



Sound Policy. Quality Care.

December 6, 2022

Chairman Michael Chernew, PhD
Medicare Payment Advisory Commission
425 I Street, Suite 701
Washington, DC 20001

RE: Options for Increasing Medicare Payment for Primary Care

Dear Chairman Chernew,

The Alliance of Specialty Medicine (the “Alliance”) represents more than 100,000 specialty physicians from 15 specialty and subspecialty societies who are dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. The undersigned members of the Alliance write to express concerns with policy options presented at the November 2022 meeting of the Medicare Payment Advisory Commission (MedPAC).

Background

During the November 2022 MedPAC meeting, staff presented policy options that aim to increase Medicare payments to primary care clinicians. Under one option, two separate fee schedules would be created — one for evaluation and management (E/M) services and one for non-E/M services. Each fee schedule would have its own conversion factor and operate under separate budget neutrality requirements. Under the second option, a new per-beneficiary payment for primary care clinicians would be established, with the payment being large enough to meaningfully reduce compensation disparities (e.g., \$20 per member per month or, on average, about \$30,000 per clinician).

According to the presentation, the number of primary care physicians (PCPs) has declined while the number of specialists has increased. The decline is partly attributed to the fact that PCPs receive lower compensation than specialists, which MedPAC suggests is due to the undervaluation of E/M services over time.

Concerns with the Commission’s Policy Options

Specialty Selection

MedPAC has a long history of developing policy options and making recommendations that prioritize primary care, with the vast majority focused on addressing compensation disparities between PCPs and specialists. [Medscape’s 2022 Physician Compensation Report](#) shows that compensation for primary care (i.e., internal medicine and family medicine) is lower than most medical specialties, ranking 24th and 27th (out of 29 medical and procedural specialties), respectively. However, what drives physicians into a medical specialty or subspecialty is almost entirely driven by individual preference in and content of the chosen specialty; compensation ranks 6th out of 11 factors considered by the Commission.

Even if compensation were higher, these data suggest that medical students will still choose other medical specialties that they find more stimulating and rewarding. As such, a sporadic “boost” in payment — even as much as \$30,000 per clinician — will not make primary care a more attractive specialty selection.

Increasing compensation with no change in effort for delivering E/M services relative to other non-E/M services would be an inappropriate use of Medicare program funds and taxpayer dollars given that it will not solve the problem the Commission cites, yet could exacerbate workforce shortages elsewhere.

Compensation Disparities

Considering the aforementioned factors, those who enter medicine as primary care clinicians have *affirmatively* chosen internal or family medicine and believe these specialties best align with their personal interests and preferences, intentionally bypassing advanced specialty training to use their medical education to deliver primary care. In fact, as found by MedPAC staff in key stakeholder interviews conducted in 2019:

Medical schools that graduate a high share of primary care physicians told us that their recruitment efforts target students who are likely to practice primary care; they also stress the importance of role models who are primary care physicians; and their students do clinical rotations in community settings, which helps students envision themselves outside of a large medical center.¹

Despite acknowledging that multiple factors go into medical student specialty selection and that Medicare payment policy alone can’t overcome all of these factors, the Commission continues to focus efforts on improving payment for primary care clinicians in order to “*reduce compensation disparities between primary care clinicians and specialists.*” This goal is deeply offensive and diminishes the value that specialists bring to the Medicare program and its beneficiaries. Again, it would be a poor use of Medicare funds to increase spending for one group of clinicians, knowing it will not resolve the issues the Commission intends to address.

Equally frustrating, the Commission seems to ignore the E/M contributions of specialty physicians. Members of the Alliance of Specialty Medicine represent physicians in multiple specialty and subspecialty fields, including rheumatology, gastroenterology, cardiology, ophthalmology, otolaryngology, neurosurgery, urology, and dermatology, among others – all of whom deliver E/M services to beneficiaries with complex and chronic conditions. MedPAC’s positions and statements belittle and undervalue that these clinicians have invested considerable resources (e.g., time, finances) into their education and training and delayed future career and family plans to become specialized in a particular area of medicine. Their advanced knowledge and skill allow them to provide thorough examinations, render accurate diagnoses, offer a complete range of treatment options, and deliver comprehensive and effective management of complex health conditions. Dismissing that these factors should inform clinician reimbursement threatens our health care system and provides a disservice to Medicare beneficiaries.

¹ Medicare Payment Advisory Commission, *Increasing the supply of primary care physicians: Findings from stakeholder interviews*, Transcript (November 7, 2019), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/default-document-library/medpac-november-2019-transcript.pdf.

Changes in Valuation

According to the staff presentation, “[a]s clinicians become more adept at delivering non-E/M services (e.g., procedures), RVUs should decline,” which “[w]ould cause payment rates for all other services to increase, since changes to the fee schedule’s codes must be budget neutral. However, RVUs are often not reduced over time, resulting in some non-E/M services becoming overvalued.” This is false.

As clinicians become more adept at delivering non-E/M services, RVUs for many services do, in fact, decline. Specific examples of services that have declined over time include cataract surgery, retinal detachment repair, endoscopy services, and spinal surgery. The work RVUs for these services have steadily decreased because the Centers for Medicare and Medicaid Services (CMS) increasingly favors time over intensity when setting values, which unfairly penalizes certain specialists for technological advancements and innovation in the care they provide. Indeed, cataract surgery (CPT 66984) – among the highest utilized surgical services in Medicare – has realized a work RVU reduction of 28.5% since 2012. In addition, several gastroenterological services have also realized steep work RVU reductions, including certain endoscopy and sigmoidoscopy services. Several of these services have realized reductions of approximately 27-34% since 2014. Further, an [October 2021 report](#) from the American Medical Association (AMA) Relative Value System Update Committee (RUC) Relativity Assessment Workgroup (RAW) describes the identification of more than 2,638 potentially misvalued services that account for \$45 billion in Medicare spending, with 41% of these services recommended for work RVU reductions and 19% recommended for deletion.

In contrast, the values of E/M services have significantly and disproportionately increased with respect to non-E/M services over time. This was apparent in the first and third five-year reviews conducted by the American Medical Association (AMA) Relative Value System Update Committee (RUC) and accepted by CMS. The upward revaluation of office and outpatient E/M services in the CY 2021 MPFS resulted in a 10.6% reduction in the conversion factor which negatively affected all other services due to a requirement for budget neutrality. The upward revaluation of “other E/M services” for 2023 is expected to result in another 1.6% downward adjustment to the conversion factor which will be shared by all the subspecialties. These changes will result in the transfer of billions of Medicare dollars from specialists to primary care physicians.

Moreover, for specialists that serve as primary care providers for their patient populations and thus rely on E/M services instead of procedures, the current Medicare Physician Fee Schedule (MPFS) devalues their advanced training and expertise in the diagnosis, treatment, and management of complex, chronic diseases, given they are paid the same as primary care clinicians for delivering E/M services.

We remind you that CMS also initiated a broad, multi-year effort to improve primary care, which led the agency to establish, reimburse and promote several new “E/M-like” services (e.g., transitional care management, chronic care management, principal care management, care plan oversight, and interprofessional consultation, among others). In addition, most advanced alternative payment models are focused on primary care delivery, with associated financial incentives driven toward primary care clinicians — not specialists. All of these Medicare revenue streams have been consistently shifted toward primary care clinicians, yet the percentage of physicians choosing to practice in primary care has not increased.

Workforce

Like primary care, many medical specialties are also facing workforce shortages. A recent [publication](#) from the Association of American Medical Colleges titled “The Complexities of Physician Supply and Demand: Projections From 2019 to 2034” demonstrates that overall, nonprimary care specialties face more significant shortages than primary care specialties (see table below).

Projected Physician Shortages by 2034

Specialty Area	Shortage Range
Primary Care (e.g. family medicine, general pediatrics, geriatric medicine)	Between 17,800 and 48,000 physicians
Nonprimary care specialties	Between 21,000 and 77,100 physicians
– Surgical specialties (e.g. general surgery, obstetrics and gynecology, orthopedic surgery)	– Between 15,800 and 30,200 physicians
– Medical specialties (e.g. cardiology, oncology, infectious diseases, pulmonology)	– Between 3,800 and 13,400 physicians
– Other specialties (e.g. anesthesiology, neurology, emergency medicine, addiction medicine)	– Between 10,300 and 35,600 physicians

A [recent study](#) by the Health Resources and Services Administration (HRSA) found similar results, with projected shortfalls in a number of non-primary care specialties (e.g., cardiology, general surgery, ophthalmology, and urology, among others).

Forwarding policy options that would improve payment for primary care clinicians — particularly as more and more beneficiaries require specialty medical care for increasing rates of chronic diseases — is detrimental to the Medicare program and devalues and undercuts specialty medical care. Even if there were more primary care physicians, they would still be unable to diagnose, treat, and manage most complex illnesses, given they do not have the requisite knowledge, skills, and abilities to do so.

Policy Options

We are deeply concerned with the policy options presented by the commission, which prioritize primary care over specialty care. Under one option, two separate fee schedules would be created — one for E/M services and one for non-E/M services — with each fee schedule having its own conversion factor and separate budget neutrality requirements. We appreciate that MedPAC suggests that all clinicians could bill under both fee schedules. However, this policy option diminishes the value of specialty medical care and the non-E/M services that many specialists provide.

Under the second option, a new per-beneficiary payment for primary care clinicians would be established to reduce compensation disparities. Again, we contend that compensation must reflect the advanced training and expertise held by specialists. Across-the-board reimbursement improvements for one subset of clinicians runs counter to the mandatory “relative” value payment system.

Conclusion

It seems that until primary care reimbursement is equal to that of specialty care, the Commission will not be satisfied. This is unfortunate, given specialty care is an essential and needed component of the health care system, and increasingly so as chronic, complex diseases become more common. No other clinician, provider-type or health care professional can replace the value offered by specialty physicians. We, therefore, urge you to reconsider your policy options and, instead, encourage other public and private entities to consider alternative means of increasing interest in primary care specialties, including providing additional training positions that do not come at the expense of specialty training positions given the specialty workforce shortages, to increase the number of primary care physicians available to Medicare beneficiaries.

We appreciate the opportunity to share our concerns. Should you have any questions, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society