Dear Chairman Hackbarth and Vice Chairman Berenson,

The American Academy of Neurology (AAN) represents more than 24,500 physicians who manage and coordinate care for some of the highest cost Medicare beneficiaries with complex, often progressive neurologic conditions such as Alzheimer’s disease, stroke and epilepsy. The AAN has serious concerns about the draft recommendation to Congress under consideration by MedPAC to repeal the SGR by instituting unilateral cuts for three years and then a seven year payment freeze to non-“primary care” physicians as was discussed during the Commission’s September 14-15 meeting.

Specifically, we’d like to draw your attention to the following issues:

- Imperfect and “Unclear” Definition of Primary Care
- Neurology Workforce Shortages and Patient Access Issues
- Increasing Prevalence of Neurologic and Age-related Disorders
- Conclusion/Implications

**Imperfect and “Unclear” Definition of Primary Care**

The draft recommendation, if implemented, would institute three-years of 5.9% cuts to physicians in all specialties other than those classified as “primary care physicians” under the Affordable Care Act (ACA) definition. The definition of “primary care” used by MedPAC Commissioners and Congress in the ACA continues to be of concern to the AAN.

The definition has two criteria: first, it requires that a specialty be listed as eligible; and second, it requires an eligible individual physician to bill at least 60 percent of allowed medical charges in a previous year to primary care services (E/M services). Under these criteria, the definition of primary care already has been acknowledged by MedPAC as imperfect, specifically due to the fact that the first criterion represents a self-reported measure. The second criterion, on the other hand, is designed to ensure that the practitioner has a practice that is focused on primary care, giving protection or assurance that the benefits are being given only to appropriate groups of physicians that perform a majority of their services as E/M services.

The ‘primary care’ model described this way looks exactly like the average neurology practice. Neurologists bill on average 61 percent of charges using E/M codes. E/M codes capture inpatient and outpatient new and established visits, observation care, nursing facility, hospital care, emergency department services, critical care, case...
management, preventive care, prolonged services, and—prior to CMS’s elimination—consultation services. CMS eliminated payment for consultation codes under the rationale, at least in part, that the care is essentially the same as that provided by the inpatient and office visit codes, therefore neurologists are billing even more new patient office visits codes (99201-99205)—the same code series used by primary care physicians. These new patient visits fall into levels from 1-5, with the most complex visit at level 5. According to 2010 Medicare data, neurology is the single largest biller of CPT® code 99205.

In other words, neurology belongs to a small group of specialties that use E/M codes to bill a significant portion of cognitive services just as “primary care” physicians themselves perform and bill. In June, MedPAC acknowledged that Congress must act to protect access to the small number of physician specialties that look much more like “primary care” in terms of their billings, practices, and income than they look like procedural specialties (MedPAC 2011). Indeed, neurology practices are similar to that of primary care in terms of their billings and income but also in terms of challenges they face, including access problems and workforce shortages.

If MedPAC is interested in incentivizing cognitive care provided by physicians, it must change its definition of “primary care” to include specialty physicians who also spend a majority of their time providing similar cognitive care services for patients with more complex conditions. MedPAC should consider defining “primary care” in terms of care continuity, care coordination, and integration of services rather than defining it as office visits or as service delivery to patients or as being provided by only four physician specialties fortunate to have been listed as eligible.

The AAN is concerned that the draft recommendation for broad cuts to the conversion factor for all specialties lumped as one does not improve patient care or end the disparities that currently exist between cognitive, non-procedural care and procedural care. If anything, penalties assigned to the conversion factor will only increase the incentive to provide more procedural care.

Evidence of Neurology Workforce Shortages and Patient Access Issues
Physician shortages can manifest in a number of ways, including longer waiting times for appointments, or shorter visit times with physicians (Dill and Salsberg 2008). The following is a snapshot of neurology workforce shortages already manifested:

**Reported regional shortages of neurologists**
The annual study of physician workforce in Massachusetts has reported severe shortages in neurology workforce three years in a row since 2008 (MMS Physician Workforce Study 2010). Other studies suggest that uneven geographic distribution of neurologists results in shortages in rural areas. Specifically, the maldistribution ranges from 11.02 neurologists per 100,000 in Washington DC to 1.78 neurologists per 100,000 in Wyoming (Avitzur 2010).

**Shortage by Reported Difficulty Scheduling Referral Appointments**
Several studies point to difficulties in scheduling appointments for referral to neurologists. According to the Government Accountability Office (GAO), physicians experience difficulty referring low income children—children covered by Medicaid and CHIP—to specialty care. Neurology was cited as one of the three most difficult specialties to refer children to. The authors linked the difficulty referring low income children to a neurologist with shortages in neurology workforce (GAO 2011). Also, a 2010 survey of physicians by the Michigan Department of Community Health found that neurology was among the most difficult specialties to refer patients for visits. With the exception of dermatology, all other specialties described as “difficult to refer to” were cognitive specialties like psychiatry and rheumatology (MDCH Survey of Physicians 2010).

**Shortage by Patient Wait Time for a New Visit with a Neurologist**
The reported mean wait time for a new patient visit into a neurology practice is longer at 28.1 days (AAN Medical Economics Issues Survey 2010) than the average time for a cardiology appointment at 15.5 days, for orthopedic surgery at 16.8 days, and even for family practice at 20.3 days (Merritt Hawkins and Associates 2009).
Shortage of US Medical Students Choosing to Enter the Neurology Workforce

Neurology has an unusually high number of non-US international medical school graduates (IMGs). Non-US IMGs are foreign citizens who, after their residency, will be required to obtain visa status in order to practice medicine in the US. In 2007, non-US IMGs filled on average less than 10% of offered PGY-1 positions in other specialties, but in neurology a stunning 35% of PGY-1 positions were filled by non-US IMGs (NRMP as cited in Ebell, et al 2008). Although a precise effect of high non-US IMGs rates is unknown, there is a risk that the difficulties they experience entering US practices might negatively impact the neurology workforce. More importantly, a study published in JAMA reported that there is a strong direct correlation between higher salaries and higher fill rates with US graduates. 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 (Ebell, et al 2008).

Fewer US medical students chose to go into neurology because neurologists are not adequately recognized for their additional expertise and training. Primary care physicians, on the other hand, are not prepared in their residency and fellowship trainings to manage complex neurologic conditions. In fact, often primary care physicians do not feel confident dealing with complex neurologic patients. For example, a 2010 study of the attitudes of US medical trainees toward neurology education found that medical students and residents perceived neurology as the most difficult specialty. In addition, students and residents felt least confident when dealing with patients with neurologic complaints. According to the authors, this lack of confidence in treating neurologic conditions is alarming “in the face of the rising number of patients with neurological disorders managed in primary care settings” (Zinchuk et al. 2010).

Payment Cuts Exacerbate Patient Access Problems

As far back as 2005, in an AAN member survey, 57.6% of neurologists reported a decrease in compensation for cognitive (non-procedural) services per unit time worked (AAN Survey on the Reimbursement of Cognitive Services 2005). The single biggest adjustment reported (62.6% of respondents) was seeing more patients overall. Similarly, an additional 34.8% reported seeing more patients per unit of time. An alarming 24.7% reported that they reduced the percentage of ‘return’ visit patients, and 28.6% reported that they reduced the percentage of patients whose insurance reimburses less than others. It is evident that further decreases will lessen the time patients will have with neurologists who are managing not only their complex conditions, but also their equally complex drug therapies.

Increasing Prevalence of Neurologic and Age-related Disorders

The future demand for neurologic services will rise above the current demand due to increasing prevalence of neurologic and age-related disorders. For example, currently 5.4 million Americans are diagnosed with Alzheimer’s but this number is expected to triple by 2050 (AF 2011). Neurologists treat patients who fall into the most elderly, high cost and vulnerable of the Medicare population.

For example, stroke and Alzheimer’s rank as the third and sixth leading cause of death in the US, respectively (NCHS 2011). Also, in a 2010 analysis of recent estimates on the number of practicing neurologists, Freeman and Vatz suggest that, “when combined with the aging patient population and the prevalence of neurologic disorders with increasing age, there will be higher demand for the estimated supply of adult neurologists, especially in already underserved areas” (Freeman and Vatz 2010).

The AAN supports your efforts to improve the practice climate for primary care physicians but they must have access to specialists like neurologists to whom they can refer the increasing number of complex patients. If MedPAC and Congress continue to treat specialists that perform a majority of cognitive services just like heavily procedural specialties, it will discourage more medical students from obtaining extra training and entering into cognitive specialties.

Conclusion/Implications

The AAN agrees that the SGR is a flawed formula that must be permanently fixed. However, in its recommendations for a fix, MedPAC must take into consideration that it is overly simplistic to lump all
non-“primary care” specialties together. In fact, the continuing practice of lumping cognitive specialties that perform a majority of E/M services and face the same challenges as “primary care” physicians together with more highly paid procedural specialties will lead to penalties and—even more troubling—underpayments for physicians with specialized training to coordinate care for the most complex, highest need Medicare beneficiaries.

It is generally well-recognized that there are insufficient primary care physicians and the shortage will be exacerbated in the future. Medicare beneficiaries still need a physician to care for chronic disease and perform the coordination activities. A number of non-procedural specialties do perform this service to the Medicare and Medicaid population and, as such, should also be encouraged to provide that service through the recognition of the contribution to this population. MedPAC must give serious consideration to the fact that there are a small number of physician specialties that spend a majority of their time in cognitive, non-procedural care (E/M services) and look much more like “primary care” in terms of their access and workforce issues, billings, practice patterns, and income than they look like highly procedural specialties.

In addition, in the larger picture of continued health care reform, the AAN is concerned that MedPAC’s draft recommendation for the SGR “fix” does little to incent the kind of care coordination and time spent with patients that “primary care” and other specialists provide, but rather continues to reward and pay for highly procedural care. In fact, the notion that current health care policies favor procedural specialties over cognitive specialties is well documented. For example, between 2000 and 2008, Medicare payments for procedural services grew by 84 percent while payments for cognitive services grew by only 48 percent (Sigsbee 2011).

We are concerned that your recommendation to revalue overpriced services in a budget neutral manner will not have the desired effect. While it could result in increasing the reimbursements for cognitive care by increasing the reimbursements for E/M services, some of those increases may continue to flow to proceduralists through the global surgical periods. We must find other ways to “fix” this system that include recognition of specialties that coordinate and manage care for patients with chronic conditions that add a layer of complexity that primary care physicians currently desire when they refer to colleagues with additional training and expertise. Failure to recognize this, coupled with full implementation of the recommendation, would result in less appropriate care for some of the highest need, highest cost Medicare beneficiaries.

Thank you for your attention to the AAN’s concerns. Should you have questions or require further information prior to the MedPAC vote on this draft recommendation in October, please contact Rod Larson at rlarson@aan.com or by phone at (651) 695-2772.

Sincerely,

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CC: Catherine M. Rydell, CAE
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