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A Posit Question on Doctors' Pay

BACKGROUND: On August 12, 2011, the American Academy of Family Physicians announced “a lawsuit filed by six primary care physicians in Georgia that seeks to terminate the current relationship between CMS and the AMA/Specialty Society Relative Value Scale Update Committee, or RUC, as a step toward achieving a more equitable payment system that accurately reflects the value of primary care physician services.” Website: <http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20110812ruclawsuit.html>

Currently, the RUC has 29 members, 23 of whom come from medical specialty societies, and acts as an expert panel making recommendations on the relative values of various CPT codes. The panel deliberates behind closed doors with little transparency. Over the last 20 years, CMS has accepted 94 percent of the RUC’s recommendations. [Reference: see Dr. George Meyer’s article in the Sept/Oct *SSVM*.] The lawsuit seeks to have the RUC declared a Federal Advisory Committee, which would force officials to open up the RUC’s proceedings and records to the public. In addition, the lawsuit attempts to stop the implementation of the 2012 Physician Fee Schedule, claiming it discriminates against primary care services.

POSIT: “Do you think specialty services are overvalued relative to primary care services?”

Responses: Yes, 52 / No, 13. Seventeen comments follow:

A sharper dichotomy would be between compensation for thinking and compensation for doing. Thinking/reasoning/educating are vastly undervalued. And so long as CMS disproportionately rewards the performance of procedures, they will be done in excess, continuing to drive up the cost of healthcare for everyone. — **Howard Slyter, MD**

The problem is not if specialty or primary care is over or underpaid. The issue is providers are underpaid and the RUC is a mechanism to balance a budget. The AMA represents only about 35 percent of physicians, and I do not feel they really represent the other 65 percent. The goals of transparency and representation are laudable! — **J. Dale Smith, MD**

Value should be based on number of years of training, degree of expertise, experience, and other agreed-upon criteria. — **Alton Curtis, MD**

There is no question that primary care physicians are severely undervalued relative to specialists and that the RVRBS is directly contributing to the demise of primary care, especially internal medicine. The US will soon face a future without internal medicine physicians. Meanwhile, in many areas in the US, specialists now earn *ten* times what primary care physicians earn. The PPRC and the RBRVS were supposed to correct this inequity. Instead it has made it much worse. — **Michael Patmas, MD**

...both services are undervalued and [the] system should be more transparent. — **William Bommer, MD**

I would say that preventative care and the medical management of conditions is grossly undervalued. Procedures are definitely overvalued. Procedures lead to money. Counseling and discussion and advice lead to little money. I think that primary care needs to be rewarded more than it is today; by how much I can't say. Since there is a finite amount of money available, if one area has increased reimbursement, another area has to suffer decreased reimbursement. ... Society has to decide whether primary care is of greater importance/value than tertiary care. Society hasn't done this. Based on reimbursement rates, the government and the medical profession have already done so. They obviously feel that tertiary care is of greater importance than primary care. A total hip is of greater value than managing hypertension, etc. I should state that I'm a primary care (pediatrician) physician. — **Maynard Johnston, MD**

The most critical problem is that there is no mechanism for routinely reassessing how many minutes of physician effort are necessary to provide a specific service, and thereby routinely re-evaluating the RVUs assigned to that service. Many specialty services, such as CT scans and colonoscopies, are overcompensated simply because physician productivity has improved and a productive physician can provide the same (or better) service in less time than was necessary a decade ago. We need a transparent and equitable process that routinely captures these gains in efficiency and productivity, for the benefit of the entire economy. Thanks to barriers to entry, ineffective competition, asymmetric information, and regulated pricing (in which the RUC plays a major role), health care is virtually the only sector of the economy in which improved efficiency and productivity do not lead to lower prices. — **Patrick Romano, MD, MPH**

I would also like to see Psychiatry and OBGYN acknowledged as primary care. — **Christopher White, MS I**

Taking away money from specialists will not help primary care; better to get more money overall for medicine. — **Christian Serdahl, MD**

"Equitable"?!? Let's be honest. This is just one specialty desiring a larger slice of a pie (that *was* initially cut unfairly with FP's initial approval) that is quickly shrinking. — **John Tucker, MD**

Why is this controversial? It is a fact that in countries where there is no great disparity between what surgeons and family practitioners earn, such as Russia, – surprise! – there are more female surgeons than male, and no shortage of family practitioners. You cannot blame our smarter medical students when they see the longer hours, lower earnings and greater difficulty in keeping up-to-date, why they eschew family practice – that's why they're smarter! — **Geoffrey Woo-Ming, MD**

CMS, under Congressional approval, should allow primary care physicians to have their own global budget for Medicare fees, apart from the budget for all other physicians, thereby dividing the SGR calculation into two segments. Using this approach, Medicare should establish parity reimbursement for PCPs compared with the weighted average reimbursement of all other specialties combined. Primary care medicine will not flourish without parity reimbursement. — **Gerald Rogan, MD**

Particularly for surgical services, because the payment is “global” and all post-operative care is included, the per-hour rate I believe is lower than for office-based services. Plus we have the onus in plastic surgery of having to “prove” medical necessity practically each and every time, so that payment is delayed by “appeals,” which increases cost and further dilutes reimbursement. — **Debra Johnson, MD**

But no matter what the change for the better or worse, [it's] too late for us doctors in [our] late 50s and beyond. — **Pau Fong, MD**

I'm embarrassed about how little my Internist gets paid from my insurance which is Medicare. — **Peter Carruth, MD**

The highest value health care systems, when thought of as a pyramid, invest in the base, [consisting of] a strong primary care system focused on wellness and prevention. Our pyramid is upside down, where high-cost, technologically-advanced, illness-centric services predominate; changing the RUC is a promising step to right that pyramid. — **Adam Dougherty, MSII**

The problem is not the relative value; the problem is that all reimbursement is too low and is decreasing. As a retired medical provider who is now a Medicare consumer, I am seeing reimbursement drop from 1/3 of billing to 1/5 of billing. I also hear from friends that care is becoming more difficult to obtain (*e.g.* the Mayo Clinic is not accepting Medicare patients). People value the outstanding medical care that is available in our country. Lawsuits and a major publicity campaign need to focus on increased reimbursement for all practicing physicians. Infighting for shrinking dollars is self-defeating. Are we divided and conquered? Or not? We do have a choice. — **Richard Park, MD**

Posits are simplistic one sided statements intended to promote discussion among members. Therefore your comments are particularly relevant. Results do not constitute valid polling data and may not reflect the position of the Editorial Committee, or SSVMS Board of Directors.

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