

COMMENT AND RESPONSE

The Primary Care–Specialty Income Gap

TO THE EDITOR: I read with interest Bodenheimer and colleagues' recent article (1). I am compelled to correct a number of statements within the article and to set the record straight regarding the American Medical Association (AMA) Specialty Society Relative Value Scale Update Committee (RUC) and its role in updating the Resource-Based Relative Value Scale (RBRVS). I hope to provide a balanced perspective of this important committee and its efforts to represent *all* physicians.

The Medicare RBRVS is designed to pay physician services relative to the resources (physician work, practice expense, and professional liability insurance) required to provide the service. The authors state that the RBRVS was designed to "lessen the fee disparity between office visits . . . and procedures provided by specialists" (1). Although this was not specifically stated by policymakers, conventional wisdom was that the RBRVS would redistribute payments to evaluation and management (E&M) services. In fact, the RBRVS has continued to redistribute to E&M services, as shown by the service changes in the **Table**.

Bodenheimer and colleagues assert that gastroenterologists are paid more than primary care physicians for similar work effort. In fact, the Medicare payment system precludes specialty pay differentials. A primary care physician is paid the same as a gastroenterologist or any other specialist for the same service, whether an office visit or a colonoscopy. The relative valuation is higher for a colonoscopy than for an office visit, as one would expect because the colonoscopy requires greater resources. The authors are incorrect in asserting that the colonoscopy is of similar duration as an office visit. Data published on the Centers for Medicare & Medicaid Services (CMS) Web site lists the total time for Current Procedural Terminology (CPT) codes 45378 and 99214 as 75 and 40 minutes, respectively (2). The intensity of the colonoscopy is also higher.

Medicare did not agree to "allow" the AMA to create the RUC. The AMA and national specialty societies chose to exercise their First Amendment right to petition the government. Organized medicine created the RUC to serve *all* physicians in submitting recommendations to CMS to improve the RBRVS. The CMS is the final decision maker, choosing to reject or adopt only a portion of the RUC recommendations, as they did when the RUC's recommended increases to E&M services were not approved in 1997.

Bodenheimer and colleagues incorrectly state that the Medicare Payment Advisory Commission (MedPAC) criticized the RUC survey process. It has never publicly critiqued the RUC methods used to

develop relative values. Rather, MedPAC voiced concern that the CMS and the medical community had not identified services that may be overvalued. The RUC has responded directly to this MedPAC concern by creating a Five-Year Review Identification Workgroup, which has already obtained data that will help identify issues to be addressed in future reviews.

The RUC also continues to recommend improvements in practice expense and professional liability insurance valuation, which half of the payment system comprises. The RUC has repeatedly called on the CMS to address equipment utilization and other flaws in the practice expense formula that would positively impact payment for E&M services.

Although the CMS ultimately rejected the recommendation, the RUC strongly advocated substantial E&M service increases in the 1997 Five-Year Review. The decision not to request review of E&M services in 2002 was made by specialty societies representing primary care—*not* the RUC. These societies submitted comments in the most recent review. The RUC engaged in an intense review over 14 months (not 6 months, as Bodenheimer and colleagues state), convening 5 face-to-face meetings (not 2 meetings, as the authors state) and several conference calls. Volunteer physicians from several specialties contributed substantial personal time for this review.

The review was contentious and deliberative. The socioeconomic experts who serve on the RUC are intelligent physicians who understand that their recommendations affect the entire community of health professionals. All physicians should have expected that the debate and consideration of E&M services valuation would be serious and intense. In the end, the RUC recommended significant increases to E&M services, which were implemented by the CMS on 1 January 2007. These permanent increases result in an additional \$4.5 billion in E&M services payments each year! To imply that they are small and insignificant is preposterous. Family physicians may see their overall Medicare payment increase by 5% or more. A document on the American College of Physicians' Web site states: "ACP estimates that internists will typically see an increase of \$5 000 to \$10 000 in total Medicare allowable charges" (3).

The increases to E&M services came at a price. The RBRVS is a "budget-neutral" system, allowing for improvements in valuation for services but requiring an adjustment across the entire system to compensate for these improvements. These offsets are normally applied to the conversion factor, which is transparent and affects all health care professionals similarly. Despite protests from the RUC and most medical specialties, CMS chose instead to address budget neutrality through a "work adjuster," affecting physicians who receive a greater proportion of their payment from their own personal work effort. Bodenheimer and colleagues would have served their primary care constituents better by highlighting the short-sighted CMS decision to change the budget neutrality methods.

Table. Fifteen-Year Resource-Based Relative Value Scale Impact*

Service	CPT Code	1992 RVU	2007 RVU	Change, %
Colonoscopy	45378	8.48	5.56	−34.43
Cataract	66984	30.34	17.99	−40.71
Chest radiography	71020–26	0.34	0.30	−11.76
Office visit, level 3	99213	1.00	1.66	66.00
Office visit, level 4	99214	1.52	2.52	65.79

* CPT = Current Procedural Terminology; RVU = relative value unit.

Physicians must remain focused and work together to eliminate the flawed sustainable growth rate formula and declining Medicare payments so that physicians have the resources to address the care of chronically ill elderly persons.

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Potential Financial Conflicts of Interest: Dr. Rich is the Chairman of the American Medical Association Specialty Society Relative Value Scale Update Committee.

References

1. Bodenheimer T, Berenson RA, Rudolf P. The primary care-specialty income gap: why it matters. *Ann Intern Med.* 2007;146:301-6. [PMID: 17310054]
2. Centers for Medicare & Medicaid Services. Physician time files. Accessed at www.cms.hhs.gov/apps/ama/license.asp?file=/physicianfeesched/downloads/phy_time_file.zip on 7 May 2007.
3. American College of Physicians Practice Management Center. What internists need to know about medicare changes 2007. Accessed at www.acponline.org/private/pmc/medchg07.pdf on 7 May 2007.

IN RESPONSE: We are glad that Dr. Rich has entered into a dialogue about the RUC's role in the multifactorial causation of the primary care-specialty income gap. He is correct that relative value units (RVUs) for E&M services have increased while values for some procedural codes have decreased. However, in its 2007 report to Congress, MedPAC states (1): "The three five-year [RUC] reviews, completed in 1996, 2001, and 2006, led to substantially more recommendations for increases than decreases in the relative values of services, even though many services are likely to become overvalued."

The RUC's method for estimating procedure times—a key factor in determining RVU values—is flawed and overvalues many procedural services. Dr. Rich cites the CMS Web site as indicating that the total time for diagnostic colonoscopy is 70 minutes; however, this is actually based on RUC estimates. The RUC has also estimated intraservice colonoscopy time at 30 minutes. Yet, a recent *New England Journal of Medicine* article found that the average diagnostic colonoscopy intraservice time is 13.5 minutes (2). These findings mirror a study of operative logs for 60 procedures, demonstrating that actual procedure times were, on average, 31 minutes shorter than the RUC's time estimates on which RVU values are based. The RUC overestimated time spent on several procedures by more than 60 minutes (3). The RUC and CMS should consider using objective data rather than physician-generated estimates to determine procedure times.

Our main concern, and we hope Dr. Rich agrees, is the impact of the primary care-specialty income gap on medical student career choices. If the pipeline into primary care continues to dry up, the decline of primary care will be a catastrophe for everyone, including specialists. Thus, we need to look at the bottom line: dollars. In 2007, a colonoscopy pays \$196.69, where as a CPT code 99214 office visit pays \$90.20 (amounts vary by location), even though the times spent are similar and—we would argue—the complex office visit has higher intensity. Moreover, colonoscopies require fewer rather than more resources because they are generally done in a

facility in which the physician is not paying overhead costs for personnel and equipment.

Ultimately, we must consider a fundamental change in physician payment, moving from a fee-for-service system toward a blended payment system that rewards high-quality, team-based primary care practices that are adequately compensated for the challenge of managing an aging population with multiple chronic conditions (4).

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References

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2. Barclay RL, Vicari JJ, Doughty AS, Johanson JF, Greenlaw RL. Colonoscopic withdrawal times and adenoma detection during screening colonoscopy. *N Engl J Med.* 2006;355:2533-41. [PMID: 17167136]
3. McCall N, Cromwell J, Braun P. Validation of physician survey estimates of surgical time using operating room logs. *Med Care Res Rev.* 2006;63:764-77. [PMID: 17099125]
4. Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. *J Gen Intern Med.* 2007;22:410-5. [PMID: 17356977]

CORRECTION

Correction: The Effect of Adding Exenatide to a Thiazolidinedione in Suboptimally Controlled Type 2 Diabetes

The recent article on the effect of adding exenatide to a thiazolidinedione in patients with suboptimally controlled type 2 diabetes (1) contained some errors. In the Adverse Events and Follow-up section, the last sentence of the first paragraph should have read: "The investigator assessed the severity of each adverse event (mild, moderate, or severe)." In the Adverse Events section, the sentence on incidence of nausea was misinterpreted. It should have read: "Nausea was mostly mild (21 [44%] exenatide recipients *who experienced nausea*) or moderate (19 [40%] exenatide recipients *who experienced nausea*) and intermittent." Similarly, the sentence about incidence of vomiting in that same section should have read: "Vomiting was mostly mild (5 [31%] exenatide recipients *who experienced vomiting*) or moderate (10 [63%] exenatide recipients *who experienced vomiting*)."

Reference

1. Zinman B, Hoogwerf BJ, Durán García S, Milton DR, Giaconia JM, Kim DD, et al. The effect of adding exenatide to a thiazolidinedione in suboptimally controlled type 2 diabetes: a randomized trial. *Ann Intern Med.* 2007;146:477-85. [PMID: 17404349]