

The Widening Primary Care-Specialty Income Gap

WHY??

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Median compensation, 1995-2004, MGMA data

In thousands of dollars

| | 1995 | 2004 | 10-yr increase |
|------------------------|------|------|----------------|
| All primary care | 133 | 162 | 21% |
| Family practice | 129 | 156 | 21%' |
| Internal medicine | 139 | 169 | 21% |
| All specialists | 216 | 297 | 38% |
| Invasive cardiology | 337 | 428 | 27% |
| Noninvasive cardiology | 239 | 352 | 47% |
| Dermatology | 177 | 309 | 75% |
| Gastroenterology | 210 | 369 | 76% |
| Heme/Oncology | 189 | 350 | 86% |
| Orthopedics | 302 | 397 | 31% |
| Radiology | 248 | 407 | 64% |
| Surgery, general | 217 | 283 | 30% |

Physician compensation, 2004

- **Who earned less than \$100,000?**
 - 17% of primary care physicians (almost all working full time)
- **Who earned over \$600,000?**
 - 20% of invasive cardiologists
 - 25% of neurosurgeons
 - 23% of plastic surgeons
 - 14% of orthopedists

Why the gap?

- **For decades, physician fee-for-service payment has been based on RVUs (relative value units). Each service has a code (e.g. 99213 for intermediate office visit), and each code has a value in relation to other codes. For example, 99213 might have a value of 1 and 99214 (extended office visit) might have a relative value of 2. If the fee for 99213 were \$50, then the fee for 99214 would be \$100.**
- **Historically relative values were skewed in favor of procedures; a surgery taking 1/2 hour might have 10 RVUs (\$500) compared with an office visit taking 1/2 hour that pays 2 RVUs (\$100).**

Why the gap?

- **Resource-Based Relative Value Scale (RBRVS) system was adopted by Medicare in 1991 and copied by many private insurers.**
- **Designed to lessen the historical disparity between office visits -- bread and butter of primary care – and procedures provided by specialists.**
- **Why, then is the primary care-specialist income gap becoming wider, not narrower?**

Why the gap?

- **5 reasons**
 - **#1: How RVUs are determined**
 - **#2: How RVUs are updated (the “RUC”)**
 - **#3: Volume**
 - **#4: Impact of private insurance**
 - **#5: Role of SGR**

#1: How RVUs are determined

- **2005 Medicare fee for CPT code 99214: 30 minute office visit (Evaluation & management -- E/M -- code)**
 - **Relative value unit (RVU): 2.18**
 - **Conversion factor: 37.9**
 - **Fee $2.18 \times 37.9 = \$82.62$ (Varies with location)**

- **2005 Medicare fee for CPT code 45378: colonoscopy (takes about 30 minutes)**
 - **RVU: 5.46**
 - **Conversion factor: 37.9**
 - **Fee $5.46 \times 37.9 = \$206.93$**

Why is the gastroenterologist paid 274% of the family physician's payment for 30 minutes of work?



#1: How RVUs are determined

- **3 factors go into the RVU**
 - **Work (about 50%)**
 - **Practice expense (about 45%)**
 - **Malpractice insurance costs (about 5%)**

#1: How RVUs are determined

- **Most of the difference between the office visit and the colonoscopy is in the work portion of the RVU**
- **Colonoscopy has a work portion of the RVU over 300 times that of the work portion of the office visit**

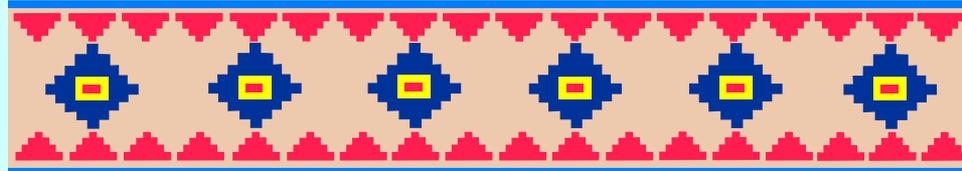
30 minutes does not = 30 minutes

- **The work portion of the RVU includes**
 - **Time**
 - **Intensity (amount of work per unit time)**
- **99214 Office visit vs. colonoscopy, time is the same. Intensity is much higher for colonoscopy**
 - **Even though a GI specialist has done 800 colonoscopies and can do them almost without thinking,**
 - **It is considered more intense than caring for an elderly patient with CHF, diabetes, depression and acute dizziness**

**Primary care physicians need
gastroenterologists
We/ gastroenterologists
But something is very wrong**



Gastroenterologists need primary care physicians, too



If PCPs didn't exist, GIs would be doing pap smears, management of hypertension, and smoking cessation counseling

#2: How RVUs are updated (the “RUC”)

- Medicare mandates that RVUs be updated every 5 years**
- CMS has delegated the update process to the Relative Value Update Committee (RUC)**
- The RUC is a committee of the AMA**
- It recommends RVU changes to CMS, which must approve them**

#2: How RVUs are updated (the “RUC”)

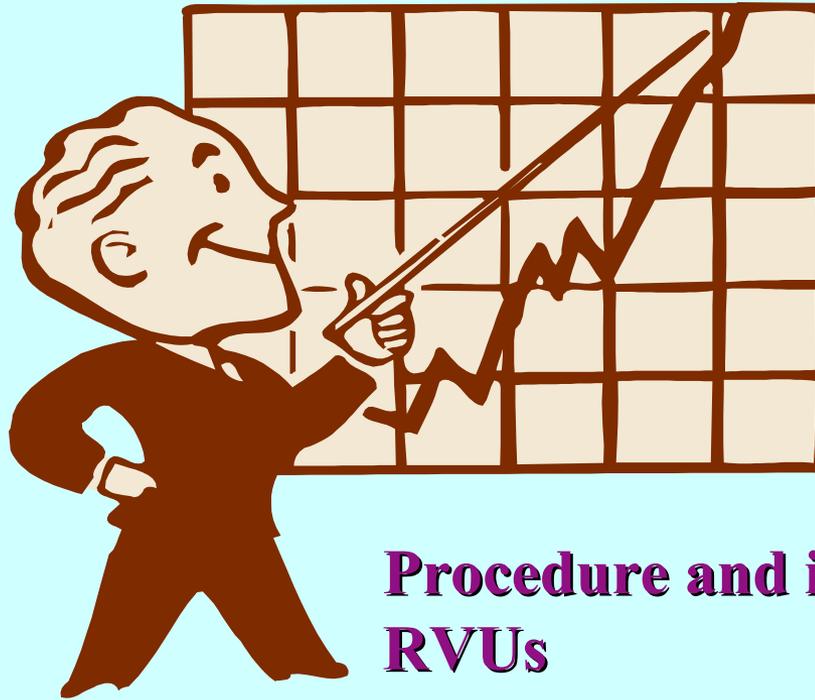
- **The RUC has 29 members, most named by specialty societies, including primary care specialties**
- **Even though PCPs provide about half of all Medicare visits, primary care has only 14% of the seats on the RUC**
- **Specialty societies request changes in RVU values; survey at least 30 of their members to find out if a certain service should receive a higher or lower RVU value**

#2: How RVUs are updated (the “RUC”)

- **If you are an ophthalmologist, and cataract surgery which used to take 50 minutes now takes 30 minutes, one might expect the RVU value should go down (and it did go down when RBRVS was put into effect)**
- **But if your specialty societies surveys you to ask what you think the cataract surgery RVU should be, are you going to say it should go down?**
- **Of course not. You recommend that the RVU go up**
- **How do you justify that?**
- **Since we do in 30 minutes what we used to do in 50 minutes, clearly each minute is more intense, so the work portion of the RVU should go up**

#2: How RVUs are updated (the “RUC”)

- This update method strongly biases toward increasing RVUs rather than decreasing RVUs.**
- The 86% of RUC members who are not primary care tend to vote together on RVU updates**
- In the 2000 update process, the RUC recommended 469 increases in RVUs and only 27 reductions**
- In the 2000 update process, E/M codes were not discussed at all. Procedure and imaging codes went up and office codes remained the same**
- CMS accepts virtually all RUC recommendations**



**Procedure and imaging
RVUs**

3: Volume

- **E/M visits make up 80% of primary care income**
- **E/M Medicare volume increased 15% 1999-2003**
- **Imaging Medicare volume increased by 45%**
- **Income = price (fee) x volume. Fee = \$300, you do 100 in a year, income = \$30,000. 150/year, \$45,000.**
- **Primary care physicians cannot do E/M visits in shorter time; it reduces quality and increases physician stress**
- **Specialists can do procedures in shorter time**
 - **Technology improves**
 - **The more you do a procedure, the faster you become**

**Increases in volume of Medicare services,
1999-2003**

| Type of service | Volume increase |
|--|------------------------|
| Evaluation and management services | 15% |
| Major surgery | 14% |
| “Other procedures” (chemotherapy, endoscopy, minor surgery) | 26% |
| Diagnostic tests | 36% |
| Imaging | 45% |

**Medicare payment to physicians. Statement of Glenn Hackbarth,
November 17, 2005. Medicare Payment Advisory Commission (MedPAC).**

www.medpac.gov

3: Volume

- **A major contributor to the widening income gap between primary care and specialties is volume of services delivered**
- **Many procedural specialists and physicians performing imaging services (mainly radiologists and cardiologists) had huge income gains by providing a higher volume of services**
- **In many cases this was possible because the services could be provided in less time**
- **Volume increased only slightly for primary care office visits. Visits cannot be done faster without reducing quality and physician/patient satisfaction (which drop with shorter visit times)**

#4: Impact of private insurance

- **For Medicare, the conversion factor is the same for all CPT codes (37.9 in 2006)**
- **Payment = RVU x conversion factor**
- **Big difference!! For many private insurers, the conversion factor varies**
- **Specialists often enjoy conversion factors higher than primary care conversion factors**

#4: Impact of private insurance

- **2002 survey of 34 large commercial insurance plans in different geographic regions (HMO, PPO, traditional insurance)**
- **On average**
 - **Office visits received** 104% of Medicare fee
 - **Surgery, dx procedures, imaging:** 120% of Medicare fee
- **In highest paid markets**
 - **Office visits:** 147% of Medicare fee
 - **Surgeries:** 330% of Medicare fee
 - **Dx procedures/imaging:** 250% of Medicare fee

Dyckman and Associates, Washington DC, August 2003

#4: Impact of private insurance

- **Another survey (2001):**
- **Private insurers paid**
 - **Office visits: 104% of Medicare fee**
 - **Procedures, imaging: 133% of Medicare fee**

Direct Research, LLC. Vienna, VA. August 2003

#4: Impact of private insurance

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 - **Fee $5.46 \times 37.9 = \$206.93$**
- **2005 private insurance fee for CPT code 45378: colonoscopy**
 - **RVU: 5.46**
 - **Conversion factor 45.5 (120% of Medicare)**
 - **Fee $5.46 \times 45.5 = \$248.43$**
- **Markets in which gastroenterologists are well organized: colonoscopy fee**
 - **RVU: 5.46**
 - **Conversion factor 75.8 (200% of Medicare)**
 - **Fee $5.46 \times 75.8 = \$413.87$**

#5: Role of the SGR

- **SGR = Sustained Growth Rate**
- **The total amount of money that Medicare pays physicians each year is based on a formula called the SGR**
- **Total Medicare physician payment rises based on number of Medicare beneficiaries, physician practice expense rise, and increase in gross domestic product**

#5: Role of the SGR

- **If the volume of Medicare physician services goes up faster than the SGR, then the conversion factor is reduced the following year**
- **Example: If SGR formula allows total Medicare physician payment to rise by 5% in 2005, but total Medicare physician payment rose 10% in 2005 due to increases in volume, then the conversion factor (and thereby physician fees) go down by 5% in 2006**
- **Remember how Medicare physician fees were supposed to fall by 4.4% in 2006 (until an act of Congress reversed it)? That was because of the SGR.**
- **The SGR hurts primary care the worst**

**Increases in volume of Medicare services,
1999-2003**

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These trends continued in 2004-2005

#5: Role of the SGR

- **Volume growth in procedures, diagnostic tests, and imaging are the reason why Medicare physician payments have exceeded the SGR limit. Growth in primary care office visits did not contribute to exceeding the SGR limit**
- **Even though primary care did not cause the excess Medicare physician payments, primary care physicians fees are reduced the same percentage as fees for physicians responsible for the volume growth in procedures, diagnostic tests, and imaging.**
- **While specialist income benefits from the volume growth, and primary care income does not, primary care fees are cut the same amount as specialist fees under the SGR.**

#5: Role of the SGR

- **The 2006 conversion factor is 1% below the 2001 conversion factor**
- **If the SGR formula is not changed, the conversion factor is expected to drop by 5% per year for the next 6 years**
- **Thus even though office visit will get a substantial increase from the 2005 RUC 5 year update process, that increase will be eroded by reductions in the conversion factor**

Summarizing the income gap

- **Unequal payment for equal time benefits procedural specialists**
- **Many procedure RVUs have increased in the RUC's 5 year reviews, but primary care RVUs did not increase 1995 - 2006**
- **Rapid growth in volume of procedures and imaging has increased some specialist incomes**
- **Private insurers tend to pay specialists at a higher percent of the Medicare fee than they pay primary care physicians**
- **Under the SGR system, Medicare physician payments are excessive because of procedure, testing, & imaging volume growth,; primary care physicians are penalized even though they did not contribute to the volume growth**

Primary care 2006



What should we do??

- **Medicare Payment Advisory Commission (MedPAC): March '06 report to Congress:**
 - **Alter SGR system so it does not penalize primary care**
 - **CMS should send overvalued codes to the RUC to have RVU values reduced. Currently, most RUC recommendations are to increase RVUs**
 - **Change RUC composition: more primary care**

What should we do??

- **American College of Physicians**
 - **Increase office visit RVUs substantially**
 - **Pay for phone and e-mail encounters**
 - **Make a payment for coordinating care for patients with complex chronic conditions**
 - **Substantial pay for performance dollars**
 - **Revise SGR formula so it does not penalize primary care**

The Impending Collapse of Primary Care Medicine, January 30, 2006
www.acponline.org/hpp/statehc06.htm

What should we do??

- **American Academy of Family Physicians**
 - **Repeal SGR. Medicare payments should increase based on cost of providing care**
 - **Pay for performance**
 - **Do not pay for services that are unnecessary, ineffective or redundant**
 - **Reimburse physicians for time and effort spent in coordinating care for patients as a per month, per patient payment on top of fee-for-service**

**Testimony to House of Representatives, November 17, 2005.
www.aafp.org/x659.xml**

All these suggestions are a great start toward rescuing primary care



❖ Is it time for a coalition of primary care professionals and organizations to agree on a concrete proposal?

and

Persuade government and private payers to adopt it?

**Rescue
Primary
Care**

