Summary

AAN and Cognitive Specialty Coalition efforts to address the disparity in payment systems for cognitive non-procedural physician work

June 2010: Congressman Perlmutter, at the AAN’s request, sent a letter to the chair of the Medicare Payment Advisory Commission (MedPAC) asking them to develop ways to better incent the coordination and management of patients with chronic conditions.

Perlmutter Letter to MedPAC

October 2010: Congressional and patient organizations sent letters to Speaker Pelosi calling for a legislative fix to include neurology as an eligible specialty for the E/M incentive.

Letters to Speaker Pelosi

November 2010: MedPAC held a discussion on physician payment adequacy, specifically within the context of a DRAFT physician payment update recommendation for 2012. Dr. Robert Berenson, the commission’s vice-chair, underscored the need not only to focus on incentives for primary care but also to begin looking at payment adequacy for “cognitive specialties.” Members of the cognitive specialties sent letters to MedPAC reinforcing the issue raised by Dr. Berenson.

IDSA Letter to MedPAC

December 20, 2010, AAN Letter to MedPAC

January 2011: The AAN and members of the Cognitive Specialty Coalition (AAN, IDSA, Neuro-ophthalmology, Rheumatology, two Endocrine Societies) coordinated a joint appearance and testimony at the MedPAC meeting on January 13-14. Dr. Peter Donofrio and AAN staff represented the Academy. Several congressional meetings also were conducted during the two days to address the result of the elimination of the consult codes and the payment disparities.

March, 2011: The Cognitive Specialty Coalition requested a meeting with MedPAC staff in follow-up to the January meeting. Dr. Raphaelson and staff represented the AAN. All members provided data and information to MedPAC staff. Following the meeting, the AAN sent MedPAC staff a draft of the Work Intensity Study and information on E/M coding requirements.

March 1, 2011: 129 advocates from 42 states and the District of Columbia attended Neurology on the Hill. Participants asked Congress to help preserve patients’ access to neurologists by incentivizing cognitive care through various proposals including neurology as an eligible specialty in the Patient Protection and Affordable Care Act’s E/M bonus.

Neurology on the Hill Document
March 16, 2011: Senator Klobuchar introduced a bill to amend the Social Security Act to include neurologists as an eligible specialty to receive incentive payments for primary care services (E/M bonus) under the Medicare program.

**Sen. Klobuchar Legislation**

April, 2011: At the request of the House of Representative Energy and Commerce Committee, the AAN submitted a letter highlighting the payment disparity and offered several alternatives to the committee to replace the SGR.

**April 27, 2011, AAN letter to House Energy and Commerce Committee**

May, 2011: CMS released data on the impact of the elimination of the consult codes. After consultation with MEM and AAN leadership, a plan was drafted to focus efforts on the payment disparity of cognitive vs. procedural physician work.

The AAN and Rheumatology jointly met with Dr. Jonathon Blum, CMS Director of the Center for Medicare Management. Dr. Raphaelson and staff represented the AAN.

**Pre-meeting Issues Brief Sent to Dr. Blum**

**Summary of Blum Meeting**

**Follow-up Letter to Dr. Blum from the AAN and ACR**

June, 2011- AAN emailed a letter from Dr. Sigsbee informing membership that better reimbursement for cognitive work is the Academy’s top priority.

**Dr. Sigsbee Membership Email**

A conference call was held with AAN members and leadership to discuss specific recommendations on alternatives to the SGR.

AAN efforts were rewarded as MedPAC released its June report and included language urging realignment of payments to help ensure an adequate supply of cognitive specialists.

**MedPAC Excerpt**

**Cognitive Specialty Coalition Press Release**

**MedPAC Letter from Coalition**

Congressman Grimm introduced the PATH Act that includes a provision requested by the AAN to authorize the HHS Secretary to add specialties as eligible for the primary care bonus.

**The PATH Act**
August, 2011: A meeting of the Cognitive Specialty Coalition was held in Washington, DC, on August 10 to discuss a joint strategy, developed by AAN staff, for messaging to Congress and other policymakers.

Cognitive Specialty Coalition Document for August 10 Meeting

Summary of August 10 Coalition Meeting

Additional Actions:

- Since January 1, 2011, the AAN’s Washington lobbyists have had 157 separate visits with members of Congress or their staffs on the issue of consult codes, adding neurology to the E/M incentive, or the issue of recognizing cognitive care.
- CHP staff asked Dr. Gary Gronseth to conduct a new literature review of any new published research that demonstrates the value of neurologists.

Evidence of High Quality and Cost-Efficient Neurologic Care

- CHP staff continues to collect data and research to support our advocacy efforts.

Workforce Data

Compelling Statistics
Chairman Glenn M. Hackbarth
MedPAC
601 New Jersey Avenue NW
Suite 9000
Washington, DC 20001

Dear Chairman Hackbarth:

With the passage of healthcare reform, Congress has created incentives designed to overcome some of the undervaluation of evaluation and management (E/M) services in the physician fee schedule. Section 5501 of HR 3590 lists eligible physicians and sets a 60 percent threshold of Medicare charges required under E/M codes. Section 1202 of the Health Care and Education Reconciliation Act of 2010, HR 4872 will substantially increase Medicaid payments for primary care services.

I appreciate the Commission’s recommendations on these issues and hope it will increase the availability of E/M services provided to our Medicare and Medicaid beneficiaries.

As Congress considers incentivizing primary care services, I believe their principal physician should be incentivized to spend more time with patients in face-to-face visits. That may be a primary care physician, but for many with chronic conditions patients, such as my daughter who has epilepsy, a specialist provides the principal care. As an example, neurologists perform significant amounts of face-to-face E/M services (diagnosis, treatment and ongoing management) for high-cost Medicare beneficiaries with complex chronic neurological diseases such as Alzheimer’s, Parkinson’s, multiple sclerosis, and epilepsy. They often act as principal care provider. However, language in both HR 3590 and HR 4872, neurologists are not eligible for these incentives.

I would like to request a recommendation from MedPAC on ways to improve direct care by focusing on E/M services or other incentives for coordinating care for those with chronic conditions. Patients who rely on physicians, such as a neurologist, as their primary care physician depend on their valuable services. Please feel free to contact my staff Jose Rodriguez (202) 225-2645 or email jose.rodriguez2@mail.house.gov if you should have any further questions.

Sincerely,

[Signature]

Ed Perlmutter
Member of Congress
The Hon. Nancy Pelosi
Speaker of the House
H-232 The Capitol
Washington, DC 20515

October 5, 2010

Dear Mdm. Speaker:

With the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, Congress has created incentives designed to overcome some of the undervaluation of evaluation and management (E/M) services in the physician fee schedule. If successful, the incentives will encourage physicians to spend face-to-face time administering the diagnosis, treatment and ongoing management of a patient’s care.

Primary care physicians will benefit from this incentive. However, it appears from the language in HR 3590 that, in certain situations, another group of physicians who provide significant amounts of this care, neurologists, are not eligible.

HR 3590 creates a 10 percent bonus for listed physicians if an individual physician bills more than 60 percent of all of their charges to certain E/M codes. The average neurologist is over 60 percent. However, neurology is not listed.

This oversight leaves out the physician who provides care coordination and management for patients with specialized, expensive diseases, such as Alzheimer’s disease, Parkinson’s disease, multiple sclerosis and epilepsy.

Neurologists bring specified experience in neurologic illness to these patients and frequently take responsibility for the entirety of a patient’s care. For instance, patients with Alzheimer’s disease often rely on their neurologist to coordinate their care, addressing non-neurologic problems and communicating with other care providers. This type of care is billed under the E/M codes that HR 3590 stipulates for the bonus and incentivizes physicians whose practices rely heavily on E/M.

As you’ll see in an attached letter, this is a concern to many groups representing millions of patients who rely on neurologists.

We believe this oversight should be corrected as soon as possible in a manner where any costs associated are paid for without transferring or reducing resources from those already included in the primary care incentives. We encourage you to find an appropriate legislative vehicle in 111th Congress. We look forward to working with you to identify the proper policy and offsets to address this issue.

Sincerely,

Michael C. Burgess, M.D.
Member of Congress

Russ Carnahan
Member of Congress
Barney Frank
Member of Congress

Gabrielle Giffords
Member of Congress

Jesse L. Jackson, Jr.
Member of Congress

Parker Griffith, M.D.
Member of Congress

John Sullivan
Member of Congress

Alcee L. Hastings
Member of Congress
October 1, 2010

The Honorable Nancy Pelosi
Speaker of the House
H-232 The Capitol
Washington, DC 20515

Dear Madam Speaker:

On behalf of the millions of Americans and caregivers affected by neurological conditions, the undersigned organizations request your support for legislation that will correct an error in the Patient Protection and Affordable Care Act. This oversight led to the omission of neurology from the list of specialties eligible to receive the Medicare payment incentives under HR 3590 and increased Medicaid rates in the Reconciliation bill, HR 4872.

We are concerned the omission of neurologists from these provisions will affect access to care for patients with neurologic diseases like ALS, Alzheimer's, epilepsy, headache, multiple sclerosis (MS), Parkinson's disease, peripheral neuropathy, traumatic brain injury (TBI), and stroke.

The Patient Protection and Affordable Care Act provides a bonus to physicians who: (i) specialize in family medicine, internal medicine, geriatric medicine; and (ii) have allowed charges for evaluation and management services that account for at least 60 percent of the physician's or practitioner's total allowed charges. In both the Affordable Care Act and the reconciliation bill, neurology is the only group of physicians who are responsible for coordinating overall patient care that are left out of the incentive.

We applaud Congress' steps to bolster family and internal medicine, but hope that this oversight of neurology could be remedied for patients who expect health care reform to fully support primary care, which for our patients is provided by their neurologist.

Neurologists provide specialized, coordinated life-long care for some of the most costly diseases such as Alzheimer's disease and stroke. Many other prevalent neurological diseases such as ALS, epilepsy, headache, MS, peripheral neuropathy, Parkinson's disease, and TBI, especially in seniors and children, are best cared for by trained neurologists.

Neurology practices are heavily focused on patient evaluation, management and coordination of care. In fact, on average, neurologists bill 61-percent of their services as described in the second criteria leaving neurology as the only specialty that routinely coordinates care for patients that is not eligible for these incentives.

One intent of the health care reform effort is to improve access to primary care services. For Medicare and Medicaid patients like ours this would not be realized by excluding neurology. This is a critical issue to our members and stands to affect the future care of patients with complex neurological conditions. Singling out neurologists as ineligible could have long-lasting ramifications for people with neurologic
conditions, and leaves these patients in danger of losing care by a profession that is already facing reduced supply and increased demand.

Please ask your constituents with neurological disease who they consider their primary care physician to be for the management and care coordination of their neurological condition. We expect that you will hear overwhelmingly that the answer will be their neurologist. Please let us know what we can do to work with you to add neurology to the list of specialties eligible for these incentives before access to care for patients is compromised.

Sincerely

Alliance for Headache Disorders Advocacy
ALS Association
Alzheimer’s Foundation
American Association of Neurorehabilitation
American Brain Coalition
American Headache Society
Benign Essential Blepharospasm Research Foundation
Brain Injury Association of America
Epilepsy Foundation
International Dravet Epilepsy Action League
International Essential Tremor Foundation
Multiple Sclerosis Association of America
Muscular Dystrophy Association
National Ataxia Foundation
National Multiple Sclerosis Society
Neuropathy Association
Parkinson’s Action Network
Spinal Muscular Atrophy Foundation
Sturge-Weber Foundation
Tremor Action Network
United Spinal Association
December 10, 2010

Glenn M. Hackbarth, J.D.
Chairman
MedPAC
601 New Jersey Avenue, NW
Suite 9000
Washington, DC 20001

Re: December 2nd MedPAC Discussion—Physician Payment Adequacy

Mr. Hackbarth:

I am writing on behalf of the Infectious Diseases Society of America (IDSA) in response to the Medicare Payment Advisory Commission’s (MedPAC) recent discussion concerning physician payment adequacy within the context of the 2012 payment update recommendation.

IDSA represents more than 9,300 physicians and scientists devoted to patient care, education, research, and community health planning in infectious diseases (ID). The Society’s members focus on the epidemiology, diagnosis, investigation, prevention and treatment of infectious diseases in the United States and abroad. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, surgical infections, those with cancer or transplants who have life-threatening infections caused by unusual or drug-resistant microorganisms and new and emerging infections, such as severe acute respiratory syndrome (SARS) and H1N1 influenza.

At the December 2nd MedPAC Meeting, Dr. Robert Berenson underscored the need not only to focus on incentives for primary care but also to begin looking at payment adequacy for “cognitive specialties.” Psychiatry and Neuro-Ophthalmology were singled out as two cognitive specialties in which low Medicare payments for Evaluation and Management Services (E&M) relative to procedures are causing challenges. However, these should by no means be thought of as the only cognitive specialties facing such challenges: Infectious Diseases, Endocrinology, Rheumatology, and Neurology are all in similar situations. It is no coincidence that these are the same specialties that have been adamantly opposed to Medicare’s decision to eliminate payments for the consultation service codes, a decision which is gradually being adopted by private payers as well.

Infectious Diseases is almost a purely cognitive specialty. According to a 2007 analysis conducted by the American Medical Association’s (AMA) Relative Value

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1 Specialty Request to Reinstate Consultation Codes. Sign-on Letter to Congress. October 5, 2010
Update Committee (RUC), ID physicians bill a higher proportion of E&M services (92%) than do general internists (82%) and family practitioners (85%).\textsuperscript{2} ID only lags behind Psychiatry and Geriatric Medicine in the percentage of its charges which are comprised of E&M services. The RUC’s findings are corroborated by a more recent analysis published in the Archives of Internal Medicine which revealed that ID physicians’ mean hourly wage was $66.26, above family practice and internal medicine but notably below psychiatry and most other “cognitive specialties.”\textsuperscript{3}

Continued access to ID physicians and other “cognitive specialists,” who have been severely impacted by the elimination of payments for consultations\textsuperscript{4} and by the persistent undervaluation of cognitive services in the current fee-for-service payment system, will depend on the ability of Accountable Care Organizations and on innovative payment models to incentivize a broader spectrum of activities than strictly those that involve direct patient care. **IDSA urges MedPAC to dig deeper into the data from its patient access survey to not only assess Medicare beneficiaries’ access to primary care physicians compared to all specialists but also to draw a distinction between cognitive and procedural specialties.**

IDSA clinical leaders and staff would be interested in further discussing the payment challenges of “cognitive specialties” with MedPAC officials. Perhaps as a starting point, the aforementioned specialties could jointly meet with MedPAC at the beginning of next year. If there is interest in such an idea, IDSA would be happy to take the lead in arranging a meeting. Please contact Jason A. Scull, IDSA’s Program Officer for Clinical Affairs, at jscull@idsociety.org or phone at 703-299-5146 with any questions or concerns.

Sincerely,

James Hughes, MD, FIDSA
President, IDSA

cc:
Robert Berenson, MD
Vice-Chair, MedPAC

Mark Miller
Executive Director, MedPAC

Chrisitina Boccuti
MedPAC

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December 20, 2010

Glenn M. Hackbarth, J.D.
Chairman
MedPAC
601 New Jersey Avenue, NW
Suite 9000
Washington, DC 20001

Re: December 2nd MedPAC Discussion—Physician Payment Adequacy

Dear Mr. Hackbarth:

The American Academy of Neurology, representing more than 22,000 neurologists and neuroscience professionals, was pleased to hear Dr. Berenson’s comment at the December 2nd MedPAC meeting about considering the needs of “cognitive specialties” during the discussion about physician payment advocacy. The Academy is eager to communicate with MedPAC about recognizing the valuable care provided by neurologists and other cognitive specialists.

Neurologists on average receive over 60% of their Medicare payments from providing E/M services. While much attention is being paid to the plight of primary care physicians, it is vital that cognitive specialties, which also rely heavily on E/M reimbursement, are not ignored. Recent legislative and policy decisions, such as the elimination of payment for consultations and excluding cognitive specialties from the 10% E/M bonus, only place a heavier burden on struggling neurologists.

Neurologists care for individuals with chronic diseases that consume substantial healthcare resources. Millions of Americans are afflicted with neurologic disorders, including 5 million with Alzheimer’s disease, more than 1 million with Parkinson’s disease, 700,000 Americans suffer from stroke, more than 2 million are affected by epilepsy and seizures, and 35 million with migraines. The estimated annual cost of neurologic disorders is $400 billion in medical and related expenses.

National health insurer data reveals that internal medicine physicians and family practice physicians see a very small proportion (1% or less) of neurology cases, a majority of which fall into the category of uncomplicated migraine headache without co-morbidities. The data clearly shows that neurologists provide the overwhelming majority of care for neurologic conditions and, in particular, for conditions that require ongoing evaluation and management services associated with the diagnosis and treatment of Parkinson’s disease, Multiple Sclerosis, and Epilepsy.

Lengthy discussion and great skill are required to present a new diagnosis of dementia, MS, Parkinson’s disease, epilepsy, ALS, or any other serious neurologic condition with a patient and family and then recommend treatment options. Neurologists have less time to spend with their patients due to the declining compensation for cognitive care. As a result, patients may experience reduced quality of care and have limited access to neurologic services.
There are no definitive tests to diagnose many neurological disorders, and they often have no cure. Treatment of neurologic conditions requires an intensive evaluation of the patient and detailed history. Treatments for many diseases are rapidly changing and include effective but potentially deleterious and expensive therapies. Considerable experience and training is necessary to safely and appropriately employ these treatments. Neurologists have specialized skills to manage their patients’ medications, lifestyle modifications, and appropriate therapies. Neurologists provide high-quality, patient-centered care and coordinate with other care providers.

Neurologists frequently can provide better quality care to patients with neurological disorders than other physicians, and may reduce costs and improve outcomes. MS patients are more satisfied when their care is provided by a neurologist. Neurologists, who understand the disorders, order fewer unnecessary tests than other physicians. In fact, studies show patients who receive care from neurologists tend to be discharged earlier from the hospital, receive more accurate diagnoses, and receive fewer unnecessary tests and procedures. Stroke patients have a lower mortality rate and less disability when treated by a neurologist.

The AAN has been working with the Infectious Disease Society of America (IDSA) and other cognitive specialties to remedy deleterious payment policies. Our societies would appreciate the opportunity to meet with MedPAC or provide comment at the January meeting to ensure the needs of the increasing number of patients who are treated by cognitive specialists continue to be met.

Should you have questions or require further information, please contact Amanda Becker, AAN Associate Director, Medical Economics, by phone at (651) 695-2718 or by email at abecker@aan.com.

Sincerely,

Robert C. Griggs, MD, FAAN
President, American Academy of Neurology

cc:
Robert Berenson, MD
Vice-Chair, MedPAC

Mark Miller
Executive Director, MedPAC


Preserving Patient Access to Neurologists

Background
Neurologists care for individuals with chronic diseases that consume substantial health care resources. The estimated annual cost of neurologic disorders is $400 billion. It takes significant time and skill to provide ongoing cognitive care to manage complex chronic conditions for people with neurologic diseases like ALS, Alzheimer's, multiple sclerosis, epilepsy, traumatic brain injury, Parkinson's disease, headache, and stroke. These diseases often represent the highest need, highest cost Medicare beneficiaries making access to neurologic care all the more critical as the US population ages.

Neurologists have years of specialized training in the diagnosis and treatment of neurologic disease. Such care involves extensive care coordination and face-to-face time with patients, also called evaluation and management (E/M) services. In fact, neurologists on average receive more than 60 percent of their Medicare payments from providing E/M services. While much attention is being paid to the plight of primary care physicians, who also rely heavily on E/M reimbursement, it is vital that cognitive specialties are not ignored. Recent legislative and policy decisions, such as the elimination of payment for consultations and the exclusion of neurology from the 10-percent E/M bonus in the Patient Protection and Affordable Care Act, only place a heavier burden on struggling neurologists.

Problem
Neurology faces a looming shortage as its workforce ages, fewer US medical students choose to go into neurology, and financial disincentives continue to undervalue cognitive care.

Consequences
Continuation of current payment policies that undervalue cognitive care services will irreparably damage the neurology workforce and result in fewer patients having access to physicians with the appropriate training to provide high-quality patient-centered neurologic care.

Legislative Solutions
• Support legislation to add neurology as an eligible specialty in the primary care incentive program established by the Patient Protection and Affordable Care Act
• Provide stability in the Medicare program by permanently replacing the broken sustainable growth rate (SGR) formula with a payment system based on actual practice costs
• Address the current shortage of pediatric neurologists by supporting $5 million in the FY 2011 Omnibus Appropriations package to implement the Health Care Workforce Loan Repayment Programs authorized by Section 5203 of the Patient Protection and Affordable Care Act
AMENDMENT NO._______ Calendar No.______

Purpose: To ensure adequate access to care for beneficiaries by improving Medicare reimbursements to primary care practitioners in all specialties.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.

H. R. 3590

To amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

Referred to the Committee on _______________ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Ms. KLOBUCHAR to the amendment (No. _____) proposed by Mr. REID

Viz:

1. On page 1441, line 5, strike ‘‘or pediatric medicine’’

2. and insert ‘‘neurology, or pediatric medicine’’.
Dear Chairman Upton and Ranking Member Waxman:

The American Academy of Neurology (AAN), representing more than 24,000 neurologists and neuroscience professionals, is pleased to submit comments in response to the House Energy and Commerce Committees request for proposals to replace the current Medicare sustainable growth rate (SGR) formula.

Neurologists provide better quality care to patients with neurological disorders like dementia, Parkinson’s, epilepsy, stroke, and migraine than other physicians. Where studied, care by a neurologist reduced costs and improved outcomes. Patients who receive care from neurologists often are discharged earlier from the hospital, receive more accurate diagnoses, and receive fewer unnecessary tests and procedures. For example, stroke patients have a lower mortality rate, and less disability when treated by a neurologist.

The Academy believes that without fundamental changes in payment policy, patient care will suffer, particularly for those with neurologic disease. Current policy has made cognitive specialties like neurology less attractive, leading to physician workforce shortfalls to treat this population, largely due to the economic pressure to emphasize procedures over direct patient care.

What is needed is a complete revision of the Medicare fee schedule, narrowing the payment gap between evaluation and management services and procedures.

Although the gap in median income between primary care physicians and specialists is well publicized, a recent review Medicare data demonstrates that the disparity is actually between procedural vs. non-procedural physicians. Health care policy discussions focused on this gap currently pit primary care physicians against all specialists. However, a number of specialists are also nonprocedural in that they derive the bulk of their income from evaluation and management. Nonprocedural specialties like neurology are experiencing the same economic disadvantages as primary care, with the resulting difficulty in attracting graduating US medical students into the specialty.
The Affordable Care Act (ACA), however, treats specialists as a monolithic group, ignoring the fact that several specialties spend the majority of their time in face-to-face patient care. The concept of primary care versus all specialties combined is both overly simplistic and inaccurate. The true dichotomy is between primary care and nonprocedural specialties taken together versus the procedural specialties. With this change in perspective, the current income gap has little medical rationale, and furthermore has unfortunate consequences on the quality and equitable allocation of patient care. This has led to misaligned financial incentives, leading to a procedure-centered instead of a patient-centered health care system.

We believe that steps could be taken to assure the availability of a balanced physician workforce, the availability of a full spectrum of expertise, and access of patients with chronic conditions to the appropriate physician. These solutions focus less on costly procedures and more on face-to-face cognitive care that would provide higher quality, more appropriate care at lower cost to both Medicare and patients.

With the elimination of the consult codes in 2010 by CMS and lack of inclusion in the primary care incentive for 2011 and beyond, cognitive specialists like neurologists are now reimbursed less than primary care physicians for treating the same patients. Immediate steps are needed to ensure that the cognitive care workforce remains viable in the near future.

Congress should immediately:

- Include specialists who routinely coordinate care and meet the 60% threshold for the primary care incentive as eligible.
- Reinstate payment for the consult codes eliminated by CMS starting in 2010.

Long-term shifts that move care from procedural to non-procedural care are essential for the long-term benefit of the Medicare program.

The current Medicare fee schedule is flawed in large part due to inherent biases that favor procedures and imaging services. These biases persist in spite of data showing inequity of provider reimbursement and the rapid growth of these services without a corresponding increase in medical need. Though recent legislation has been introduced to attempt to correct these biases by focusing on reform of the American Medical Association’s Relative Value Update Committee (RUC), the Academy believes this approach will ultimately fall short of providing any basis for meaningful change. The problems associated with the devaluation of primary care services has more to do with the lack of goals put forth by CMS than with shortcoming of the RUC process. A more effective approach would be for Congress to give specific guidance to CMS to use RBRVS to create a new fee schedule that would favor primary and cognitive specialty care. Correction of the current undervaluation of primary care and cognitive physician work intensity would be one way to achieve this.

For the longer term Congress should:

- Change the misaligned financial incentives and close the income gap for both primary care and nonprocedural specialties.
• Support research to identify physician intensity of services to better show the parity of work from both procedural and non-procedural specialties.
• Pass meaningful malpractice reform that ensures that care provided by physicians is not subject to pressures that drive the use of high cost defensive medicine.
• Explore alternatives to the SGR such as:
  o Replace the SGR model which holds all providers accountable to the same target with one where services are grouped by service categories and held to separate growth targets. Categories should be based on service (not specialty) such as: primary care; cognitive specialty care (or other E/M); imaging and tests; major procedures; minor procedures; and anesthesia.
  o Support mechanisms for growth target (or SGR) exemptions for providers participating in alternative quality-based models such as accountable care organizations or patient-centered medical homes.
  o Cut the conversion factor to allow for substantial bonuses for primary care and other critical cognitive care specialties like neurology, rheumatology, and infectious disease.
  o Pay all physicians based on time, removing incentives to spend inadequate time with patients, read images too quickly, or focus on procedures that may be of marginal utility. This model would return the practice of medicine to a truly patient-centered focus by freeing physicians to meet their patients’ needs. This model would allow reimbursement for the time physicians spend doing paperwork, telehealth activities, and more extensive care coordination. Providing more targeted care would likely decrease health care utilization, improve outcomes, and increase patient satisfaction. Hourly rates would still need to distinguish by service provided, however, these rates could be defined in terms of patient value instead of the relative value structure used in the current Medicare FFS model.

It is clear that these changes will not be welcomed by all physician groups, but in order to control costs and ensure an appropriate mix of physicians for all Medicare beneficiaries, fundamental changes in the health care delivery system must occur.

Sincerely,

Bruce Sigsbee, MD, FAAN
President, American Academy of Neurology
A Successful Healthcare System Requires A Balance of Physicians
Primary care physicians are an essential component to any health care system. Equally important are specialists. Health care reform and other administrative decisions have recently devalued the importance of cognitive specialist. These are physicians who primarily perform evaluation and management services to diagnose complex diseases and treat chronic, debilitating conditions. Cognitive specialists such as Rheumatologists, Neurologists, Endocrinologists, Hematologists, and Infectious Disease specialists have been lumped in with surgical/procedural specialists which is not an accurate representation of the current state of health care providers.

A successful health care system must have primary care physicians to handle coordination of care and routine issues and who refer complex, chronic diseases to appropriate specialists. The specialist has the expertise and additional training to manage complex conditions such as rheumatoid arthritis, lupus, multiple sclerosis, Alzheimer’s disease, diabetes and thyroid disorders.

Cognitive Specialty Physician Workforce is Threatened
Physician specialists have expertise in a single area of medicine. They obtain the specialty designation by continuing their medical education for an additional 2-3 years of training. This additional training prepares specialists to handle complex diseases and determine best treatment options. Workforce and training surveys forecast shortages in various specialties, such as endocrinology, neurology and rheumatology over the next 20 years. This is particularly concerning with the aging baby boomer generation.

Recent Policy Changes Devalue Specialty Care
Cognitive specialists are highly valued by patients, but undervalued by the Centers for Medicare and Medicaid Services (CMS). In 2010, CMS eliminated consultation service codes used to recognize the services of a specialist. This policy change fails to acknowledge specialty expertise and the detailed work that is performed in a consultation, thereby deterring medical students from pursue training as cognitive specialties. This could result in a reduction of the nation’s ability to meet future healthcare needs, especially in the diagnosis and treatment of complex, chronic conditions.

Congress also undervalues cognitive specialists. The Affordable Care Act provides a 10 percent payment bonus to designated primary care physicians to improve their workforce. The primary care bonus combined with Medicare’s current consultations policy means that cognitive specialists are now reimbursed at a level less than that of primary care for the same E&M services, despite the fact that their patients are sicker and more complex.

Failure to Incentivize Cognitive Specialists Threatens Patient Care
The currently skewed reimbursement model promotes primary care physicians and physicians who perform procedures, and provides no incentives to pursue cognitive specialties. Without an adequate and fair payment system and a balanced physician workforce, patients will be unable to access necessary and appropriate, high-quality, cost-effective health care.

What is the Solution?

Medicare should appropriately reimburse “cognitive specialists” who care for patients with complex medical conditions that require a level of expertise which is beyond the training of the primary care physician.

We request that CMS consider solutions that recognize the value of specialty care for patients with complex medical conditions to ensure care coordination, better outcomes and cost savings in the healthcare system.
Meeting with John Blum

Attending from AAN, Dr. Marc Raphaelson, Mark Pascu,

Attending from ACR, Aiken Hackett, Tim Hutchison, and Dr. Ed Herzig

Attending from CMS were John Blum, Dr. Jeffrey Kelman, and in Baltimore, Marc Harstein and Todd Smith.

The meeting started with Dr. Herzig discussing his concerns about the physician workforce and an upcoming shortage in rheumatologists and was seconded by Dr. Raphaelson noting neurology had similar problems.

Blum asked if this was the same for other specialties?

Dr. Herzig noted that it wasn’t something that he could prove but felt that one was coming soon and he felt it was in part due to the differing reimbursement for physicians who did procedures. Dr. Raphaelson noted that CMS data would not accurately reflect, for example, the number of neurologists who accept Medicare patients, but who severely limit the number of patients they see. He requested that CMS develop better tools to track poor access to specialty care at an earlier stage.

Blum acknowledged that he wasn’t satisfied with the data on shortages that CMS picks up. He also asked if we wanted a rebalancing of the balance of payments. He specifically asked what policy changes might help.

Dr. Raphaelson noted that a consultation requires more resources than simpler new patient visits, but the E&M coding scale has a ceiling effect; level 5 visits include a range of difficulty, so complex consult work is not recognized under the current system. He requested that CMS have a clear policy to value the extra years in training for specialists. The -52 modifier might be used, for example, to identify higher complexity level 5 services performed by a specialist with training and credentials specified by CMS.

Dr. Raphaelson noted that he is the RUC representative from AAN. He noted that CMS might make and publicize policy decisions that might better guide RUC’s work. Blum asked for specifics.

Marc H. noted that intensity was very difficult to measure and may not be able to do it appropriately. But time is measures the same all over. The problems in payment policy are that many things are determined using different methodologies for paying physicians.

Dr. Raphaelson noted that he had suggestions as an individual that were not necessarily AAN supported. He suggested that CMS support newer, more scientific ways to measure physician work intensity (such as the work the AAN sponsored at the University of Cincinnati) and more reliable time measurements for physician services. CMS also might recommend that the RUC database meet the standards for transparency and rigor as it requires from outside databases. He suggested that a new approach would be needed, guided by policy, to re-evaluate the 20-year history of relative values for physician payment.
Blum wanted to see some principles from the Academy on what should be done with RUC or payment policy in general.

Blum noted that our meeting was timely as they were working to try to come to some solutions on payment policy. He would like to see something from us, any principles on what should be done, or ideas of what to do. Any data that we can give him showing that there is a shortage different from other specialties would be good, as well as any ideas on process changes, like changes to RUC would be good to send him as well.
June 28, 2011

Jonathan Blum  
Director  
Center for Medicare Management  
Centers for Medicare & Medicaid Services  
200 Independence Ave, S.W.  
Washington, D.C. 20201

Dear Mr. Blum,

The American Academy of Neurology (AAN) and the American College of Rheumatology (ACR) greatly appreciate the opportunity to meet with you and other officials from the Centers for Medicare & Medicaid Services (CMS) on Monday, May 23 to discuss the current and projected workforce concerns for cognitive specialties due to the imbalance in the physician payment system.

Neurologists and rheumatologists should be recognized as “cognitive specialists.” These are physicians, like endocrinologists, hematologists, and infectious diseases specialists, who receive additional training in a specific field of medicine and who perform predominately Evaluation & Management (E&M) services to patients with complex medical conditions. These conditions require a level of expertise to diagnose and treat that is beyond and not included in the training of the primary care or referring physician. Even though our cognitive specialists have advanced training and targeted expertise, their work is paid at the same base rate as primary care physicians, and the cognitive specialists are paid at a lower actual rate, since most do not qualify for Medicare’s primary care bonus.

As we discussed in our meeting, there is an imbalance in the physician fee schedule that weighs procedural care higher than cognitive based care. The unfortunate result of this policy is that a disproportionate number of medical students and internal medicine residents choose to specialize or subspecialize in more highly reimbursed procedural specialties. Specialties and subspecialties that are predominately cognitive based are reimbursed at lower rates than procedural based specialties. Our concern is that we cannot ensure a workforce of specialty physicians who are specialty trained to provide care for a rapidly growing patient population with complex chronic conditions. The projected workforce shortages must be addressed now to ensure the necessary manpower is available in cognitive specialties and that patients requiring complex care have access to physicians who care for them effectively and efficiently.

**Workforce Shortages of Cognitive Specialties**

The physician workforce in general will be facing numerical and geographic shortages in the future. The Health Resources and Services Administration has noted that there is a general physician shortage that will only grow in the future and it will be worse for rheumatology and neurology. Rheumatic conditions such as rheumatoid arthritis, lupus, spondylitis, and gout, and neurological conditions such as multiple sclerosis, ALS, Alzheimer’s, dementia, headaches, Parkinson’s disease,
stroke and sleep disorders are on the rise. This is due, in part, to an aging population and a prevalence of rheumatic and neurologic conditions among elderly. Beyond an aging population, it also should be noted that the burden of disease due to rheumatic and neurologic conditions will also increase. According to the Centers of Disease Control and Prevention, arthritis—which includes over 100 conditions affecting the muscles bones and joints, the most severe being inflammatory rheumatic diseases—is the leading cause of disability in the United States. Likewise, according to the World Health Organization study on the global burden of disease, 8 of 10 disorders in the three highest disability classes are neurologic disorders. Rheumatology and neurology workforces must keep pace with these emerging patient populations. The AAN and ACR have collected data that demonstrate the current and projected workforce shortages.

Rheumatology and Neurology Workforce Shortage

- In 2006, the Lewin Group performed an extensive study on the rheumatology workforce. It discovered that by 2025, there would be a deficit of 2500 rheumatologists who are needed to treat their patient group. The AAN workforce taskforce calculated that by 2020, the supply of neurologists will fall 20 percent below demand.
- The average age of a rheumatologist is 54 years. In the AAN 2009 census, the average age of a US neurologist was 53 years.
- The mean wait time for a non-urgent new arthritis patient is 38 days. The mean wait time for a new patient to see a neurologist is 28.1 days. Compared with other specialties, the mean appointment wait time for dermatology is 22.1 days and for cardiology 15.5 days.
- 35 percent of residents and fellows in rheumatology programs and 37.7 percent in neurology programs are international medical school graduates (IMGs), compared with 3.7 percent in dermatology and 2.5 percent in orthopedic surgery. Non-US IMGs constituted 35 percent neurology residents in 2007 and this overall high percent of foreign born IMG residents in neurology will most likely influence the future neurologic workforce.
- There are significant shortages of rheumatologists and neurologists in rural areas. For example, 300,000 children suffer from juvenile arthritis, yet there are eight states without a single pediatric rheumatologist which include AK, ID, MT, ND, NV, SD, WV, and WY. Additionally, in 1999 the number of neurologists per 100 000 population ranged from 6.62 (Massachusetts) to 2.14 (Mississippi). Currently, the number of neurologists per 100 000 population ranges from 11.02 (Washington) to merely 1.78 (Wyoming).

Causes of These Workforce Shortages

The reasons behind workforce shortages for both rheumatology and neurology are numerous and complex. However, one reason that stands out is low reimbursement. Current health care regulations and policies disadvantage cognitive specialty physicians. For example, between 2000 and 2008, Medicare payments for procedural services grew by 84 percent, while payments for cognitive services grew by 48 percent. There are a number of unintended consequences caused by this imbalance in reimbursement.

As cognitive specialties, rheumatology and neurology experience difficulties attracting US medical students and graduates. For example, there is a strong correlation between residency match and compensation and for that reason neurology has trouble filling its residency slots. Furthermore, because compensation plays also a factor in physician assistants (PA) specialty choice, rheumatology and neurology experience difficulty attracting PAs as well. Because the PA salary is similar to that of the physician, rheumatologists and neurologists hire fewer PAs (19 rheumatologists per PA, 30 neurologists per PA, compared with three physicians per PA for procedural specialties like
dermatology and orthopedic surgery). This is particularly troubling because PAs are, in part, looked to ease the workforce shortages.

Overall, the low fellowship match and a difficulty attracting US medical students as well as PAs will result in a reduced supply of rheumatologists and neurologists relative to the increasing need for cognitive care.

**Recognizing Value of Cognitive Specialty Care in New Payment Models**

The health care system is transforming; and with that, we must acknowledge the necessity of specialty care in this new system. As new care delivery models such as the Patient-Centered Medical Home and Accountable Care Organizations, which focus on care coordination and place primary care physicians at the center, are tested, the need for a diverse and robust specialty physician workforce, especially cognitive specialists, is critical to ensure the more expensive patients with complex chronic conditions receive optimal care. Any proposed integrative health care delivery model that promotes coordination, provides optimal patient care, and reduces unnecessary spending on duplicate tests, fragmented care, preventable illness, and hospitalizations must have the expertise and availability of cognitive specialists. **It is critical that any new payment policies recognize the value of cognitive specialty care for patients with complex medical conditions.**

Revisions to the current CMS payment system are underway. We applaud the Medicare Payment Advisory Commission’s (MedPAC) proposal, in its recent Report to Congress, to better measure the actual time physicians spend on patient visits and on procedures. Preliminary research in press indicates that the intensity of cognitive physician work may be similar to the intensity of surgical work. This initiative and other MedPAC ideas may provide the intellectual evidence to point to a fairer payment policy.

In conclusion, we request that CMS recognize that the pay disparities among physician types will disproportionately impact cognitive specialty manpower and these physicians ability to provide timely, high-quality care for patients with complex chronic conditions. We support MedPAC’s recommendation to “Realign payments for physician and other health professionals to help ensure an adequate supply of practitioners in cognitive (nonprocedural) specialties who focus on managing patients with chronic conditions.”

Again, we appreciate you taking the time to meet with us and look forward to continued dialogue with you and the CMS staff.

Sincerely,

Bruce Sigsbee, MD, FAAN
President
American Academy of Neurology

David Borenstein, MD
President
American College of Rheumatology
References


v 2010 Medical Economic Issue survey. The American Academy of Neurology.


xii Sigsbee B. The income gap. Specialties vs primary care or procedural vs nonprocedural specialties? Neurology 2011;76:923-926.


Dear AAN Member:

I want to let you know that we have been working diligently with regulators, legislators, and private insurers to improve reimbursement for cognitive care, or evaluation and management (E/M) services. We recently met with leadership of the Centers for Medicare & Medicaid Services to discuss policies to improve reimbursement. We continue to meet with members of Congress to offer solutions that focus less on costly procedures and more on face-to-face cognitive care that would provide higher quality, more appropriate care at lower cost to both Medicare and patients. And the Academy is working with a coalition of cognitive specialties to advance these goals.

The AAN believes that without fundamental changes in payment policy, patient care will suffer, particularly for those with neurologic disease. We are deeply concerned that current policy has made cognitive specialties like neurology less attractive. This is leading to physician workforce shortfalls to treat this population, largely due to the economic pressure to emphasize procedures over direct patient care. Because of the dire consequences this presents to both our patients and profession, cognitive reimbursement is the top priority of our advocacy work.

We will keep you updated in AANnews and on AAN.com on our efforts. For more information, visit the Academy's website.

Bruce Sigsbee, MD, FAAN
AAN President
SGR termination could be contingent on a set of trade-offs to improve the payment system

An alternative to expenditure target systems is to pursue a multipronged strategy with several components, each addressing aspects of Medicare’s payment approach for physicians and other health professionals. Aspects to address within the fee-for-service system include the accuracy of fee schedule payments, the Secretary’s option to adjust these fees, and the level of payments for cognitive (or nonprocedural) services relative to procedures. Outside the fee-for-service system, additional approaches could include steps toward delivery system reform and alternative payment models such as accountable care organizations, medical homes, and bundling.

Replacing the SGR with a different payment structure—devoid of the scheduled cuts—presents an opportunity to introduce needed payment changes for fee schedule services. That is, in exchange for eliminating future fee cuts, new policies could be implemented that improve and stabilize the fee schedule, restrain cost growth, and promote primary care and better coordination across sectors. The Commission is considering a range of policy ideas for reform:

• Set limited future updates in law, across all fee schedule services.

• Make the above updates contingent on the Secretary identifying and reducing the relative values for overpriced fee schedule services. The net savings the Secretary would achieve from these service-specific reductions would also be defined in law.

• Enhance efforts to continuously improve the accuracy of fee schedule payments, with particular attention to estimates of the time required to provide services.

• **Realign payments for physician and other health professionals to help ensure an adequate supply of practitioners in cognitive (nonprocedural) specialties who focus on managing patients with chronic conditions.**

• Reform delivery systems to shift payment away from the fee schedule’s disproportionate emphasis on procedures and tests and toward payment models focused more on care coordination and population health.

The above is not an exhaustive list of policies that could be considered in replacing the SGR. We will consider other policies as well. However, this set of policies, even if implemented on a staggered basis, represents a path to move away from the SGR and its negative effects. While the prospect of replacing the SGR could serve as a vehicle for hastening at least some elements of reform, a potential SGR replacement need not await full implementation of all reform elements. Reform is not a single event but a multipart process that unfolds over time.
Interim updates should apply for a minimum of one year

Considering the time and effort that will be involved in determining how to structure future payments for physician and other health professional services, interim fee schedule updates should apply for a minimum of one year—ideally at least two years—to provide stability for CMS, claims-processing contractors, and practitioners who bill Medicare. Furthermore, these updates should be scheduled well in advance of their applicable time periods to provide certainty about the level of payment. Significant problems arose in 2010 when updates applied to shorter time periods and were so delayed that they had to be applied retroactively. In addition to added administrative costs for CMS’s claims processing and cash flow problems for some clinical practices, the most disturbing outcome resulting from the short-term fixes was damage to patients’ and providers’ confidence in Medicare.
The Cognitive Specialty Coalition Commends MedPAC for Recognizing Cognitive Care Crisis

ST. PAUL, Minn. – The Cognitive Specialty Coalition (CSC) commended the Medicare Payment Advisory Commission (MedPAC) for recognizing that Congress needs to take steps to ensure that Medicare beneficiaries have access to cognitive care specialists. Cognitive specialists are physicians with additional training in a specific field of medicine who primarily provide Evaluation & Management (E&M) services to people with complex medical conditions that require a level of expertise which the referring physician is not trained to diagnose or qualified to treat.

The newly released June 2011 report specifically mentions that the end of the Sustainable Growth Rate (SGR) could depend on a set of trade-offs to improve the payment system and that one of the ideas being considered is a realignment of payments for physicians and other health professionals. The plan was designed to help ensure an adequate supply of practitioners in cognitive, nonprocedural specialties who focus on managing patients with chronic conditions. The CSC agrees and believes that any payment realignment must also apply to cognitive specialties that primarily treat acute conditions.

“In recent years it has become much more difficult to recruit young physicians into cognitive specialty care,” said Bruce Sigsbee, MD, FAAN president of the American Academy of Neurology. “Cognitive physicians spend great amounts of time with patients evaluating and managing complex conditions, but this type of care has been significantly undervalued compared to procedural care. Access to physicians for people who need this type of care is being threatened.”

“Recognizing and valuing the expert care that cognitive specialty physicians provide for their patients is essential to ensuring these patient populations have access to high quality care,” said David Borenstein, MD, president of the American College of Rheumatology. “We hope MedPAC’s proposal signals to Congress that the Medicare population relies on the advanced training and expertise of cognitive specialists and that changes should be made to ensure this type of specialty care is available.”

Thomas Slama, MD, FIDSA, president-elect of the Infectious Disease Society of America, agreed. “We all see the plight of primary care, but it is vital that MedPAC and Congress also see the value of care provided by cognitive specialists as well. MedPAC’s report is an encouraging step in that direction.”

The cognitive specialty coalition consists of representatives of the American Academy of Neurology, the Endocrine Society, the Infectious Disease Society of America, the American Association of Clinical Endocrinologists and the American College of Rheumatology. “Members of the coalition look forward to working with MedPAC and Congress in ensuring that cognitive specialists are recognized in any restructuring of the Medicare payment system.” Sigsbee said.

-more-
The American Academy of Neurology, an association of 24,000 neurologists and neuroscience professionals, is dedicated to promoting the highest quality patient-centered neurologic care. A neurologist is a doctor with specialized training in diagnosing, treating and managing disorders of the brain and nervous system such as Alzheimer’s disease, stroke, migraine, multiple sclerosis, brain injury, Parkinson’s disease and epilepsy. For more information about the American Academy of Neurology, visit http://www.aan.com.

Founded in 1916, The Endocrine Society is the world’s oldest, largest and most active organization devoted to research on hormones and the clinical practice of endocrinology. Today, The Endocrine Society’s membership consists of over 14,000 scientists, physicians, educators, nurses and students in more than 100 countries. Society members represent all basic, applied and clinical interests in endocrinology. The Endocrine Society is based in Chevy Chase, Maryland. To learn more about the Society and the field of endocrinology, visit http://www.endo-society.org.

The Infectious Disease Society of America represents more than 9,300 physicians and scientists devoted to patient care, education, research and community health planning in infectious diseases (ID). The Society’s members focus on the epidemiology, diagnosis, investigation, prevention and treatment of acute and chronic infectious diseases in the United States and abroad. For more information, visit http://www.idsociety.org.

The American Association of Clinical Endocrinologists (AACE) represents over 6,500 endocrinologists in the United States and abroad. AACE is the largest association of clinical endocrinologists in the world. The majority of AACE members are certified in Endocrinology and Metabolism and concentrate on the treatment of patients with endocrine and metabolic disorders including diabetes, thyroid disorders, metabolic bone disease, pituitary gland disorders, cholesterol disorders, hypertension and obesity. AACE members are committed to providing the highest quality of care to the patients they serve. For more information, visit http://www.aace.com.

The American College of Rheumatology is an international professional medical society that represents more than 8,000 rheumatologists and rheumatology health professionals around the world. Its mission is to advance rheumatology. For more information, visit http://www.rheumatology.org or follow ACR on Twitter at http://twitter.com/acrheum.
July 7, 2011

Glenn Hackbarth, Esq.  Robert Berenson, M.D., F.A.C.P  
Chairman  
Medicare Payment Advisory Commission  Medicare Payment Advisory Commission  
601 New Jersey Ave, NW  601 New Jersey Ave, NW  
Suite 9000  Suite 9000  
Washington, DC 20001  Washington, DC 20001  

Dear Mr. Hackbarth and Dr. Berenson:

The members of the Cognitive Specialty Coalition (CSC) are writing to commend the Medicare Payment Advisory Commission (MedPAC) for your attention to the dilemma facing cognitive care specialists. In its June 2011 Report, MedPAC concludes that Congress should act to ensure that patients will continue to have access to cognitive care specialists and, moreover, notes that the validation of physician service time can be improved. CSC is a group of physician specialty organizations whose members’ medical practice centers on providing cognitive care. Cognitive specialists are physicians with additional training in a specific field of medicine who primarily provide Evaluation & Management (E&M) services to people with complex medical conditions that require a level of expertise which the referring physician is not trained to diagnose or qualified to treat.

The June MedPAC report cites an opportunity to make needed changes in fee schedule services by replacing the sustainable growth rate (SGR) formula with a different payment structure. The CSC is particularly hopeful to see the following idea under consideration:

**Realign payments for physician and other health professionals to help ensure an adequate supply of practitioners in cognitive (nonprocedural) specialties who focus on managing patients with chronic conditions.**

The respective members of the CSC all have seen the negative impacts that an imbalance or mispricing in reimbursements and the corresponding salary differentials can have. For example, it has become more difficult to recruit physicians into cognitive care specialties. Neurology, rheumatology, infectious diseases, and endocrinology have seen this in the difficulty of filling their residency slots with US medical school graduates. A study from the Association of American Medical Colleges noted that 35 percent of residents and fellows in rheumatology programs, 37.7 percent in neurology programs, and 34 percent in endocrinology programs are international medical school graduates (IMGs), compared with 3.7 percent in dermatology and 2.5 percent in orthopedic surgery (AAMC Center for Workforce Studies 2008). The JAMA study further noted that there is a strong correlation between residency match and compensation (Ebell 2008). Results of the 2011 Infectious Diseases (ID) match show a decrease in the number of applicants, and an increase in the number of unfilled fellowship slots. Moreover, according to a survey of recently graduated ID fellows, inadequate compensation was the most frequently reported reason for job dissatisfaction.
Difficulty attracting physicians into cognitive specialties already has influenced the cognitive care workforce. Cognitive physician shortages are seen in the different mean wait times for a non-urgent new patient appointment. For a new arthritis patient, that mean wait time is 38 days (Lewin Group 2006). The mean wait time for a new patient to see a neurologist is 28.1 days (AAN 2010). And it is standard to encounter waits of 3–9 months to see an endocrinologist (JCEM 2008). Compared with other specialties, the mean appointment wait time for dermatology is 22.1 days and for cardiology 15.5 days (Merritt Hawkins and Associates 2009).

The looming physician shortages are occurring at a time when the US has an aging baby boomer population, suggesting that the need for medical care only will grow. The CSC wholeheartedly agrees with MedPAC that payments must be realigned so that an adequate supply of cognitive specialists can be maintained to treat the growing patient populations which have complex chronic and acute conditions which require medical expertise beyond primary care.

In addition, MedPAC believes that pricing inequity may be partly driven by inaccurate estimates of physician work time, especially as doctors become increasingly expert and efficient with procedures. The CSC supports ongoing efforts by the Relative Value Update Committee (RUC) to evaluate the potential use of extant databases as a means to ensure that accurate and verifiable time estimates are used in determining service values. It is important that any savings attained by lowering the time estimates for overvalued services be used to increase payments for E&M and other undervalued services (instead of reverting to the government).

We thank you for engaging with the CSC in a past meeting; we are more than happy to meet with you at any future time to continue the dialogue. The members of the CSC stand ready to provide whatever assistance you may want in order to develop any recommendations that would alleviate the current reimbursement imbalance to ensure that Medicare beneficiaries will have an appropriate number of cognitive care specialists to meet our country’s future medical needs. Should you or your staff have any questions, please feel free to contact Mark Pascu, Regulatory Affairs Manager with the American Academy of Neurology, at mpascu@aan.com or at (202) 525-2018.

Sincerely,

American Academy of Neurology
American Association of Clinical Endocrinologists
American College of Rheumatology
Infectious Diseases Society of America
North American Neuro-Ophthalmology Society
The Endocrine Society
References


“(E) Paragraph (9) effective date defined.—In this paragraph, the term ‘paragraph (9) effective date’ means July 1 of the year that begins after the date of the enactment of this paragraph.

“(F) Affiliation.—The provisions of this paragraph shall be applied to hospitals which are members of the same affiliated group (as defined by the Secretary under paragraph (4)(H)(ii)) and the reference resident level for each such hospital with respect to the cost reporting period that results in the smallest difference between the reference resident level and the otherwise applicable resident limit.”.

SEC. 3. EXPANDING PRIMARY CARE BONUS TO CERTAIN UNDERSERVED SPECIALTIES.

(a) In General.—Section 1833(x)(2)(A) of the Social Security Act (42 U.S.C. 1395l(x)(2)(A)) is amended—

(1) in clause (i)—

(A) by striking “or” at the end of subclause (I);

(B) by striking “and” at the end of subclause (II) and inserting “or”; and
(C) by adding at the end the following new subclause:

“(III) is a physician (as described in section 1861(r)(1)) who is in an underserved specialty, such as psychiatry or neurology, as specified by the Secretary, or other specialty identified by the Secretary to be in demand; and”;

(2) in clause (ii), by inserting after “(ii)” the following: “in the case of an individual described in subclause (I) or (II) of clause (i),”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for items and services furnished on or after January 1, 2012.

SEC. 4. SMALL PHYSICIAN PRACTICE RESIDENCY CREDIT.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business related credits) is amended by adding at the end the following new section:

“SEC. 45S. SMALL PHYSICIAN PRACTICE RESIDENCY CREDIT.

“(a) IN GENERAL.—For purposes of section 38, the amount of the small physician practice residency credit determined under this section for any taxable year with re-
spect to a qualified small physician practice is the sum of the following:

“(1) OVERALL AMOUNT.—The per resident dollar amount multiplied by the number of qualified teaching hospital residents who provide services to, and are trained by, such practice during the taxable year and who are in their first, second, or third post-graduate year of medical residency.

“(2) BONUS.—The sum of—

“(A) 50 percent of the per resident dollar amount multiplied by the number of such residents who are in their first post-graduate year of medical residency during the taxable year; and

“(B) 25 percent of the per resident dollar amount multiplied by the average number of such residents who are not counted under subparagraph (A) and are in their second post-graduate year during the taxable year.

“(b) QUALIFIED SMALL PHYSICIAN PRACTICE.—For purposes of this section, the term ‘qualified small physician practice’ means any trade or business of providing physicians’ services (as defined in section 1861(q) of the Social Security Act), which may be a community health center, that is owned and operated by a doctor of medicine...
or osteopathy if fewer than 50 individuals are employed
in such trade or business (including new training sites)
and the trade or business includes as part of the practice
the training of doctors of medicine or osteopathy in a rota-
tion covering at least 6 months in the taxable year All
persons treated as a single employer under subsection (a)
or (b) or section 52 or subsection (m) or (o) of section
414 shall be treated as a single trade or business for pur-
poses of the preceding sentence.

“(c) QUALIFIED TEACHING HOSPITAL RESIDENTS.—
For purposes of this section, the term ‘qualified teaching
hospital resident’ means any resident (within the meaning
of subparagraph (I) of section 1886(h)(5) of the Social
Security Act) in an approved medical residency training
program (as defined in subparagraph (A) of such section)
which provides services to the qualified small physician
practice (while utilizing the technologies and supplies of
such practice) for a period not less than—

“(1) 4 weeks in the case of a primary care resi-
dent (as defined in subparagraph (H) of such sec-
tion); or

“(2) 2 weeks in the case of any other resident.

“(d) PER RESIDENT DOLLAR AMOUNT.—For pur-
poses of this section, the term ‘per resident dollar amount’
means, in the case of a qualified small physician practice
that includes as part of the practice the training of doctors
of medicine or osteopathy in a rotation covering—

“(1) at least 6 months but less than 9 months
in the taxable year, $2,500; or

“(2) at least 9 months in the taxable year,
$3,000.

“(e) RESIDENTS NOT TAKEN INTO ACCOUNT MORE
THAN ONCE.—A qualified teaching hospital resident shall
be taken into account under subsection (a) for the taxable
in which the period described in subsection (c) ends and
shall not be so taken into account for any other taxable
year.”.

(b) CREDIT ALLOWED AS PART OF GENERAL BUSI-
NESS CREDIT.—Section 38(b) of such Code (defining cur-
rent year business credit) is amended by striking “plus”
at the end of paragraph (35), by striking the period at
the end of paragraph (36) and inserting “, plus”, and by
adding at the end the following new paragraph:

“(37) the small physician practice residency
credit determined under section 45S(a).”.

(c) CONFORMING AMENDMENT.—The table of sec-
tions for subpart D of part IV of subchapter A of chapter
1 of such Code is amended by adding at the end the fol-
lowing new item:

“Sec. 45S. Small physician practice residency credit.”.
(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.
Payment Reform Options to Improve the Value of Cognitive Care Services
August 9, 2011

Environmental Assessment

- Medicare’s sustainable growth rate formula (SGR) will cut physician pay by 29.5% on January 1, 2012 unless Congress intervenes.
- CBO estimates it will cost nearly $300B to replace the SGR with a 10-year freeze.
  - The cost for permanent SGR repeal goes up with each delayed cut, making permanent solutions increasingly unlikely the longer Congress delays serious action.
  - SGR repeal was included in some debt limit proposals, but was not part of the final agreement.
- The House Energy and Commerce Committee solicited specialty society input on SGR alternatives in April and held a series of hearings in May. MedPAC has also given increased attention to proposing payment reforms including SGR replacement and even fee-for-service (FFS) modifications.
  - Key staff in the House has indicated that the SGR “bucket proposal” is dead.
  - Several societies and the AMA are advocating for a 5-year transition period for any payment reform to take effect.
  - AAFP is advocating for a 2-3% increase for all primary care physicians in SGR reform plus an additional 10% for the primary care bonus payments. AAFP also convened its own task force to assess and possibly revalue current E/M codes.
- Activity in Congress reflects a new willingness to consider permanent SGR repeal and some corresponding interest in longer term Medicare payment reform; however, it is unclear how that focus will shift due to the ongoing negotiations over the impending federal spending cuts called for by the debt ceiling deal.
  - If Congress does not pass a second round of cuts by December 23, 2011, Medicare will automatically be cut by two percent – this will almost certainly be taken from provider reimbursements.
  - Alternatively, the Joint Committee on Deficit Reductions, which is tasked with identifying reductions of $1.2 trillion and may recommend cuts in the Medicare program including reducing reimbursement for services thought to be overpriced.
- The June 2011 MedPAC report to Congress stated that reform of the Medicare SGR fee-for-service model could provide an opportunity “to increase payments for cognitive (or nonprocedural) services relative to procedural services, and to give the Secretary discretion to adjust payments.”
- The disparity between procedural and non-procedural services is causing substantial imbalance in the health care system, affecting workforce, access to care, and quality of care.
- Recent decisions by CMS and Medicare have reduced incentives for physicians to obtain additional training and expertise
  - Elimination of the consult codes in the 2010 Medicare Physician Fee Schedule
  - Exclusion of specialists from the new 10 percent primary care bonus in the ACA
- Experts at the AAN now estimate that cognitive care services are undervalued by as much as 50 percent.
- CMS is proposing RUC re-review of all 91 E/M services, using the rationale that E/M codes are high volume services and that care coordination may not be currently appropriately accounted for within the code values.
CMS is focusing on the evolution of primary care to comprehensive patient-centered care management.

CMS’s stated goals in reassessing the value of the E/M services are: (1) enhancing patient care and; (2) changing the delivery of healthcare.

- AMA plans to oppose the RUC review of all 91 E/M services in the next two years and will create a workgroup including CPT and RUC expertise to develop strategy on other ways to address CMS’s goals.
  - The increasing disparity in incomes between procedural and nonprocedural specialties indicates that this issue has not been adequately addressed and the failure of RUC and the AMA to recognize this increasing disparity is a major problem.

Objectives

1. Return stability to the Medicare program for patients and physicians by ending the annual cycle of cuts and patches and permanently repealing the SGR formula with annual positive updates.

2. Improve value of cognitive care services by reducing the disparity between procedural and nonprocedural services. This would have major impacts across all specialties and may require significant FFS reform within Medicare and the addition of new CPT codes to better define and reflect services provided. Note referral to RUC may be appealing but not useful given its failure to restore parity thus far.

3. Reduce misaligned financial incentives within Medicare FFS and close the income gap for both primary care and nonprocedural specialties. This would also require Medicare payment reform and use of the RBRVS by CMS to create a new fee schedule that would favor primary and cognitive specialty care.

4. Improve the accuracy of Relative Value Units (RVUs), which are being used as a measure of physician productivity. Research is needed to identify physician intensity of services to better show the parity of work from both procedural and non-procedural specialties.

5. Reform or eliminate the 90-day global payments to better reflect actual services provided and end the practice of paying for duplicative care.

6. Reform the documentation requirements for E/M care. These requirements continue to limit opportunities quality innovation in EHR systems, do not improve patient care, and possibly impede communication within care teams.

Strategy Options

There are a variety of approaches that could be employed to address objectives outlined above. These are individual approaches for consideration and are not necessarily meant to be taken as a whole.

- Define and develop CPT coding change proposal that describes cognitive care services that are undervalued by current E/M codes.
- Define and develop CPT coding change proposal that captures care coordination activities related to long term, progressive disease management.
- Ask Congress to permit HHS to cut the conversion factor to allow for substantial bonuses for primary care and other critical cognitive care specialties like neurology, rheumatology, endocrinology, infectious disease, and neuro-ophthalmology. This option would face significant resistance from procedural specialties, but would provide a budget-neutral mechanism to realign Medicare payments and improve the value of cognitive care services.
- Ask Congress to give specific guidance to CMS to use RBRVS to create a new fee schedule that would favor primary and cognitive specialty care. Correction of the current undervaluation of primary care and cognitive physician work intensity would be one way to achieve this.
• Ask Congress to support mechanisms for growth target (or SGR) exemptions for providers participating in alternative quality-based models such as accountable care organizations or patient-centered medical homes. This option would have a limited impact on main objectives such as improving cognitive care value or reducing procedure and non-procedure disparities, but it would provide a means to encourage cognitive specialists to participate in innovative payment models.

• Ask Congress to require CMS to pay all physicians based on time, removing incentives to spend inadequate time with patients, read images too quickly, or focus on procedures that may be of marginal utility. This model would return the practice of medicine to a truly patient-centered focus by freeing physicians to meet their patients’ needs. This model would allow reimbursement for the time physicians spend doing paperwork, telehealth activities, and more extensive care coordination. Providing more targeted care would likely decrease health care utilization, improve outcomes, and increase patient satisfaction. Hourly rates would still need to distinguish by service provided, however, these rates could be defined in terms of patient value instead of the relative value structure used in the current Medicare FFS model. This would be the most radical option in terms of departure from the current model, and thus deals with many unknown variables and implications.

Influence Opportunities/Tactics

• Conduct meetings with stakeholders in payment reform and implementation: CMS (Blum, Berwick), MedPAC, Congress

• Unite on message and talking points
  o Consistent messaging in comment letters (i.e. proposed 2012 MPFS) and meetings (Congress, MedPAC, CMS, etc.)

• Seek opportunities to testify or submit comments to Congressional health committees

• Involve PR teams to identify media opportunities such as op-eds, stories in national publications, social media campaigns, etc.

• Conduct necessary studies for missing data and seek publication of supporting material/data
  o Pursue grants or other outside funding for further study of physician work intensity
  o Pursue funding for a study from CMS, or ask CMS to perform the study

• Activate respective grassroots networks

• Members of Cognitive Specialty Coalition should appoint knowledgeable representatives to new AMA work group

• Define and develop CPT coding change proposal that describes cognitive care services that are undervalued by current E/M codes

• Define and develop CPT coding change proposal that captures care coordination activities related to long term, progressive disease management

• Consider meeting with ACP to look for points of alignment

• Targeted letter to Blum at CMS regarding the proposed E/M review to highlight the role of cognitive specialists in care coordination, particularly with chronic, progressive diseases.
Cognitive Specialty Coalition Meeting Notes  
August 10, 2011

Sara Milo, American Association of Clinical Endocrinologists (AACE)  
Anita Sumpter, AACE  
Jill Rathbun, AACE  
Meredith Dyer, The Endocrine Society  
Stephanie Kutler, The Endocrine Society  
Jason Scull, Infectious Diseases Society of America (IDSA)  
Tiffany Schmidt, American College of Rheumatology (ACR)  
Katie Jones, ACR  
Rod Larson, American Academy of Neurology (AAN)  
Mike Amery, AAN  
Katie Kuechenmeister, AAN  
Amy Kaloides, AAN  
Karolina Wanielista, AAN  
Derek Brandt, AAN

Background
The Cognitive Specialty Coalition (CSC) reviewed the background materials that were distributed prior to the meeting. The groups generally agreed that the current RUC process is unlikely to improve the reimbursement climate for cognitive specialists in a meaningful way and that any budget-neutral FFS payment model is likely to continue to undervalue E/M relative to procedures. Participants stated that Congress has given no clear indication about what a model to replace the SGR might look like.

The group brainstormed potential areas of collaboration. Ideas discussed were to:

- Create a new E/M payment model based on episodes of care (or possibly on chronic care)
- An alternative suggestion was to consider payment based on the staging of the disease. If diseases could be assigned to a level of severity (similar to cancer), physicians could be reimbursed according to the complexity or involvement needed for the different stages (like a severity-adjusted DRG). Questions raised:
  - How would stage-based payments differ from the current E/M levels?
  - How would the episodes of care/stages be defined?
  - Using stages with bundled payment would require an episode or event, could this concept also be applied to a comprehensive payment instead?
- Submit regulatory comments highlighting the plight of cognitive care and the need for significant payment reform. In the short term, this could be done by all groups while commenting on the proposed re-review of all 91 E/M codes in the 2012 MPFS.
- Propose a new payment model that favors cognitive care to the Medicare Innovation Center.
• Investigate payments that would recognize care coordination and management. Nephrologists currently receive coordination payment that might be worth looking at in more detail.
• Host a high level meeting with the American College of Physicians (ACP) to discuss potential areas of collaboration. Meeting with the American Academy of Family Physicians (AAFP) would also be an option, but they seem hesitant to work collaboratively with other groups.
  o Note: ACP is hosting a meeting on August 11, 2011 by conference call. Any pertinent details will be distributed to the CSC by participating individuals.
• Promote loan forgiveness programs for medical students going into cognitive care specialties.
• Research medical home neighbor payments for cognitive services.
• Gather data to show how cognitive workforce shortages will affect patient access to care.
• Collectively fund a study through an external consultant that would systematically look at all the available options to incentivize cognitive care and/or the value of cognitive care specialists and ask them to make a recommendation about the best strategy.
• Meet with MedPAC and congressional committee staff to get their reactions and feedback on potential solutions developed by the CSC.
• Lobby members of the Joint Select Committee on Deficit Reduction.
• Nominate knowledgeable members to the special payment policy task force currently being formed by the AMA.

After much discussion, the group agreed to several action items:

• Amy Kaloides (AAN) will draft a proposal to collectively fund a study through an external consultant that would assess options to incentivize cognitive care, determine the value of cognitive specialists, and provide strategy recommendations.
• Based on the findings of the commissioned report, submit a proposed to the Center for Medicare and Medicaid Innovation (CMI).
• Bring CMI proposal to the Hill to garner additional support.
• Continue having coalition members meet jointly with congressional offices to educate them on cognitive care and the challenges posed by the current reimbursement system.
  o Mike Amery and Derek Brandt will begin setting up Hill visits in late August.
• Look into hosting a high level meeting with the American College of Physicians (ACP) to discuss potential areas of collaboration.
• Groups agreed to share draft comments on the E/M code re-review proposal in the MPFS before they are finalized.

Other housekeeping items:

• Jason Scull will soon be working at the American Medical Association. The interim contact for the IDSA on CSC issues is CEO Mark Leasure (mleasure@idsociety.org)
• The CSC listserv membership needs to be updated to reflect the new direction of the coalition. To add someone to the listserv, please send the contact information to Mike Amery (mamery@aan.com).
Evidence of High Quality and Cost Efficient Neurologic Care

Neurologists play a unique role in our health care system. Studies show that patients with health issues such as stroke, Parkinson’s disease, or multiple sclerosis benefit most when treated by a neurologist. Neurologists are more accurate than other physicians when diagnosing neurologic illnesses and choosing appropriate treatment. A correct diagnosis of a neurologic illness helps patients reach their full health potential and limits costs associated with unnecessary testing and prolonged hospitalization.

Neurologists provide a high-quality holistic approach when treating patients with neurologic problems; however, access to neurologists remains limited for the poor, minorities, and rural populations:

- A 2008 study on patient perceptions of MS-related care found that patients consider MS-related care significantly superior when it is delivered by neurologists compared to other physicians.\
- A study of rt-PA administration in Japan found that an increased number of stroke physicians, including neurologists and neurosurgeons, was associated with an increased usage of rt-PA—an FDA-approved treatment that is considered the most effective therapy for acute ischemic stroke. Authors contribute the correlation to two factors. First, a higher number of stroke physicians results in more efficient stroke services. Second, stroke neurologists and neurosurgeons play an important role in leading and organizing hospital’s “stroke team,” a group of medical staff who provide care and education programs for acute stroke patients.
- A 2008 study published in Neurology® found that patients of a neurologist were significantly more likely to take a disease modifying agent (DMA), attend an outpatient rehabilitation program, or see an occupational therapist, urologist, or physical therapist. However, results of this study show also that economic, insurance, racial, and geographic factors appear to limit access to neurologists. For example, of 2,156 people with MS, only 72.2 percent saw a neurologist for their usual MS care. The probability of seeing a neurologist was significantly lower for people who had been ill for more than 15 years; had difficulty walking but did not use an assistive device; required a wheelchair/scooter or were confined to bed; or did not have health insurance, were poor, lived in rural areas, or were African American.\
- A study of the availability of diagnostic and treatment services for acute stroke care in Iowa found that rural areas were more prone to fragmented neurologic care. The essential components of acute stroke treatment, such as CT, IV t-PA, 24-hour physician coverage, varied among hospitals suggesting that stroke care systems were underdeveloped in rural areas.\

More effective management of patients with neurologic problems prevents costly hospitalization. Studies show that patients consulted by a neurologist leave in-patient facilities earlier than those who are not consulted by a neurologist:

- A study of the effects of physician specialty on the health outcomes of patients with intracerebral hemorrhage found that patients seen by both neurologists and neurosurgeons stayed at a hospital for a shorter time than patients seen by internists. The median “hospital length of stay” for patients seen by neurologists was 4.5 days, for patients seen by neurosurgeons it was 5 days, whereas for patients seen by internists 7 days.
- A 2007 study focused on estimating the impact of neurology consultations on in-patient care found that neurologic intervention resulted in a significant change in diagnosis in 55.5 percent of cases and a significant change in case management in nearly 70 percent. Sixty-five percent of patients were discharged earlier as a result of neurological consultation.
- A 1995 study of treatment methods of elderly stroke patients found that patients treated by the department of neurology were discharged an average of 16 days earlier (24 versus 40 days). Also, patients who were randomly placed in neurologic wards were more likely to return home directly from the hospital. In addition, after one year, the functional status was still better in patients randomized to neurologic wards compared with those randomized to other medical wards.

Stroke patients seen by a neurologist experience better health outcomes than those seen by non-neurologists; they are also less likely to die during hospitalization:

- A study of stroke patients admitted to 113 academic hospitals over a two-year period found that neurologists improve outcomes for in-patient acute ischemic stroke patients compared to generalists. Specifically, ischemic stroke patients treated by a neurologist had a lower risk of in-hospital mortality (4.6 percent) than patients treated by non-neurologists (9.5 percent). In addition, a traditional analysis of data showed that ischemic stroke patients treated by a neurologist had shorter hospital stays and lower charges.
- In a 2003 Veterans Administration stroke study on neurologist care, stroke patients seen by a neurologist (5.6 percent) were less likely to die during hospitalization than those seen by a non-neurologist (13.5 percent).
- A 1999 study published in the Journal of Medical Care cited that the risk of 1-year mortality for stroke patients who received neurology care was 77 percent of the risk for patients who did not.
- A 1995 study looking at the connection between physician specialty and the outcome of ischemic stroke patients shows that patients admitted to neurology
services had better prognostic profiles, i.e., lower likelihood of having either completed stroke or cardiac comorbidity, and were less likely to die within one and six months of stroke onset. Also, ischemic stroke patients who were treated by neurologists experienced lower all-cause and stroke-related mortality. Even when the researchers attempted to adjust the all-cause mortality rates for the substantial difference in prognostic profiles, the magnitude of the survival advantage for patients treated by neurologists was essentially unchanged, although its statistical significance was reduced.11

Patients are more likely to benefit from neurologic testing when tests are conducted and reviewed by a neurologist. Also, neurologists are more accurate in referral diagnosis and in ordering neurologic tests, which limits costs associated with unnecessary exams and invasive surgical procedures:

- A 2006 study suggests that non-neurologists may over-utilize EEG tests. When non-neurologists ordered EEG testing without oversight, the rate of normal results was 73 percent. A high percentage of normal results suggest that EEG test may be ordered unnecessarily. However, when non-neurologists had neurologist oversight when ordering EEGs, the rate of normal results decreased dramatically to 43 percent. Over the same period of time, the rate of normal results for neurologists was 28 percent.12
- TIA (transient ischemic attack) patients treated by a neurologist were significantly more likely to undergo cerebrovascular testing but were significantly less likely to undergo surgery, compared with those patients treated by physicians in other specialties.13
- In a 1998 critical evaluation of the variations of requests for electromyography (EMG) by neurologists and general practitioners, neurologists and other specialists were more accurate compared to general practitioners in their referral diagnosis and the need for electromyography. The authors suggest that there may be a reduction in the ordering of unnecessary EMG studies by as much as 25 percent if patients were seen by a neurologist.14

7 Kaste M, Palomäki H, Sarna S. Where and how should elderly stroke patients be treated? A randomized trial. Stroke 1995;26:249-253. *Note that the hospital studied is located in Finland.
14 Mondelli M, Giacchi M, Federico A. Requests for electromyography from general practitioners and specialists: critical evaluation. Italian Journal of Neurological Sciences 1998;19:195-203. *This study was based in Italy.
Two factors - aging population and universal health care coverage - will likely increase the demand for physician services. While the US population is projected to rise by more than 50 million between 2006 and 2025, the universal health care coverage alone could add “4 percent to overall demand for physicians” (Dill and Salsberg 2008). Although the demand for physician services increases, the supply is limited by the looming shortage of graduate medical education (GME) positions (Iglehart 2011).

Many specialties has already reported workforce shortages but most recent congressional actions have ignored estimates of physicians shortages in various specialties and focused on primary care shortages only (Iglehart 2011). Although troubling, the true problem lies not in a primary care vs. specialty dichotomy, but in a dichotomy between procedural vs. cognitive care specialties. In fact, over the years, health care policies have favored procedural specialties which have led to systemic under-appreciation of cognitive care specialties such as neurology.

Neurology shortages in rural areas are well documented, as are the difficulties attracting US medical graduates to neurology residency spots (Avitzur 2010, Ebell et al 2008). Physician shortages can manifest in a number of different ways, for example in longer waiting times for appointments, or shorter visit times with physicians (Dill and Salsberg 2008).

The Academy appointed a special task force charged with developing a comprehensive report on shortages in neurology workforce. The following is a snapshot of available data:

Shortages of neurologists by wait time

- While for neurology the reported mean wait for a new patient visit is 28.1 days (AAN Medical Economics Issues Survey 2010), the average time to appointment for cardiology is 15.5 days, for orthopedic surgery 16.8 days, and for family practice it is 20.3 days (Merritt Hawkins and Associates 2009).

Shortages of neurologists by shorter visits times with physicians

- According to the AAN 2010 Practice Profile Form, neurologists devoted on average 42.3 hours per week to patient care in 2010 and almost the same amount of time, 42.4 hours per week, in 2004. However, the mean number of office and hospital visits has increased from an average of 72.7 visits per week in 2004 to an average of 81.8 visits per week in 2010. The 14% increase in the number of visits, with a constant number of hours devoted to patient care, suggests that neurologists saw more patients in the same amount of time in 2010 than in 2004.

Shortage of neurologist in rural areas

- An analysis of recent estimates of the number of practicing neurologist “when combined with the aging patient population and the prevalence of neurologic disorders with increasing age, suggest(s) that there will be higher demand for the estimated supply of adult neurologists, especially in already underserved areas” (Freeman and Vatz 2010).
The uneven geographic distribution of neurologists resulted in shortages of neurologists in rural areas. The misdistribution ranged from 11.02/100,000 in Washington, DC, to 1.78/100,000 in Wyoming (Avitzur 2010).

Procedural vs. nonprocedural specialty data

- Current health care regulations and policies favor procedural specialties over nonprocedural specialties like neurology; e.g. between 2000 and 2008, Medicare payments for procedural services grew by 84%, while payments for nonprocedural services grew by 48% (Sigsbee 2011).

Ability to attract Medical students and residents

- A study published in Journal of American Medical Association, reported that there was a strong direct correlation between higher salaries and higher fill rates with US graduates.\(^1\) The same study also reported that procedural specialties like orthopedic surgery and radiology had the highest salaries and fill rates, while cognitive specialties like neurology and primary care had the lowest salaries and the lowest fill rates. In other words, neurology experiences difficulties attracting US medical graduates because of the lower salaries due to systematic under-apparition of cognitive specialties (Ebell et al 2008).

International Medical Graduates

- ‘Non-U.S. IMG (PGY-1 and PGY-2) match’ as percent of the total number of positions in each specialty for 2011 (NRMP 2011, page 4-5).
  
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percent (Number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine (Categorical)</td>
<td>23.7% (1,215)</td>
</tr>
<tr>
<td>Neurology</td>
<td>20.8% (129)</td>
</tr>
<tr>
<td>Pathology</td>
<td>20.4% (106)</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>13.4% (363)</td>
</tr>
<tr>
<td>Psychiatry (Categorical)</td>
<td>13.4% (147)</td>
</tr>
<tr>
<td>Surgery-Preliminary (PGY-1 only)</td>
<td>10.9% (129)</td>
</tr>
<tr>
<td>Pediatrics (Categorical)</td>
<td>10.3% (256)</td>
</tr>
<tr>
<td>Medicine-Preliminary (PGY-1 only)</td>
<td>6% (115)</td>
</tr>
</tbody>
</table>

- In 2007, 37.7% of neurology residents were International Medical Graduates. Compared to 30.6% in cardiovascular disease, 18.9% in general surgery, 3.7% in dermatology, and 2.5% in orthopedic surgery (Salsberg and Rivers, 2008).

What makes shortages in neurology workforce different than in other specialties?

- Rise of neurological problems
  - 8 out of 10 disorders in the 3 highest disability classes are neurological disorders according to the Global Burden of Disease Study conducted by the World Health Organization (Menken 2000).
o Stroke is ranked as the third leading cause of death in the United States (National Center for Health Statistics).

- Aging population
  o “Aging of the population may drive demand sharply upward for specialties that predominantly serve the elderly” (Dill and Salsberg 2008).
  o “Growth in future demand could double if visit rates by age continue to increase at the same pace they have in recent years – with the greatest growth in utilization among those 75+ years of age” (Dill and Salsberg 2008).

Salary data

- Two salary reports released in 2011 reported various compensation levels for neurologists. According to Medscape Physician Compensation Report (2011), the median salary for neurologists in 2010 was $200,000, while according to MGMA (2011) the median compensation in the same year was $249,867 (please see the table below for further comparison).
- In the MGMA report (2011), the relationship between salary and production was calculated utilizing ratios of compensation to collections and compensation to work RVUs:
  o Neurologists reported earning 67.8 cents of every dollar they collect.
  o A median compensation to work RVUs ratio was $51.56.
- According to Medscape report (2011), “at the very top (of the income ladder) are orthopedic surgeons and radiologists, whose 2010 median salary was $350,000. Just one rung below are anesthesiologists and cardiologists, each of whom had a median salary last year of $325,000. Below these two groups, in descending order, are urologists, general surgeons, gastroenterologists, and dermatologists“ (Medscape 2011).
Compensations levels for physicians as reported by Medscape and MGMA – a comparison

- **Pediatric/Adolescent Medicine**: 148,000 (Medscape) 192,148 (MGMA)
- **Neurology**: 200,000 (Medscape) 249,867 (MGMA)
- **Emergency Medicine**: 250,000 (Medscape) 277,297 (MGMA)
- **Obstetrics/Gynecology**: 225,000 (Medscape) 281,190 (MGMA)
- **Ophthalmology**: 248,000 (Medscape) 330,784 (MGMA)
- **Surgery: General**: 300,000 (Medscape) 343,958 (MGMA)
- **Urology**: 305,000 (Medscape) 372,455 (MGMA)
- **Oncology/Hematology**: 285,000 (Medscape) 382,934 (MGMA)
- **Dermatology**: 290,000 (Medscape) 430,874 (MGMA)
- **Gastroenterology**: 300,000 (Medscape) 463,955 (MGMA)
- **Radiology: Diagnostic**: 350,000 (Medscape) 471,253 (MGMA)
- **Cardiology: Invasive**: 325,000 (Medscape) 500,993 (MGMA)
- **Orthopedic Surgery**: 350,000 (Medscape) 514,659 (MGMA)
References


AAN Practice Profile Form Survey 8/20/2010.


National Center for Health Statistics [online]. Available at: http://www.cdc.gov/nchs/fastats/deaths.htm


Sigsbee B. The income gap. Specialties vs primary care or procedural vs nonprocedural specialties? Neurology 2011;76:923-926 [online]. Available at: http://www.neurology.org/content/76/10/923.full.pdf
Neurologists are trained to diagnose, treat, and manage disorders of the brain and nervous system such as dementia, Alzheimer’s, Parkinson’s, epilepsy, migraine, ALS, multiple sclerosis (MS), traumatic brain injury (TBI), and stroke.

Demand for neurologic care is increasing:

- Stroke is ranked as the third leading cause of death in the United States.\textsuperscript{1}
- Alzheimer’s disease is ranked as the sixth leading cause of death in the United States.\textsuperscript{2}
- 5.4 million Americans are currently diagnosed with Alzheimer’s disease. The American Alzheimer’s association projects that the number will triple to 16 million by the year 2050.\textsuperscript{3}
- Parkinson’s disease affects 1 million Americans, with at least 60,000 new cases reported annually.\textsuperscript{4,5}
- According to a global study conducted by the World Health Organization, 8 out of 10 disorders in the 3 highest disability classes are neurologic problems.\textsuperscript{6}
- In 2008, migraine-related headaches were the first-listed diagnosis for over 3 million emergency room visits in the United States (comprising 2.4 percent of all emergency room visits).\textsuperscript{7}

Neurologists provide best quality care for patients with neurologic disorders:

- Patients consider MS-related care significantly superior when it is delivered by neurologists compared to other physicians.\textsuperscript{8}
- An increased number of stroke physicians, including neurologists and neurosurgeons, were associated with an increased usage of rt-PA – an FDA approved treatment that is considered the most effective therapy for acute ischemic stroke.\textsuperscript{9}
- Stroke patients seen by a neurologist (5.6 percent) were less likely to die during hospitalization than those seen by a non-neurologist (13.5 percent).\textsuperscript{10}
- The risk of 1-year mortality for stroke patients who received neurology care was 77 percent of the risk for patients who did not.\textsuperscript{11}
- Ischemic stroke patients admitted to neurology services had better prognostic profiles, i.e., lower likelihood of having either completed stroke or cardiac comorbidity, and were less likely to die within one and six months of stroke onset.\textsuperscript{12}

Neurologic care limits unnecessary health care cost:

- Ischemic stroke patients treated by a neurologist had a lower risk of in-hospital mortality (4.6 percent) than patients treated by non-neurologists (9.5 percent). In addition, a traditional analysis of data showed that ischemic stroke patients treated by a neurologist had shorter hospital stays and lower charges.\textsuperscript{13}
- Patients with intracerebral hemorrhage who were seen by both neurologists and neurosurgeons stayed at a hospital for a shorter time than patients seen by internists: the median ‘hospital length of stay’ for patients seen by neurologists was 4.5 days, for patients seen by neurosurgeons it was 5 days, whereas for patients seen by internists 7 days.\textsuperscript{14}
- Sixty-five percent of patients were discharged earlier as a result of neurologic consultation. Also, neurologic consultation resulted in a significant change in diagnosis in 55.5 percent of cases and a significant change in case management in nearly 70 percent of cases.\textsuperscript{15}
- Stroke patients treated by the department of neurology were discharged an average 16 days earlier (24 vs. 40 days) than patients treated in other medical departments.\textsuperscript{16}
- Non-neurologists may over-utilize EEG tests: when non-neurologists had neurologist oversight when ordering EEGs, the rate of normal results decreased dramatically from 73 percent to 43 percent. Over the same period of time, the rate of normal results for neurologists was 28 percent.\textsuperscript{17}
- There may be a 25 percent reduction in the ordering of unnecessary EMG tests if patients were seen by a neurologist.\textsuperscript{18}

We face a shortage of neurologists to treat an increasing number of neurologic patients:

- The supply of neurologists will fall 20 percent below demand by 2020.\textsuperscript{19}
- Nonprocedural specialties, like neurology, experience difficulties attracting US medical students.\textsuperscript{20}
- US medical student and residents perceive neurology as the most difficult specialty.\textsuperscript{21}
- Current health care regulations and policies favor procedural specialties over nonprocedural specialties like neurology; e.g., between 2000 and 2008, Medicare payments for procedural services grew by 84 percent, while payments for nonprocedural services grew by 48 percent.\textsuperscript{22}
1. National Center for Health Statistics. Available at: www.cdc.gov/nchs/fastats/deaths.htm
2. National Center for Health Statistics. Available at: www.cdc.gov/nchs/fastats/deaths.htm