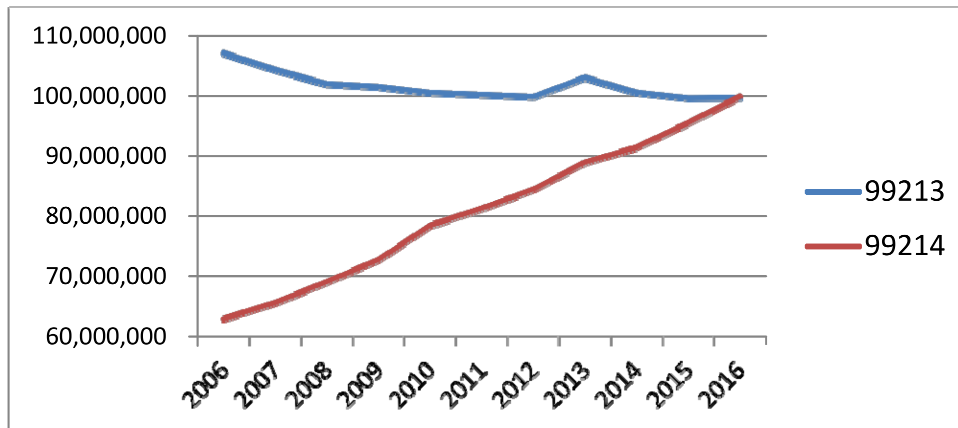
- In 1995, the RUC review of E/M services resulted in a shift of $2.7 billion to E/M services from non-E/M services and net increases in overall payment to family practice (+ 2.0 percent) and internal medicine (+ 2.5 percent). In contrast, surgical specialties saw net decreases ranging from -1.0 to -5.5 percent.[2]
- In 2005, the RUC review of E/M services resulted in a shift of $4.0 billion to E/M services from non-E/M services and net increases in overall payment to family practice (+ 5.0 percent) and internal medicine (+ 4.0 percent). In contrast, most surgical specialties saw no increase or net decreases (for example, -1.0 percent for general surgery, -3.0 percent for ophthalmology, and -6.0 percent for vascular surgery).[3]
- The 2005 RUC review of E/M services also resulted in a 37 percent increase (0.67 to 0.92) in the work value associated with CPT 99213 (mid-level office visit), the most frequently billed Medicare physician service for primary care providers at that time.

[2] Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule Calendar Year 1997. Final Rule. *Federal Register* Vol. 61; 59553. Published November 22, 1995

[3] Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; and Ambulance Inflation Factor Update for CY 2007. Final Rule. *Federal Register* Vol. 71; 69767-69768. Published December 1, 2006.

- The Affordable Care Act authorized a quarterly incentive payment program to augment Medicare payment for primary care services when furnished by primary care practitioners. This primary care incentive allowed primary care physicians a 10 percent bonus on the amount paid on all primary care services regardless of which zip code they practiced in from 2011 to 2015. In 2011 the Medicare primary care incentive payment exceeded $560 million, and in 2012 the primary care incentive payment exceeded $664 million.[4]
- Until 2016, CPT 99213 had the greatest number of claims in the PFS. However, in 2016, for the first time the number of claims for CPT 99214 surpassed the number of claims for CPT 99213 (see Chart 1). More than 50 percent of these claims are submitted by primary care providers.[5] This shows another way that that payment to primary care has increased substantially over time.

Chart 1: Change in Medicare Utilization of CPT 99213 versus CPT 99214



These changes have resulted in increased payment for E/M services as well as other services that are provided by primary care physicians, and narrowing of payment differentials between primary care relative to other specialties. We are perplexed as to why MedPAC would not mention the results of the efforts described above as part of its discussion as to whether there is a legitimate problem that needs to be addressed and how best to achieve its goals in light of the activity that has already been conducted. For these reasons we do not conclude that primary care services are undervalued relative to procedural services, and we do not agree with MedPAC's assertion that the PFS requires additional rebalancing toward primary care.

---

[4] Centers for Medicare & Medicaid Services, Primary Care Incentive Payment Program (PCIP), Medicare PCIP Payments for 2011 will exceed $560 million. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2011-Payments.pdf. Accessed January 4, 2018. Centers for Medicare & Medicaid Services, Primary Care Incentive Payment Program (PCIP), Medicare PCIP Payments for 2012 are over $664* million. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2012-Payments.pdf. Accessed January 4, 2018.
[5] American Medical Association, Relative Value Update Committee Database File 2018. Accessed December 16, 2017.

Inappropriate Focus on Specialty Income Variation

MedPAC also asserts that another indication that the PFS is imbalanced is wide income disparities between primary care and other specialties. MedPAC indicated that these compensation disparities could discourage medical school graduates and residents from choosing to practice primary care.

Income variation related to hours worked

We question MedPAC's outsized focus on income differentials between specialties and the assumption MedPAC seems to carry that the variation is inappropriate. MedPAC's data showing wide income disparities between primary care and radiology/nonsurgical procedural specialties/surgical specialties is likely explained by total number of hours worked. For example, one study found that surgeons work, on average, significantly more annual hours than family practice physicians (vascular surgeons +888 hours; thoracic surgeons +488 hours; general surgeons +326 hours; neurosurgeons +270 hours; urologists +264 hours; and orthopedic surgeons +215 hours). This study indicated that "specialists caring for more acutely ill patients or those requiring intensive monitoring (usually in hospital settings) work longer hours than physicians focused on more stable, chronically ill patients (mostly in ambulatory settings)."[6] It would be inherently rational that physicians working approximately 200 to 900 hours more each year would have incomes that are higher than the physicians who work approximately 200 to 900 hours less, yet MedPAC makes no effort to explore this.

In addition, a RAND report examined a rise in patients seeking treatment from emergency departments (EDs) due to a lack of access to primary care providers. The report found that primary care physicians appear to be sending more of their ill patients to the ED rather than admitting them to the hospital themselves. The report showed that many primary care practices do not offer after-hours or weekend care, and that the physicians who manage these practices can be difficult to reach by phone.[7]

Examining the payment per minute of various specialties further supports our position that income differentials are due to differences in the number of hours worked. Table 2 shows a comparison of total time in the PFS to total work for a broad range of categories of procedures and services (surgery, radiology, pathology, medicine, PM&R, E/Ms and Healthcare Common Procedure Coding System (HCPCS) Level II codes). This table shows that the work relative value units (RVUs) per minute of total service for these categories range from 0.023 to 0.043. This demonstrates that there is a very small difference between the per minute rate of payment for those who primarily bill E/Ms (primary care) and those who bill surgery or radiology procedures and services.

---

[6] Leigh JP, Tancredi D, Jerant A, Kravitz RL. Annual Work Hours Across Physician Specialties. *Archives of Internal Medicine*. 2011;171(13), 1211-1213

[7] Rand, The Evolving Roles of Emergency Departments. https://www.rand.org/pubs/research_briefs/RB9715.html. Accessed January 4, 2018.

Table 3: Comparison of Total Time in the PFS to Total Work						
HCPCS category	**Code Range**	**2018 Total Minutes (in millions)**	**Minutes % of Total**	**2018 Total Work RVUs (in millions)**	**Work RVUs % of Total**	**2018 Work RVU per minute**
Total	**Total**	**32,602**	**100%**	**1,263**	**100%**	**0.039**
Surgery	10021 - 69990	5,273	16%	228	18%	0.043
Radiology	70010 - 79999	2,050	6%	86	7%	0.042
Pathology	80047 - 89398	808	2%	24	2%	0.029
Medicine	90281 – 99199 *(not including 97010 - 97799)*	4,784	15%	170	13%	0.036
PM&R*	97010 - 97799	2,304	7%	54	4%	0.023
E/M	99201 - 99499	16,755	51%	680	54%	0.041
HCPCS Level II	G, P, Q codes	629	2%	21	2%	0.034

*Physical medicine and rehabilitation codes include physical and occupational therapy services.

Data sources: CY 2018 PFS final rule files; Codes with work RVUs greater than 0.00 in the ranges 10021—99499 and G0101—Q0091; Work time file for 2018; 2016 utilization data for 2018.

Factors other than compensation drive medical specialty decision-making

We do not agree with MedPAC's assertion that compensation disparities could discourage medical school graduates and residents from choosing to practice primary care. Specialty choice is a very personal and complex decision that medical students make before they graduate from medical school and many factors beyond compensation influence a medical school graduate or resident's decision regarding which specialty to pursue. As such, we believe that increasing compensation alone is not an effective way of addressing a workforce shortage in a particular specialty. For example, according to a recent study, medical students were more likely to choose primary care if they came from a rural background, sought a school with a primary care reputation, or served a primary care clerkship.[8] Furthermore, students who stated that their specialty choice was influenced by public/community outreach during medical school were more likely to choose primary care. There is also little to no evidence linking student debt and physician specialty choice. A January 2013 study in Academic Medicine found that "physicians in all specialties can repay the current level of education debt without incurring more debt" and concluded that "a primary care career remains financially viable for medical school graduates with median levels of education debt."[9]

---

[8] Erikson CE, Danish S, Jones KC, Sandberg SF, Carle AC. The role of medical school culture in primary care career choice. Academic Medicine. 2013 Dec 1;88(12):1919-26

[9] Youngclaus, James A. M.S.; Koehler, Paul A. Ph.D.; Kotlikoff, Laurence J. Ph.D.; Wiecha, John M. M.D., M.P.H. Can Medical Students Afford to Choose Primary Care? An Economic Analysis of Physician Education Debt Repayment. Academic Medicine. 2013. Issue 1, Vol. 88. p. 16-25

Physician workforce shortage

As justification for an increase in primary care payments, MedPAC is inappropriately making an assumption that there is an ***oversupply*** of non-primary care physicians. We are very concerned about attempting to address a workforce shortage for one specialty without carefully examining the workforce impact those changes could have on other specialties that are also experiencing a workforce shortage. If there were a way to encourage additional medical school graduates and residents to choose primary care, this would reduce the number of physicians going into other fields, many of which are already experiencing workforce shortages or are estimated to experience them in the near future. For example, while the Association of American Medical Colleges (AAMC) projects shortfalls in primary care between 7,300 and 43,100 physicians, the shortfall in non-primary care specialties (primarily surgery and selected other specialties) is even more acute, approximating between 33,500 and 61,800 physicians by 2030.[10] Therefore, it is clearly not appropriate to attempt to correct a primary care workforce issue without examining whether it will create or exacerbate existing workforce issues for other specialties.

Furthermore, allied health professionals are meeting the demand for primary care services, but cannot replace the role of surgeons and other specialists. Thus, any perceived primary care workforce shortage is mitigated in part by the increase of those non-physician practitioners (NPPs) who are able to provide primary care services. The number of nurse practitioners (NPs) entering the workforce each year has expanded from 6,600 in 2003 to 18,000 in 2014, and the number of primary care NPs is projected to increase by 84 percent between 2010 and 2025.[11] Thus, even if there is a shortage of primary care physicians, the number of NPPs who can provide primary care services reduces the primary care access issue.

<u>If primary care requires different payment, substantial changes to the physician fee schedule are not required</u>

Based on our comments above, we do not believe that there is an imbalance in the PFS that necessitates substantial changes to the PFS to increase payment for primary care. As such, we do not support either of the approaches that MedPAC is considering to increasing payment to primary care suggested by MedPAC staff in the November meeting. If MedPAC continues to assert that changes are needed, we urge MedPAC to focus first on appropriate payment for primary care services. Specifically, primary care providers should be paid based on the value of the care they provide. To start out by suggesting that paying appropriately must be done by "rebalancing of the PFS" seems to suggest a desired outcome independent of discussing the appropriateness of payment for particular services.

If increased reimbursement is to be paid to primary care providers or for primary care services, that payment should not be taken from other specialties. MedPAC is only considering budget neutral redistribution of payment (across the board reductions) from other services and clinicians

---

[10] IHS Markit, prepared for the Association of American Medical Colleges, 2017 Update, The Complexities of Physician Supply and Demand: Projections from 2015 to 2030. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/a5/c3/a5c3d565-14ec-48fb-974b-99fafaeecb00/aamc_projections_update_2017.pdf. Accessed January 4, 2018.

to primary care, while turning a blind eye to the large increases in payment already given to primary care over the past years. We strongly urge MedPAC against recommending these approaches; instead, we urge MedPAC to examine broader sources of funding such as payments impacting overall healthcare spending to a much greater degree than physician services.

Conclusion

The undersigned organizations are committed to relative payment accuracy under the Medicare PFS and are committed to efforts to improve quality and resource use measurement. But a discussion that focuses, not on whether Medicare is appropriately valuing services or measuring the quality of services for Medicare beneficiaries, but rather on a "rebalancing" of the PFS where MedPAC tries to engineer medical specialty selection via tinkering with Medicare payments as a tangential way to address the serious workforce shortages faced by the United States, is a misplaced effort that fails to take into account the impact on the entire health care delivery system and needs of patients both now and in the future. We urge MedPAC to redirect its efforts to those that will truly improve the accuracy of Medicare payments and improve the quality and efficiency of care for Medicare beneficiaries.

Thank you for consideration of our comments. We look forward to continuing dialogue with MedPAC on these important issues and to working together to ensure the accuracy of PFS values and improving patient care and experience.

Sincerely,

American College of Surgeons
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology—Head and Neck Surgery
American Association of Neurological Surgeons American
Association of Orthopaedic Surgeons American College of
Osteopathic Surgeons
American Society of Anesthesiologists
American Society of Breast Surgeons American
Society of Cataract and Refractive Surgery American
Society of Colon and Rectal Surgeons American
Society for Metabolic and Bariatric Surgery American
Society of Plastic Surgeons
American Society for Surgery of the Hand
American Urogynecologic Society
American Urological Association
Congress of Neurological Surgeons
Society of Gynecologic Oncology
The Society for Thoracic Surgeons
Society for Vascular Surgery