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December 7, 2022

Michael E. Chernew, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: AMA Comments on MedPAC Policy Options for Primary Care Payments

Dear Dr. Chernew:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide the Medicare Payment Advisory Commission (MedPAC) with our input as you consider methods of improving payments for primary care.

During the November 3, 2022 meeting, MedPAC discussed two options for increasing Medicare payments to primary care clinicians:

- Creating two separate fee schedules, one for Evaluation and Management (E/M) services and one for other physician services. Under this concept, there would be separate conversion factors for each schedule, and changes to codes on one fee schedule would have no effect on payment rates in the other fee schedule.
- Creating a monthly per-beneficiary payment for primary care clinicians in addition to payments for services under the current fee schedule. The payment would be made for beneficiaries "attributed" to the practice and it might be risk-adjusted based on undefined factors.

The AMA supports improving Medicare payments in ways that would enable primary care physicians to provide high-quality care for their patients and financially sustain their practices while maintaining an appropriate work-life balance. We believe that MedPAC's analyses have overlooked some of the most significant problems impacting the primary care workforce and that the options discussed do not address the root causes of problems with Medicare's physician payment system. Specifically:

1. **The size of the primary care workforce is determined by how many practicing physicians retire or resign as well as how many new medical school graduates enter primary care.** The analysis presented by MedPAC staff implies that the only way to reverse the declining number of primary care physicians is to increase the number of medical school graduates who choose primary care instead of other specialties. However, we believe that the biggest near-term impact on the size of the physician workforce will likely be achieved by reducing the rate at which already-practicing physicians retire, resign, or reduce their hours.

- A report by the Association of American Medical Colleges , *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034*, estimates that the shortage of primary care physicians will be affected as much or more by when current physicians retire as by how many new physicians enter the workforce.
- More than 1 in 5 physicians say they will likely leave their practice within the next two years.

2. **The most serious problem facing the primary care workforce (and the physician workforce in general) is burnout, and the biggest cause of burnout is high administrative burden and long working hours, not the amount physicians are paid.** Two important ways to reduce burnout are to reduce the time and costs associated with excessive and inefficient prior authorizations and unnecessarily complex and burdensome quality reporting requirements.
   - Over 60 percent of physicians are experiencing burnout, the highest levels on record, and only 30 percent of physicians are satisfied with work-life integration. Primary care physicians have some of the highest rates of burnout and lowest levels of job satisfaction of any specialty.
   - Medscape's *National Physician Burnout & Suicide Report 2020* reported that the biggest causes of burnout are "too many bureaucratic tasks" and "spending too many hours at work," not "insufficient compensation." In fact, the report found that almost half of physicians would take a salary *reduction* in order to work fewer hours and that 9-18 percent of physicians would take a salary reduction of more than $50,000 in order to work 20 percent fewer hours.
   - Major causes of administrative burdens for physicians, particularly primary care physicians, are related to prior authorizations required by health plans and reporting of quality measures. For example, it has been estimated that participation in the Merit-Based Incentive Payment System (MIPS) costs physicians an average of more than $12,000 per year.

3. **Compensation differences between primary care physicians and specialists are affected as much or more by employment contracts and differences in commercial and Medicaid payment rates than by differences in Medicare payments.**
   - Although Medicare implemented substantial increases to E/M office visits in 2021 as recommended by the AMA/Specialty Society RVS Update Committee (RUC), primary care physicians may not yet see an increase in compensation due to terms in their employment contracts. The American Academy of Family Physicians found that employers anticipated that adopting the 2021 work relative value unit (RVU) increases for primary care would have been financially untenable while overall revenues were declining due to COVID-19, the reduced conversion factor, and other reasons. Instead of using the new RVUs, they may have continued using the RVUs in the prior year's fee schedule, or they may have adopted the new RVUs but adjusted other parts of the compensation formula, such as the conversion factor or base pay, to help alleviate the economic impact.
   - Studies have shown that commercial payments to specialty physicians are much higher compared to Medicare rates than payments to primary care physicians. An Urban Institute study found that commercial insurers paid family physicians 10 percent more than Medicare rates, while paying 50 percent more to orthopedic surgeons, 80 percent more for radiologists, and more than twice as much to neurosurgeons. A Congressional Budget Office survey of similar research found that commercial payments averaged 144 percent of Medicare payments for specialty services but only 117 percent of Medicare for primary care services. A study of the amounts commercial insurance plans pay for individual physician services found that average commercial insurance payments

for established patient office visits were 11 percent higher than Medicare payments, but payments for procedures such as knee arthroscopies and breast biopsies were twice as high as Medicare payments.

- Although Medicaid payment rates are lower than Medicare payments for most physician services, Medicaid payments for primary care physicians are 14 percent lower relative to Medicare than payments for specialists.
- MedPAC's 2010 study *What if All Physician Services Were Paid Under the Medicare Fee Schedule?* found that surgical specialties were paid 19 percent more than primary care physicians due to deviations from Medicare payment rates by all payers and radiologists were paid 23 percent more.

4. **Compensation differences between primary care physicians and specialists are also caused by the ability of hospitals to pay employed physicians more than they would earn through Medicare physician payments.** Hospitals can pay the physicians they employ using revenues not only from payments for the physicians' services, but also payments for the hospital services those physicians order or deliver, such as admissions, tests, and treatments.
   - A study by Merritt Hawkins found that cardiovascular surgeons, invasive cardiologists, neurosurgeons, and orthopedic surgeons generated an average of more than $3.3 million per year in net revenue for their affiliated hospitals from the services they perform or order, whereas family physicians only generated an average of only $2.1 million. If the hospitals return even a small portion of that differential to the physicians in their salaries, the difference in physician compensation would be significant.
   - Medicare payments to hospitals have increased by 60 percent in the past 20 years, compared to a 11 percent increase in Medicare payments for physician services. The increases in payments to hospitals have been greater than the rate of inflation, while the increases in payments to physicians have been far below inflation. The higher payments to hospitals give them greater ability to provide higher compensation to physicians than the physicians could earn on their own from Medicare payments.

5. **Both compensation and work-life balance for primary care physicians would be improved by making more primary care services eligible for payment and by providing annual increases in payment that match their increases in costs.**
   - Because Medicare has not paid primary care physicians at all for many of the activities required for good patient care, such as answering phone calls from patients, and coordinating care with other physicians, physicians have been forced to spend large amounts of time on activities that do not generate revenues. For example, although there have been Current Procedural Terminology (CPT®) codes and RVUs assigned to telephone calls for years, Medicare has only provided payments for these services since the Public Health Emergency began, and there are plans to terminate the payments in the near future. Increasing payments for traditional office visits would not address these gaps.
   - Despite widespread agreement that effective primary care should be delivered through a team consisting of physicians and other staff, Medicare payments are focused primarily on services delivered directly by physicians. Primary care physicians could work fewer hours in total and spend more time with the patients who need to see them if they could delegate more tasks to nurses and medical assistants and still receive Medicare payments for these services. Increasing

payments for traditional office visits would not address this problem. Although monthly per-beneficiary payments could be appropriate for supporting some types of primary care services, such as chronic condition management, paying an arbitrary amount each month for "attributed" patients regardless of the actual services delivered would create new administrative burdens and further distortions in payments.

- Medicare payments to physicians have declined by 20 percent relative to inflation over the past two decades. In 2023, every Medicare provider will be receiving payment updates except for physicians. Primary care physicians (and all other physicians) need to receive annual updates that cover the increased costs they incur.

6. **The RUC has made significant efforts to ensure that appropriate RVUs are assigned to the services that both primary care physicians and specialists deliver, although the Centers for Medicare & Medicaid Services (CMS) has not adopted all of these recommendations or has delayed in doing so.** As a result of the RUC's efforts, Medicare payments to primary care and internal medicine now represent almost half of Medicare physician payments (46 percent in 2020) compared to only 37 percent in 1991, whereas Medicare payments to surgical specialties decreased from 32 percent of total physician payments in 1991 to only 18 percent in 2020.

   - The RUC has recommended increases in E/M services each time that the primary care organizations and/or CMS have requested review. However, CMS did not fully implement the RUC recommended increases in E/M values in 1997, requiring the RUC to repeat these recommendations which were ultimately implemented in 2007. The most recent improvements in 2021 were implemented and led to more than $5 billion in redistribution from other services to E/M services. Since the inception of the Resource-Based Relative Value Scale (RBRVS), Medicare payment for a mid-level office visit (99213) has increased from $31 in 1992 to $92 in 2022. In comparison, payments for cataract surgery (66984) have decreased from $941 to $545 and payments for MRI of the lumbar spine (72148) have decreased from $485 to $208.

   - The RUC review of many preventive services has led to increased Medicare payments for preventive medicine. The most dramatic improvement, immunization administration (90471) payment, increased from less than $4 in 2002 to $17 in 2021, as a result of years of advocacy by the RUC and the AMA to ensure that the time and costs required to provide immunizations are recognized. The preventive medicine office visits were also considered under the 4th Five-Year Review of the RBRVS and CMS published the RUC recommendations to increase valuation by 15-20 percent on January 1, 2012.

   - In 2012, the CPT Editorial Panel developed new codes to describe Transitional Care Management (TCM) and Chronic Care Management (CCM) services to be reported for care coordination provided over a 30-day period. The RUC reviewed the physician work and practice costs associated with the provision of these services and submitted its recommendations to CMS the same year. CMS implemented the RUC recommendations for TCM payments in 2013, but it did not begin paying for CCM services until 2015. The RUC reviewed the TCM services in 2018 and recommended an increase due to a change in physician work required to perform these services. CMS did not implement the increase until 2020.

   - The RUC insisted that Medicare practice expense payments be determined based on consistent data collection efforts, leading to the AMA-led Physician Practice Information (PPI) Survey. The RUC support of this effort led CMS to begin implementation of these data in 2010. The RUC also took over responsibility for a failed CMS consultant effort to itemize direct practice expense inputs at the service level, ultimately leading to standardization and redistribution to primary care

services. The practice expense and professional liability insurance relative value units for E/M code 99213 have increased 324 percent since the inception of the RBRVS.

- In May 2008, the RUC submitted comprehensive recommendations to CMS regarding the resources required by primary care practices to provide medical home services. CMS, the American Academy of Family Physicians, and the American College of Physicians all expressed appreciation for the RUC's unanimous decision to submit robust recommendations for the physician work and practice costs required to serve as a medical home. However, the RUC recommendations were not implemented by CMS. Current medical home models pay monthly management rates well below the level that would reflect the resource costs identified by the RUC.
- In 2006, the RUC established the Five-Year Identification Workgroup (now referred to as the Relativity Assessment Workgroup) to identify potentially misvalued services using objective mechanisms for re-evaluation prior to the next Five-Year Review. The RUC's efforts have resulted in more than $5 billion in annual redistribution within the Medicare Physician Payment Schedule.

7. **The benefits of the increases in RVUs for E/M services have been diminished or neutralized by budget neutrality requirements. The serious problems caused by budget neutrality requirements would *not* be solved by creating two *separate* fee schedules; indeed, this could make the current problem *worse*. A more comprehensive solution is needed that addresses the root causes of the problem.**

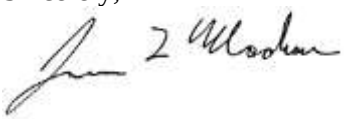
   - Under current budget neutrality rules, any increase in the existing payment for a primary care service or any newly created payment will result in cuts in the payments for other primary care services (as well as cuts to payments to other physicians), even if the higher payment or new payment would improve the quality of care or reduce spending on hospital services. Since most of the services delivered by primary care physicians are E/M services, creating a separate budget neutrality category for E/M services would not solve this problem and it could even make it worse.
   - An effective solution to the budget neutrality problem requires changes in the law, including: (1) exempting new, high-value services from budget neutrality requirements, (2) increasing the spending impact threshold that triggers budget neutrality adjustments, and (3) revising budget neutrality adjustments based on speculative and inaccurate estimates of service utilization by CMS.

8. **Creating separate conversion factors for different subsets of services would create greater distortions in payment rather than greater equity.**

   - The Medicare program used separate conversion factors for primary care services, surgical services, and other non-surgical services when the physician fee schedule was first created, but this created serious problems, and the Physician Payment Review Commission (one of MedPAC's predecessors) recommended eliminating separate conversion factors. Congress replaced the separate conversion factors with a single conversion factor in 1998.
   - Rather than pitting primary care physicians and specialists against each other, as separate conversion factors would do, the Medicare program should be supporting and encouraging coordination and collaboration among physicians by paying adequately for both primary care and specialty services that are delivered to the patients who need them.

We would be happy to work with you to develop effective ways to attract and retain primary care physicians and, more generally, to improve the ability of the Medicare program to support high-quality care for all patients. Please contact Margaret Garikes, Vice President of Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409 to let us know how we can help.

Sincerely,



James L. Madara, MD

cc: James E. Mathews, PhD
MedPAC Commissioners