The Future of Primary Care:
Physician payment reforms, past, present and future

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Massachusetts General Hospital
Associate Professor of Medicine
Harvard Medical School

Our journey and our promise

I chose primary care because of family stories

WHG Jr 1939-1985 and WHG Sr 1909-1962

The WHGs (1962) Jr age 53, Sr age 79

Saving primary care

1. Pipeline issues: Medical training, pre and post graduate, must align with national needs
2. Practice reform: Must be local
3. Payment reform: Without income parity, PC will disappear and so will all the cognates.

My goals

1. Explain the RBRVS, our monetary system, and how physician services are priced ("valued")
2. Know all the core PC service codes : E/M, IPPE, AWVs, TCMs and CCM
3. Understand the implications of MACRA, the Medicare Access and CHIP Reauthorization Act of 2015. Now called the Quality Payment Program (QPP)
4. Know what is being done achieve payment parity for the cognates

How are doctors paid?

Payment Policies

Congress with Executive Approval

- Medicare (1965)
- Medicaid (1965)
- RBRVS (1989)
- HITECH (2009)
- Affordable Care Act (2010)
- MACRA (2015)

Policy Implementation

Executive branch: Center s for Medicare and Medicaid Services (CMS)

- RBRVS Physician Fee Schedule, 1992
- Sustainable Growth Formula, 1997
- Meaningful Use, 2011
- Health Care Exchanges, 2012
- Value-based Purchasing, 2019

Omnibus Budget Reconciliation 1988

"Provides for the gradual transition, from 1992 through 1995, to the determination of Medicare payments for physician services pursuant to a fee schedule which takes into account the relative value of the work, practice expenses, and malpractice risks associated with each physician service…."

Thus began RBRVS…

Medicare fee schedule

On January 1 each year, the Center for Medicare and Medicaid Services (CMS) issues a physician fee schedule (PFS)

The valuation for each service is provided in RVUs (relative value units)

Payment is calculate by multiplying the total relative value units times conversion factor, roughly $36

What are the service codes used in primary care?

E/M (Evaluation and Management) are the codes used by all physicians for the non procedural service, outpatient new patients (99201-5) and established patient (99211-5) codes

Intended for the evaluation and management of patient conditions…no disease prevention or health promotion

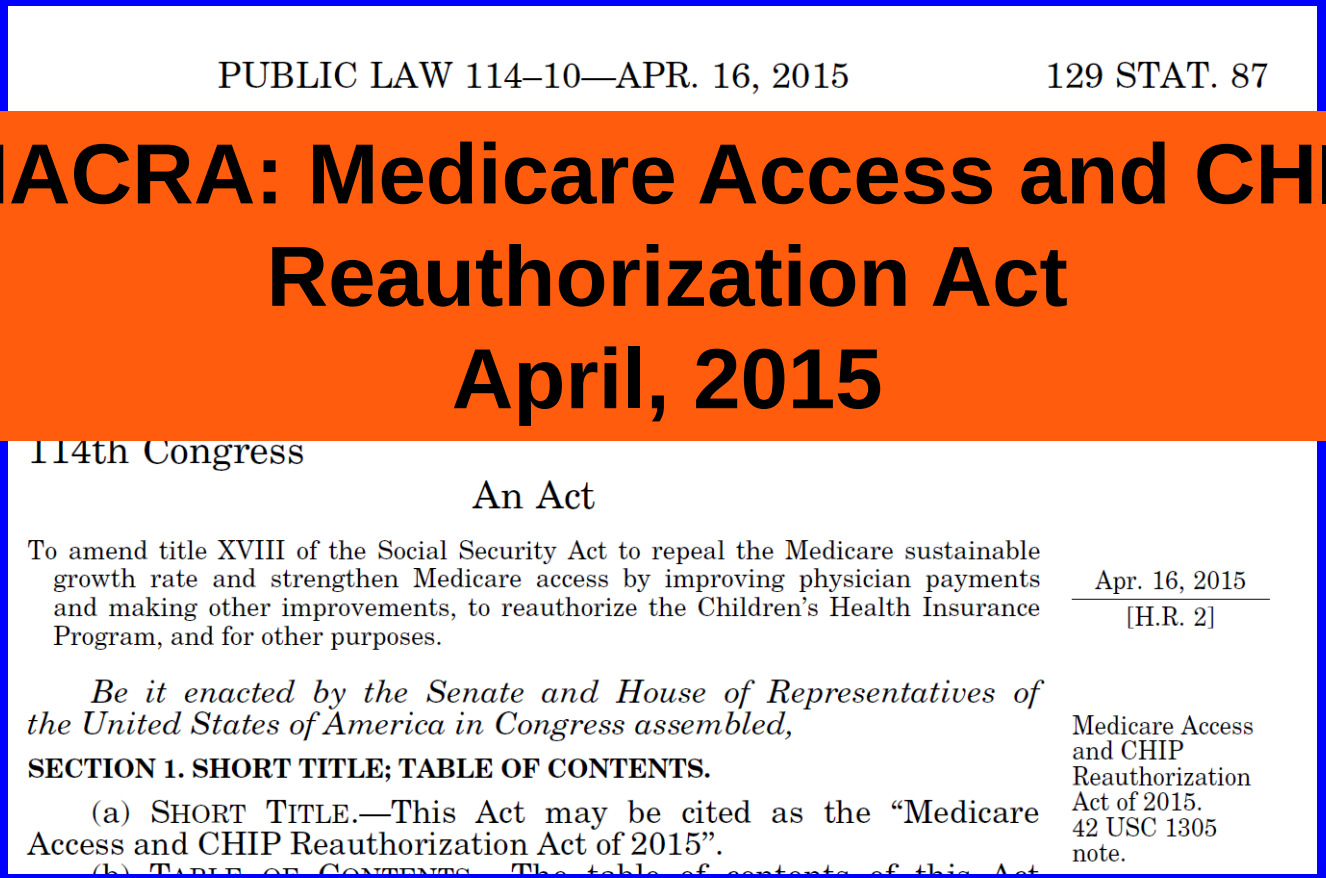
All models of care delivery use RBRVS building blocks to calculate the work done

Salary models use the PFS to establish productivity goals/bonus thresholds.

PCMH compensation models derived from the services delivered by each clinician based on the PFS

ACO revenue distribution AND resource allocation derived from the relative values assigned to the work done

MACRA: Medicare Access and CHIP Reauthorization Act April, 2015



PUBLIC LAW 114–10—APR. 16, 2015 129 STAT. 87

114th Congress

An Act

To amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes.

Apr. 16, 2015
[H.R. 2]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

Medicare Access and CHIP Reauthorization Act of 2015. 42 USC 1305 note.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Access and CHIP Reauthorization Act of 2015".

- Health care costs will "bend"
  - Incentives for "quality" will improve the "value" of health care expenditures
  - Incentives must be for more than "nominal risk"

The physician fee schedule is the Achilles' heel of MACRA

NEJM
April 7, 2016
Berenson and Goodson

Our message:

"Implementing new incentives and quality measures in new payment models while maintaining broken fee schedule is a prescription for failure."

Basic terminology

What we do: **CPT** (Current Procedural Terminology): What we do, descriptions of services. Proprietary to the AMA.

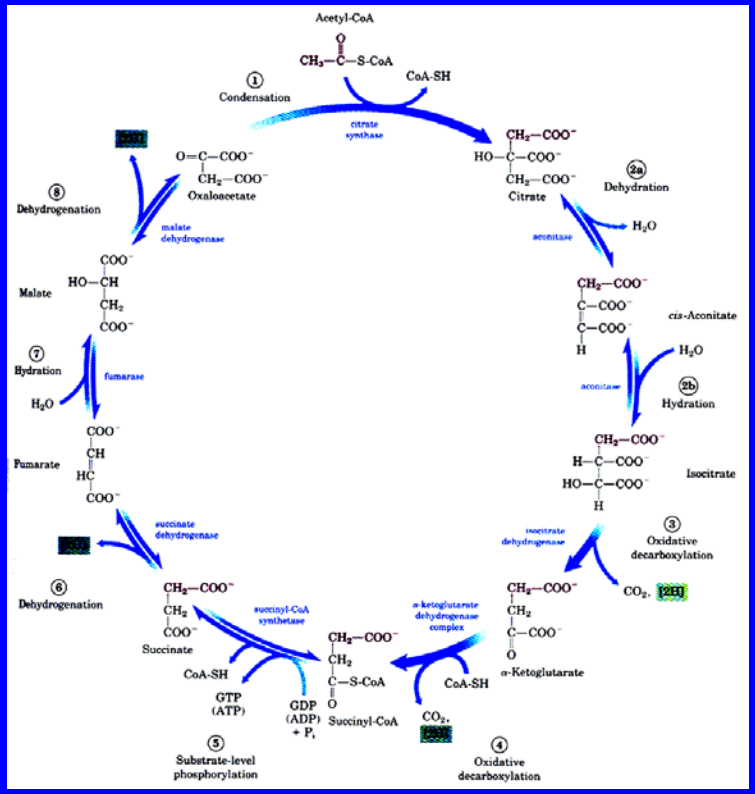
Why we do it: **ICD** (International Classification of Diseases): The diagnostic code assigned to each disease or condition, ICD 10

We are paid in ***RVUs*** (Relative Value Units, the "coin of the realm") for each CMS service with an RVU value

Welcome to our world: The land of RVUs

"The devil of the details"

Let's talk about coding: Kreb's vs. RBRVS (Resource-based Relative Value Scale)



The origins of E/M undervaluation began at the beginning

The journey to the land of RBRVS:

The road to the RBRVS: Step 1: Crisis of sustainability

1980s: Medicare payment crisis from "usual and customary" payments, Congress reacts

1985: HCFA begins RBRVS study. CPT 4 has 7000 codes (6900 are for procedures)

1987-89: Hsiao study and his assumptions:

- Payment for work and costs
- Intensity = technical skill+mental/physical effort+psychological stress (not time!)
- Time intervals: Pre, intra and post-service

1988: The Harvard Report, Hsiao and Braun: The RBRVS "tablets"

A NATIONAL STUDY OF RESOURCE-BASED
RELATIVE VALUE SCALES FOR PHYSICIAN SERVICES

FINAL REPORT

by William C. Hsiao, Ph.D.
Peter Braun, M.D.
Edmund Becker, Ph.D.
Nancyanne Causino, Ed.D.
Nathan P. Couch, M.D.
Margaret DeNicola, R.N., M.P.H.
Daniel Dunn, Ph.D.
Nancy L. Kelly, Ph.D.
Thomas Ketcham, M.P.H.
Arthur Sobol, M.A.
Diana Verrilli, B.A.
Douwe B. Yntema, Ph.D.

Federal Project Officer: Jack Langenbrunner

Department of Health Policy and Management
Harvard School of Public Health
and the Department of Psychology,
Harvard University (Dr. Yntema)

HCFA Contract No. 17-C-98795/1-03

September 27, 1988

The road to RBRVS: Step 2: Research to policy

1987-89: Hsiao study

Payment =

(Work)(1 + Practice Costs)(1 + Opportunity Costs)

1986-89: Congressional Physician Payment Review Commission (PPRC, later to become MedPAC)

Payment =

Work + Practice Expense + Malpractice

1992: Resource-based relative value scale (RBRVS)

Some critical assumptions in RBRVS

Bundling: Payments made for the pre visit, face to face, and post visit work of each encounter = pre-, intra- and post-service times. For a 99214:

Pre visit = 5 minutes

Intra visit = 25 minutes

Post visit = 10 minutes

Global payments: Payments made for the projected average care experience for a given service (zero, 10 days, 90 days).

In summary: RBRVS is the "monetary system" of health care payment

Resource-based relative value scale (RBRVS)

- Weighted system (Geographically)
- Assigns worth = "RVUs" to each CPT code
- 3 components: Total RVUs = W + P + M
  - **W**ork "…Clinical work…" (52%)
  - **P**ractice Expense "overhead" (44%)
  - **M**alpractice "liability insurance" (4%)

Physician payment since 1992

Payment =

$$[(RVU_W \times GPCI_W)+(RVU_P \times GPCI_P)+(RVU_M \times GPCI_M)] \times CF$$

$$= [\text{Total RVUs}] \times CF$$

RVUs = “coin of the realm”

1 RVU = $35.78 in 2017

Common outpatient E&M wRVUs

New	Established
99202 - 0.93	99212 - 0.48
99203 - 1.42	99213 - 0.97
99204 - 2.43	**99214 - 1.50**
99205 - 3.17	99215 - 2.11

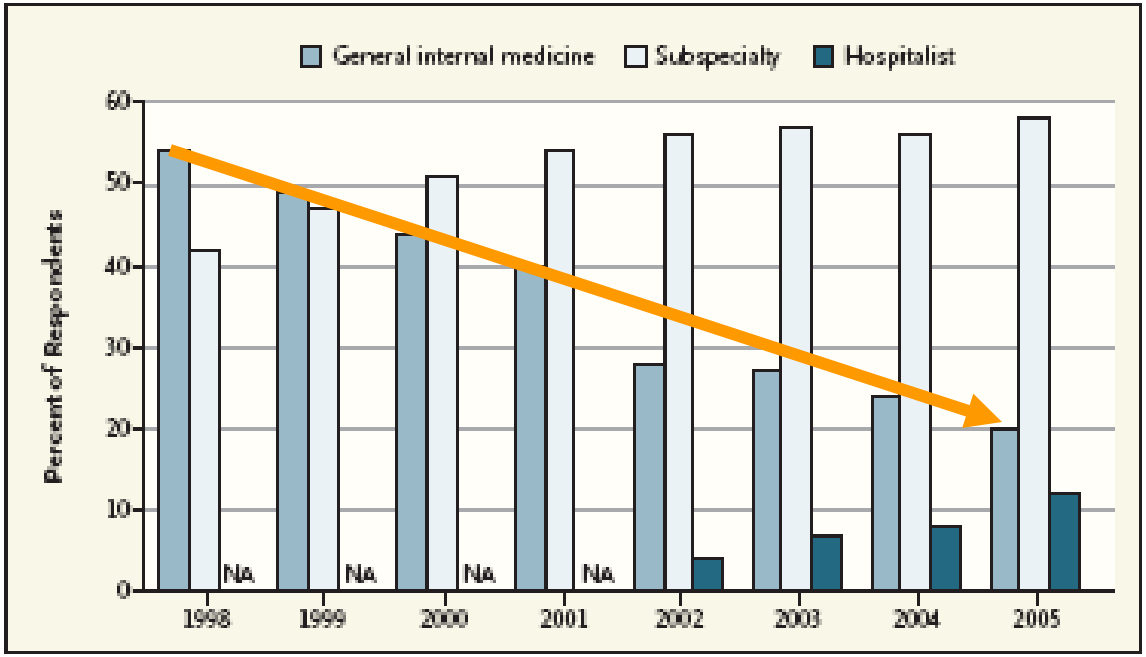
99214 Total non facility RVUs =
1.50 + 1.53 (PE) + 0.10 (M) = 3.13 RVUs
= $ 112 (2017CF = $35.78)

So what has happened to primary care since 1992?

- Expansion of complexity/ intensity or primary care
  - --Combination therapies
  - --More ambitious treatment goals (P4P)
  - --Shifting demographics
- Expansion of primary care agenda
  - --Disease prevention
  - --Screening
  - --Health promotion

Resident interest in primary care has plummeted!

The proportion of third year residents in GIM is falling:

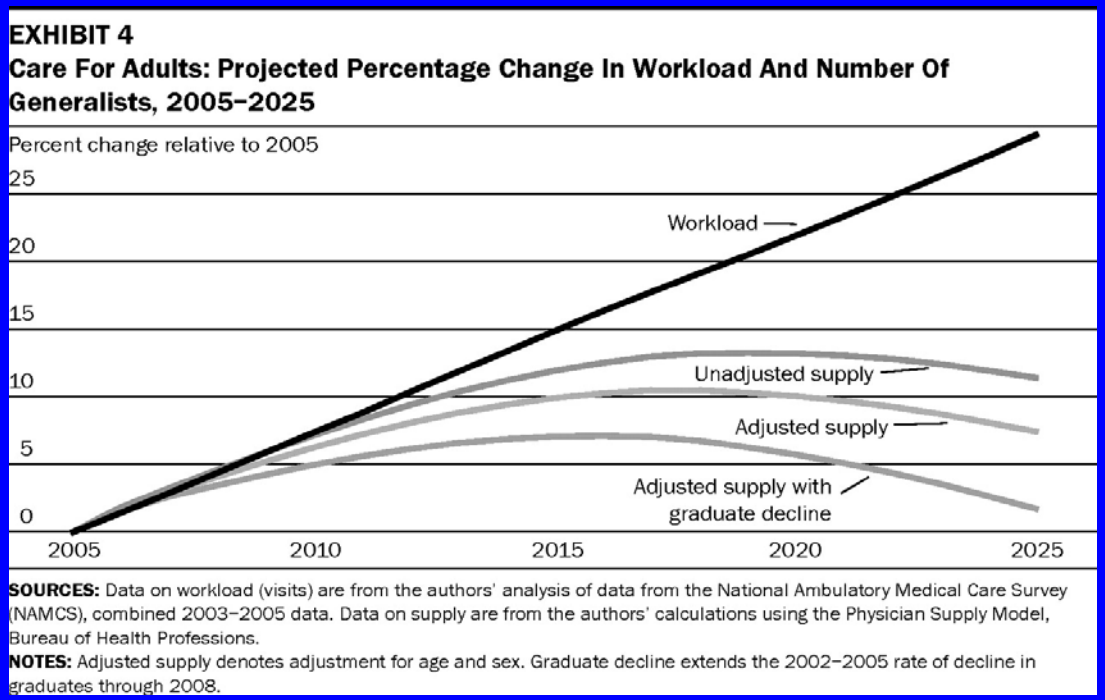


Proportions of Third-Year Internal Medical Residents Choosing Careers as Generalists, Subspecialists, and Hospitalists.

Woo, N Engl J Med 2006;355:

A Primary Care workforce crisis is inevitable without action

44,000 PC MD deficit by 2020



Primary care workload 2025

Primary care workforce without correction 2025

Colwell et al. Health Affairs 2008;29:232

PC pay is HALF OR LESS than specialty payment

General family practice	$197,655
General internal medicine	$205,441
Pediatrics	$202,832
Gastroenterology	$389,385
Orthopedic surgery	$476,083
Diagnostic radiology	$438,115
Dermatology	$350,627

Source: American Medical Group Association 2009 survey

Evaluation and management services are dramatically undervalued

	Total time	RVUs	Payment
Established OP E/M, 99214	35	2.64	$95
Colonoscopy	24	5.87	$211
Cataract extraction and lens implantation	23.5	17.17	$638

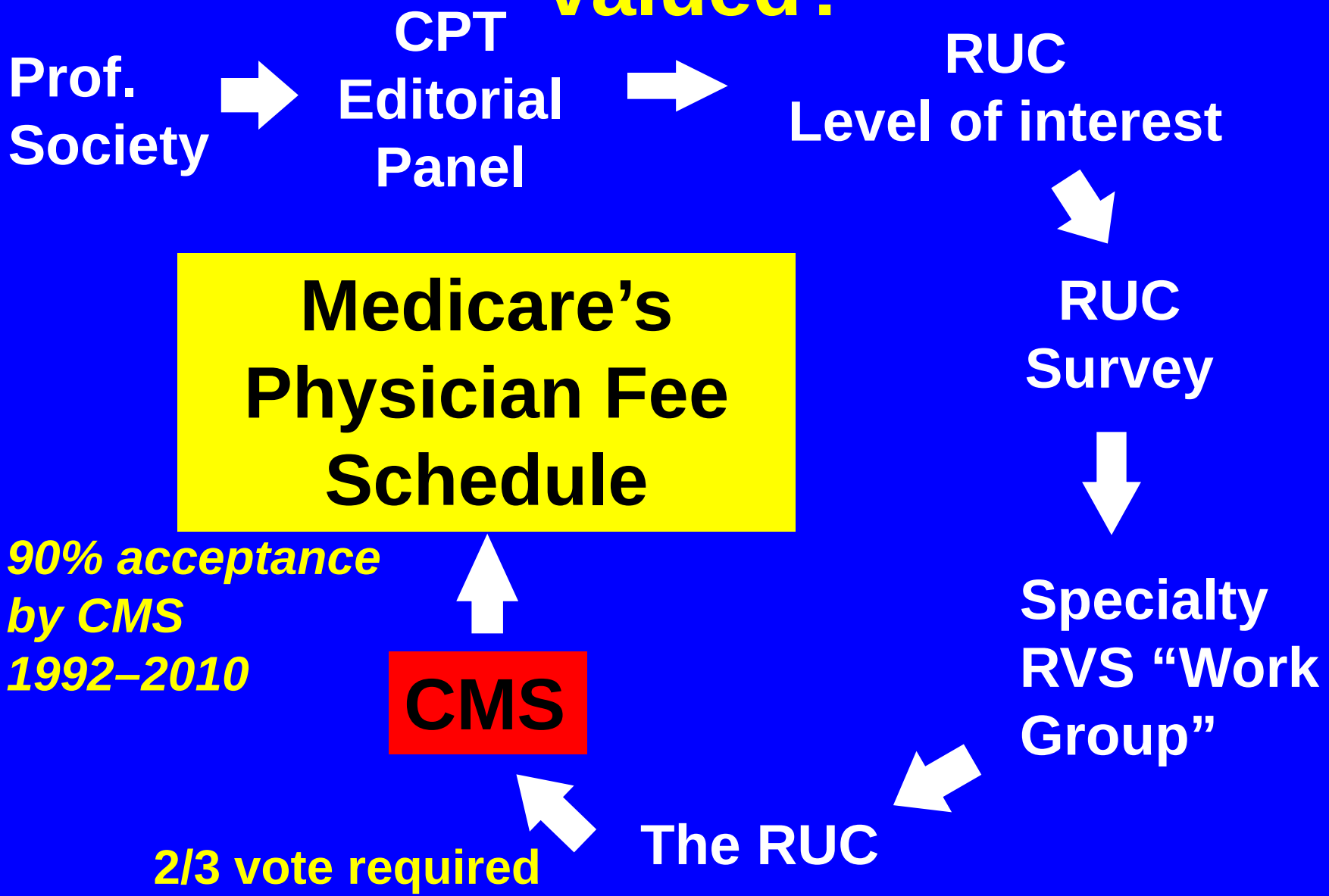
Sinsky, SGIM 2010

How did we get into this predicament?

Bill Hsiao knew that primary care and other cognitively intense work was not properly valued from the beginning of the RBRVS.

Hsiao (1988): "Important research needs to be done including…Developing a more suitable extrapolation method for E/M services…to address the ambiguity in the …descriptions of these services."

How are serviced defined and valued?



Who is on the AMA's RUC?

Composition strongly favors specialists, 20/25

Primary Care (6):

- Emergency medicine
- Family medicine
- Geriatrics
- Internal medicine
- Pediatrics
- Primary care**

Non PC specialists (5):

- Psychiatry
- Neurology
- BM transplant**
- Cardiology
- Renal**

Proceduralists (14):

- Anesthesia
- Dermatology
- ENT
- General surgery
- GI surgery**
- Neurosurgery
- OB/GYN
- Orthopedic surgery
- Ophthalmology
- Pathology
- Plastic surgery
- Radiology
- Thoracic surgery
- Urology

**Rotating seats

Corn fields in Iowa and Nebraska

Iowa

Nebraska

Doctors and farmers

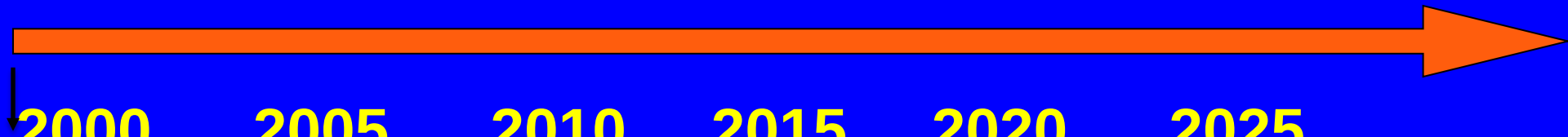
- Doctors = Farmers in Iowa or Nebraska
  - Time (hours you work) = Acres
  - Specialty = Iowa or Nebraska
  - Productivity (RVUs per hour of work) = bushels/acre
- Income = acres (hours worked) x productivity (RVUs/hour) x corn price (conversion factor)
- Imagine if your grow corn in Nebraska but the farmers of Iowa control your fertilizer (your productivity)

Is there hope for primary care

CMS (2008-16) recognized the dilemma faced by primary care

- CPT controlled by AMA
- RUC controlled by AMA and managed by proceduralists and specialists
- Only one set of E&M code families, new and established, used by all MDs
- PC MDs need access to more RVUs…but how??

CMS and Primary Care Payment



2000 2005 2010 2015 2020 2025

E/M, 99201-5, 99211-5

IPPE, 2005

AWVs, 2011

TCMs, 2013

CCM, 2015, 2017

Prolonged Srvs, 2017

TWO Medicare wellness and prevention service codes

SERVICE	PATIENT COSTS
Problem focused clinical care : 99201-5 New Patients 99213- 5 Established Patients	Subject to co-insurance and/or deductible
IPPE (Welcome to Medicare) G0402	100% During 1st year of Part B enrollment
AWV (Annual Wellness Visits) G0438 (first) G0439 (subsequent)	100% after 1st year of Part B enrollment Annual benefit (+ 366 days)

Key point: AWVs can stand alone or have an added E&M visit

- The E/M must be submitted with a “-25” modifier.
- The decision to combine service codes can only be made by the clinician. This cannot be done by anyone else!

Example of combining service codes

- For example:
  - 66 year old established patient is seen for Initial Annual Wellness Visit
  - The visit also addresses the management of her HTN, DM and hypercholesterolemia. She is on 5 medications. Labs are ordered.
  - Coding= G0438 (Initial AWV) + 99214
    = 1.50 + 2.43 = 3.93 work RVUs
    = 8.02 total RVUs
    = $287

99495-6: Transitional Care Management (TCM) codes:

--Medicare's incentive to manage patients as they leave facilities an return to home

--This is a bundled payment for PC services for 29 days of care

--Bill can be submitted on the day of face-to-face care

99496 TCM services (high):

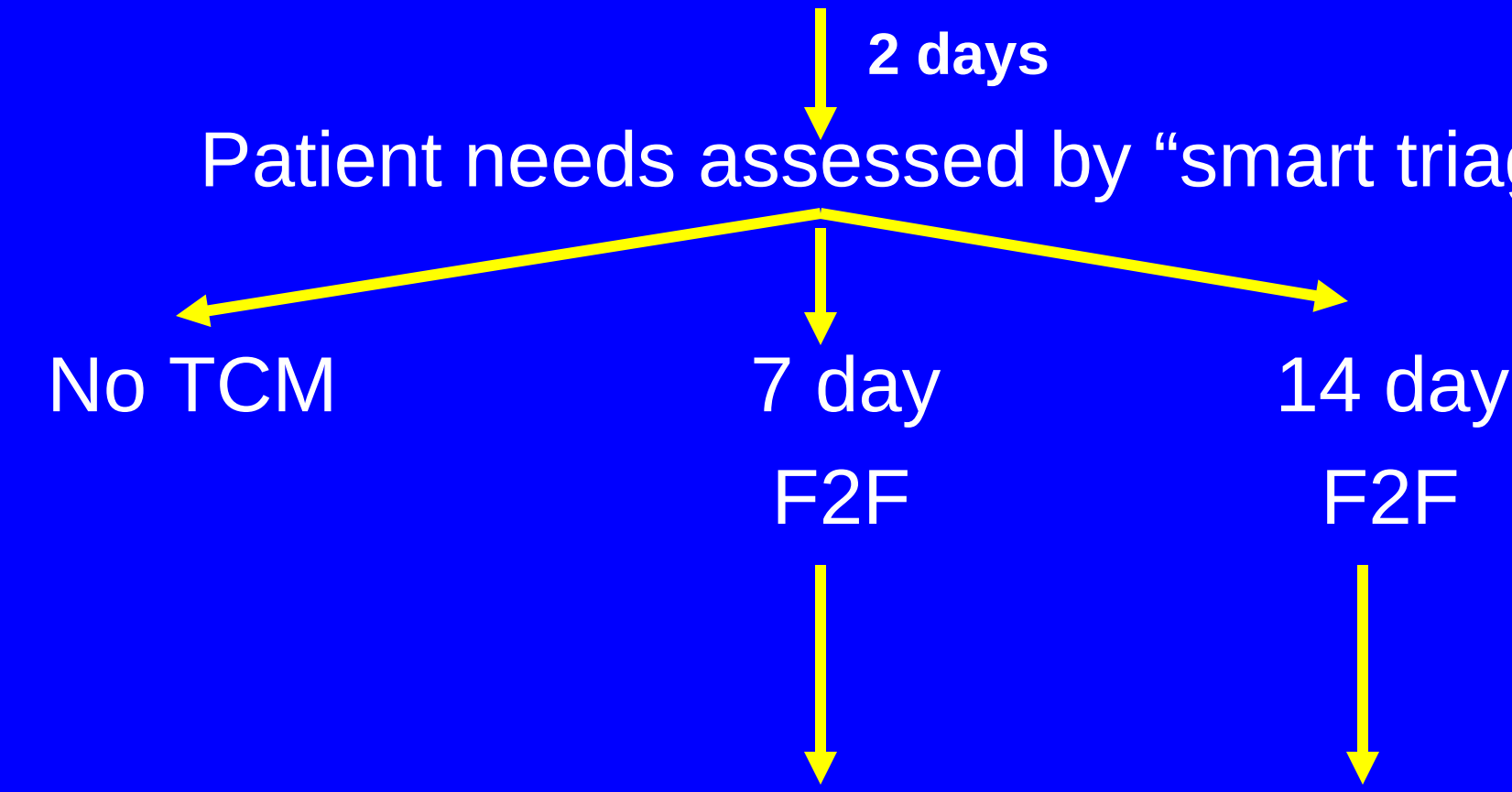
- **Communication** by direct contact (face to face), telephone or electronically with the patient and/or caretaker **within 2 business days of discharge**
- A **face-to-face encounter with 7 days**
- MDM of **high complexity**
- **Work RVUs = 3.05**
- **Total 6.79 (non facility) and 5.81 (facility)**
  = $244 (non facility)

99495 TCM services (moderate):

- **Communication** by direct contact (face to face), telephone or electronically with the patient and/or caretaker **within 2 business days of discharge**
- A **face-to-face encounter with 14 days**
- MDM of at least **moderate complexity**
- **Work RVUs = 2.11**
- **Total 4.82 (non facility) and 3.96 (facility)**
  = $173 (non facility)

Workflow: Know discharge date

Patient leaves facility



Key practice roles for the TCMs

- Who will ensure that all discharge patients are tracked (usually the Front Desk but all need to be aware)?
- Who will make the two day call and triage?
- Who will schedule the face to face visit?
- Who will ensure that the final documentation requirements are met?

Prolonged service codes, 2017

- **Prolonged service code 99358 (facility 3.16, non-facility 3.16):** Prolonged E/M services before or after direct patient care, first 60 minutes.
  - Cannot be reported with CCM initiation, Complex CCM (see later) or TCMs
- **Prolonged service code 99359 (facility 1.52, non-facility 1.52):** Prolonged E/M services before or after direct patient care, each additional 30 minutes

Prolonged service codes: Caveats

- The clock starts after 40 minutes total time. Medicare allows cumulative time over 31 minutes to equal 60 minutes (i.e. 3.16 RVUs added after 31 min.)
- MD and “other practitioner” professional time can be combined
- 99359 requires 60 minutes plus at least 16 minutes (over half of the 30 minutes) = $\geq$76 minutes
- Only time would need to be documented
- Must be related to an E/M encounter…but service delivery can be on a separate day.
- The beneficiary is liable for 20%

Chronic care management codes

- **CCM service code 99490 (facility 0.91, non-facility 1.19):** This is the existing service code that requires 20 minutes of asynchronous, non-face-to-face clinical staff time per month.
- **CCM service code G0506 (facility 1.29, non-facility 1.78):** This new service code designed to cover the time required to develop a CCM plan
- **CCM service code 99487 (facility 1.47, non-facility 2.61):** This is a new service code covers the first 60 minutes of extended CCM care provided per month.
- **CCM service code 99489 (facility 0.74, non-facility 1.31):** This new service code covers each additional 30 minutes beyond the first 60 minutes

Which patients are eligible for CCM code billing?

- Any Medicare patient, “expected to live 12 months or until death”
- Patients with two or more chronic conditions
- One CCM provider per Medicare beneficiary
- No prior IPPE (Welcome to Medicare) or AWV (Annual Wellness Visit) is required.
- Non Medicare carriers have no obligation to pay for CMS or CPT defined services.
- Indefinite
- Subject to 20% patient or supplement co-pay

Medicare payment reforms

For a hypothetical physician with 500 Medicare patients:

Revenue from 99214 (3 visits per patient per year) = 1500 x 3.13 x $35.78 = **$167,987**

Added revenue for subsequent AWVs

= 500 x 3.26 x $35.78 = $58,321

Added revenue for TCMs (60 moderate and 20 high MDM discharges, 60 x 4.82 x $35.78 = $10,348 and 20 x 6.79 x $35.78 = $4,859) = $15,207

Total NEW PC revenue = **$73,528 (total $241,515)**

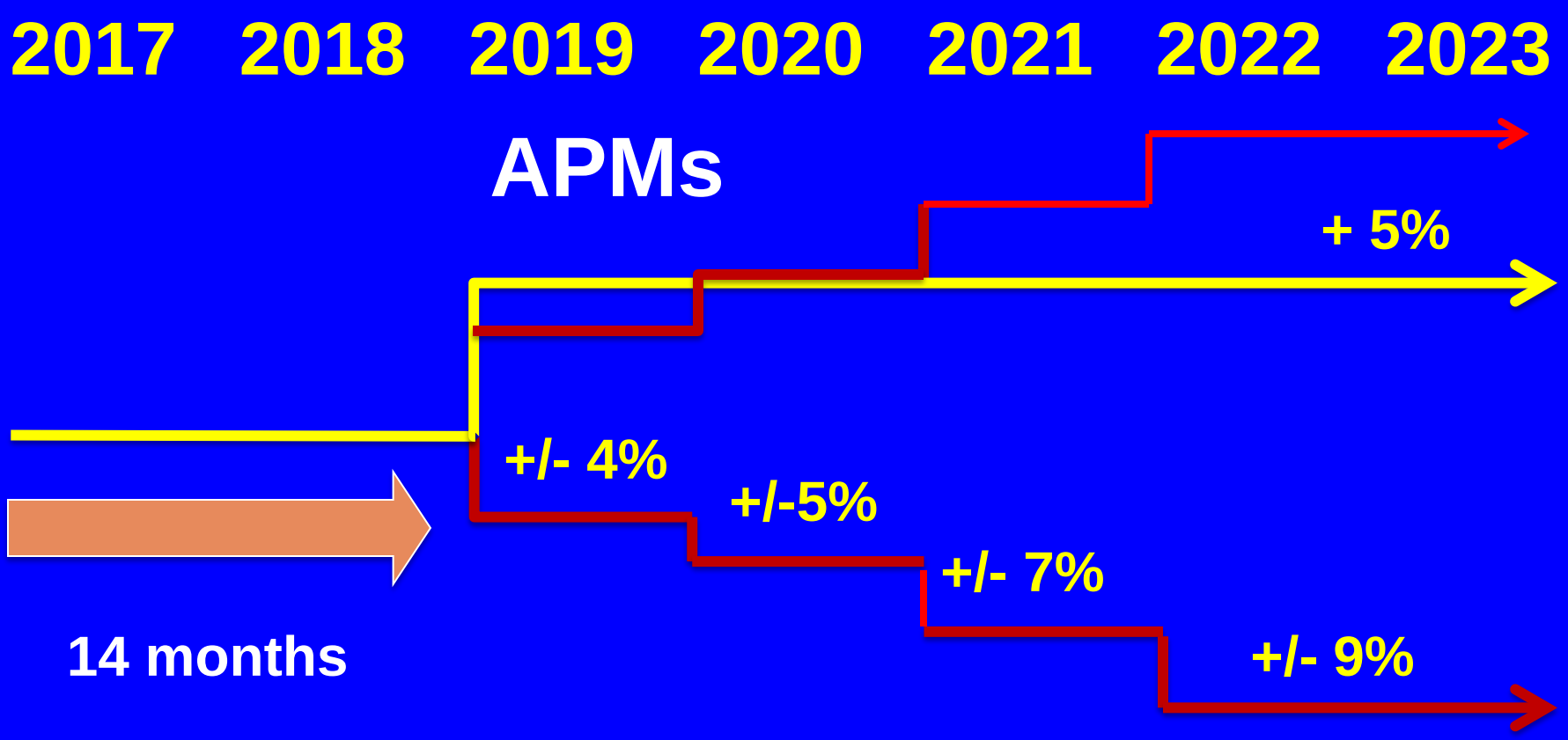
Medicare Access and CHIP Reauthorization Act, MACRA Beginning or Ending?

MACRA Payment Options

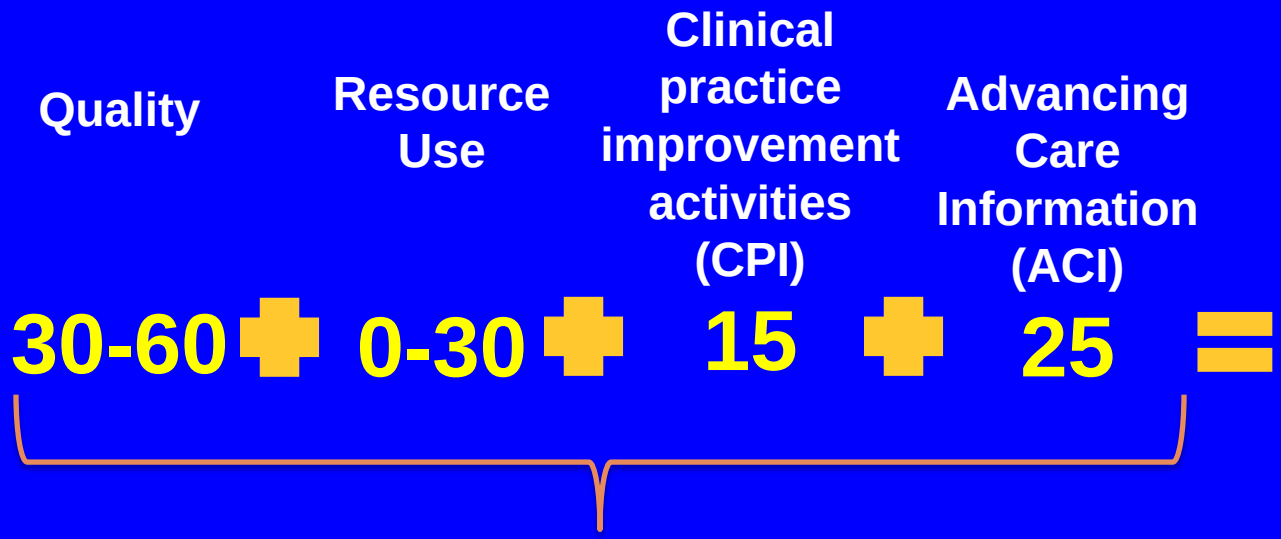
Merit-based Incentive Payment System (MIPS)

Alternative Payment Models (APMs)

MIPS penalties and APM incentives



How will Physicians be scored under MIPS?



Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

MIPS Timeline

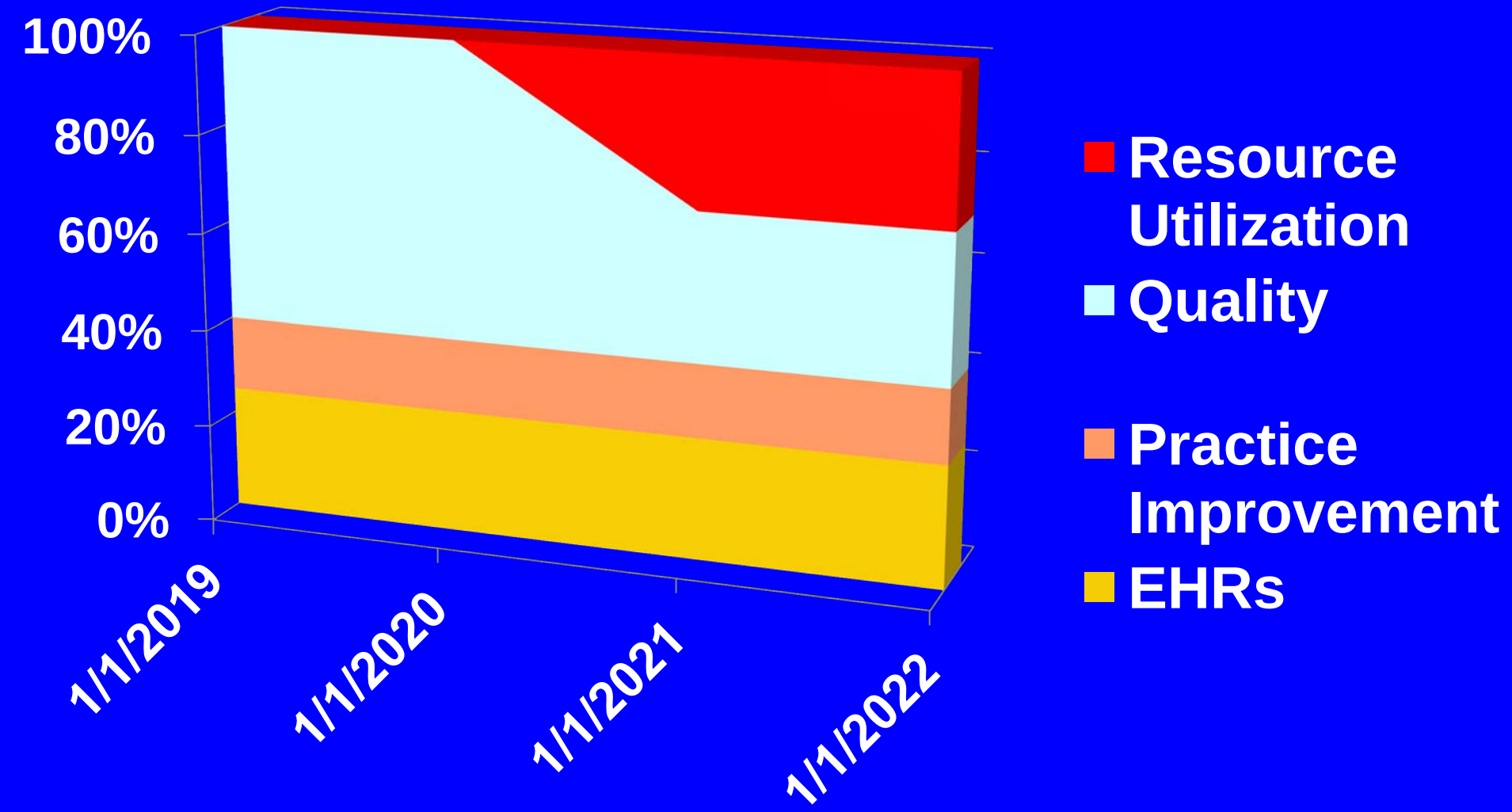
2017-18: Initial MIPS scores

2018: July 1st CMS attribution models

2019: January 1st MIPS and APMs start, payments adjusted based on 2017

Note, MIPS “Reporting year” data changes the “payment year,” two years later

Timeline for your MIPS Composite Practice Scores (CPS)



Where will the data come from?

- Quality
  - Physician, EHR vendor, intermediary
- Resource use
  - Claims with attribution and risk adjustment
- Practice improvement
  - Physician reporting
- Advancing Care Information
  - EHR Vendor

Quality (0-60 points)

Disease treatment

- CV: Hypertension (<140/90), Beta blocker for 6 mos. post acute MI
- Diabetes care: HbA1c <9%, foot care, eye, nephropathy
- Asthma: Persistent on controller medications

Prevention

- Ischemic vascular disease on ASA
- Tobacco cessation screening and cessation

Screening

- Cervical CA screening
- Breast CA screening, 50-74, biannual
- Colorectal CA screening
- BMI screening and follow up

Patient experience (CAHPS)

Resource Use (0-30 points)

Your clinical Care

- No cervical CA screening <21 yrs
- No imaging for LBP
- Avoidance of antibiotics in bronchitis

But what about…

- Clinical care delivered by colleagues
- Clinical care driven by patient demands

Practice Improvement (0-15 points)

- Access
  - Same day appointments
- Care delivery
  - Medication reconciliation
  - Population management
- Communication
  - Test results communication
  - Plan of care (POC) for complex patients
  - Shared decision-making
- “MOC assessments”

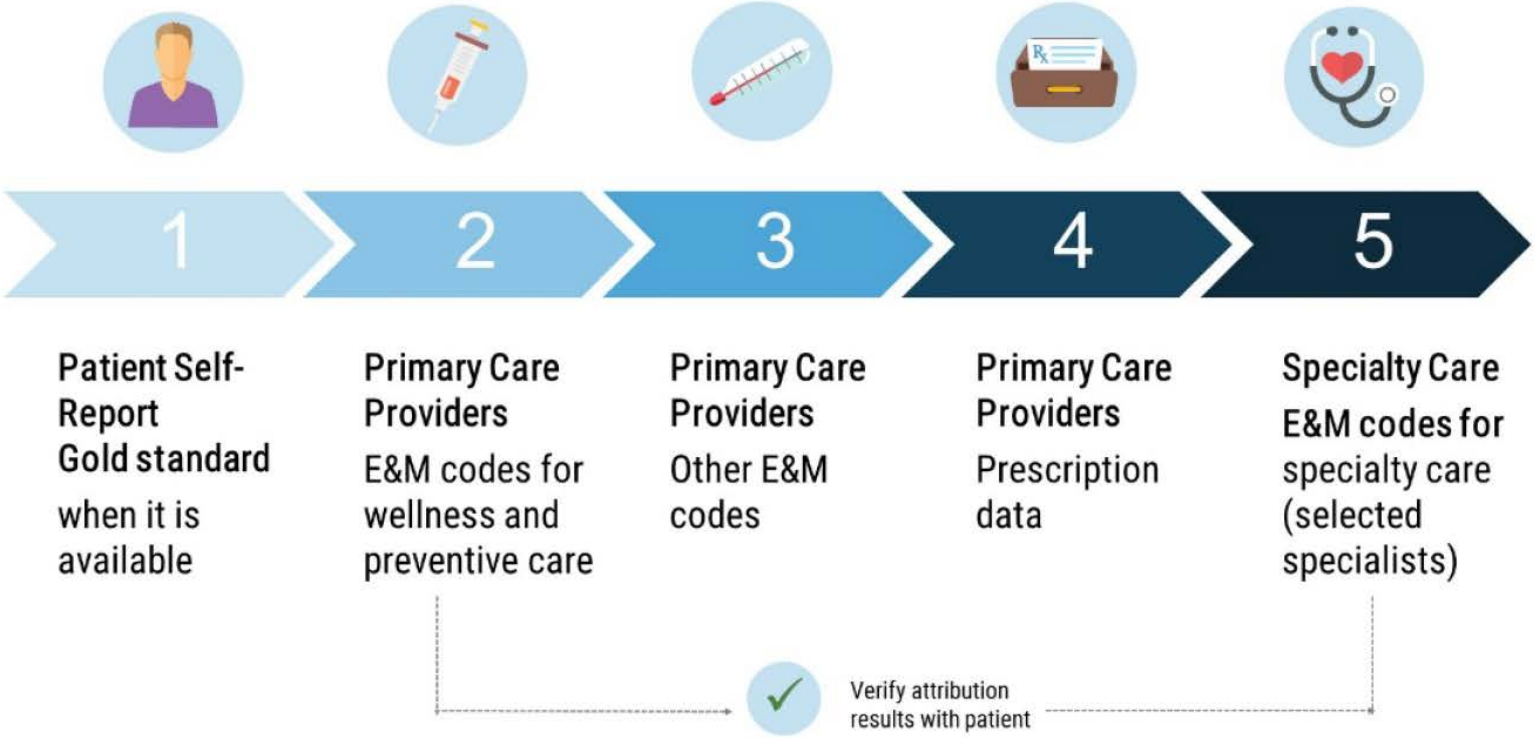
Advanced Care Information (0-25 points)

- Clinical Functionality – 15 Criteria
- Care Coordination & Clinical Quality measures (CQM) – 13 Criteria
- Privacy and Security – 11 Criteria
- Design and Performance – 9 Criteria
- Patient electronic Access and Secure Messaging – 9 Criteria
- Public Health Reporting – 7 Criteria

MACRA: The critical unknowns?

- **Patient attribution:** How will MDs know which patients they are accountable for? Attribution will begin retrospectively. Will patients accept prospective attribution?
- **Risk adjustment:** Will risk adjustment tools be adequate. Can HCC (Hierarchical Condition Category) risk adjustment account for individual patient panels?

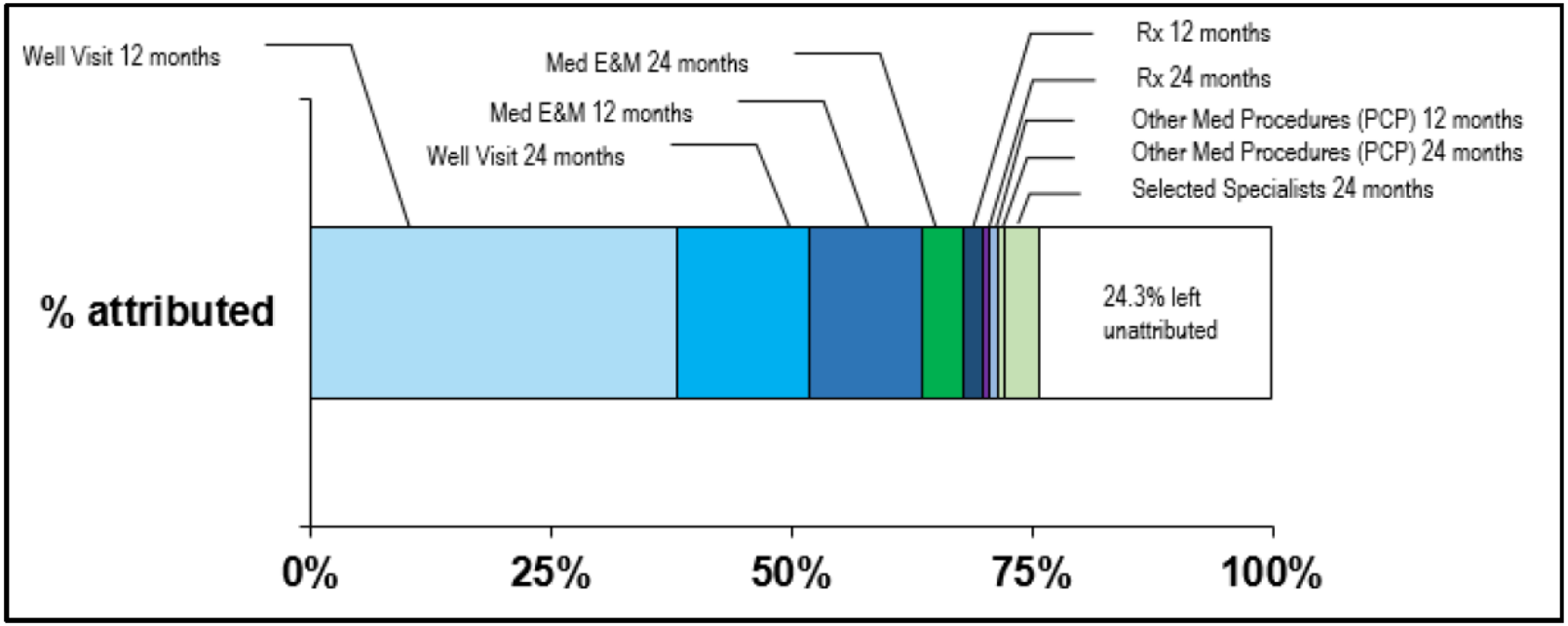
Learning Action Network patient attribution flowchart



https://hcp-lan.org/groups/pbp/pa-final-whitepaper/

But 25% of patients cannot be attributed in optimal circumstances

Figure 2: Blue Cross Blue Shield of Massachusetts Attribution Levels



https://hcp-lan.org/groups/pbp/pa-final-whitepaper/

Cost: Total per capita costs "attributed" to a beneficiary

Sum of Part A and B spending for each beneficiary attributed to TIN

Two step attribution process (includes TCM, CCM codes)

Risk adjustment methodology uses:

- Age, sex, disability status
- CMS HCC score in preceding year
- ESRD

Adapted from Measure Information Form, CMS
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-TPCC-MIF.pdf

Risk Adjustment in Medicare Advantage Plans

NON-SPECIFIC CODING		SPECIFIC CODING	
ICD 10 Code	RAF*	ICD 10 Code	RAF*
Demographic RAF	**0.395**	Demographic RAF	**0.395**
E11.9: Type 2 diabetes mellitus without complications	0.104	E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease	0.318
N18.9 Chronic kidney disease, unspecified	0.000	N18.4: Chronic kidney disease, stage 4	0.237
E66.9: Obesity unspecified	0.000	E66.01: Morbid Obesity	0.273
F32.8: Other depressive epsiodes	0.000	F32.1: Major depressive illness, single episode, moderately severe	0.395
I25.9 Chronic ischemic heart disease, unspecified	0.000	I25.119: Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris	0.140
Total	0.499	**Total**	1.758

***Payment Year 2017, Average Total RAF FFS Medicare is 1.000*

***Difference in RAF: 1.259

Carnavali F, Arron M, Risk Adjustment in Medicare Advantage Plans, SGIM Forum 2017:40(2)

Alternative Payment Models (APMs)

- Eligible APMs
  - Quality measures comparable to those in MIPS
  - Certified EHR technology
- Risk defined:
  - Bear more than “nominal” financial risk for monetary losses OR
  - Be a medical home model expanded under CMMI authority

Take home points for MACRA

1. Most physicians will likely be part of MIPS option
2. Much of the data will be generated by Medicare automatically.
3. Primary care is at the epicenter regardless of APM or MACRA pathway

COMMENTARY

Unintended Consequences of Resource-Based Relative Value Scale Reimbursement

John D. Goodson, MD

terol levels were managed actively. Targets for secondary prevention decreased with successive clinical studies, and

2007

2013

CHEST Commentary

The Undervaluation of Evaluation and Management Professional Services

The Lasting Impact of Current Procedural Terminology Code Deficiencies on Physician Payment

Erik A. Kumetz, MA; and John D. Goodson, MD

SGIM
Society of General Internal Medicine
Creating Value for Patients

SGIM White Paper: The case for the redefinition and revaluation of the outpatient Evaluation and Management (E&M) service codes and the development of new documentation expectations

May 2015

Atul Nakhasi and John Goodson, MD

Endorsed by the SGIM Council July 10, 2015

2015

Finding new best friends for primary care: The Cognitive Care Alliance

February 2015: SGIM open call for representatives of cognate specialty societies

March 2015: Agreement on principles

- Meeting with CMS leadership in DC
- Meetings with Congressional staff
- Discussion with MedPAC

Coalition letter to CMS: March 23, 2015

March 23, 2015

Mr. Sean Cavanaugh
Deputy Administrator and Director
Center for Medicare
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Proposal to redefine and revalue outpatient Evaluation and Management (E&M) service codes

Dear Mr. Cavanaugh:

The undersigned specialty societies request that the Centers for Medicare and Medicaid Services (CMS) engage in a process to create additional outpatient evaluation and management (E&M) codes. We believe that the existing office codes (CPT 99201-5 and 9921-5) no longer accurately or adequately reflect the work currently provided to and required by Medicare beneficiaries.

The coalition signees

American Academy of Allergy, Asthma and Immunology
American Academy of Family Physicians
American Academy of Neurology
American College of Allergy, Asthma and Immunology
American College of Rheumatology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy
American Society of Hematology
American Psychiatric Association
Endocrine Society
Joint Council of Allergy Asthma and Immunology
Society of General Internal Medicine

Medicare responds:

"…we recognize that these E/M codes may not reflect all the services and resources involved with furnishing certain kinds of care, particularly comprehensive, coordinated, care management for certain categories of beneficiaries."

COGNITIVE CARE ALLIANCE

- SGIM (Founder)
- American Academy of Neurology
- American Association for the Study of Liver Diseases
- American College of Rheumatology
- American Gastroenterology Association
- American Society of Hematology
- Coalition of State Rheumatology Organizations
- Infectious Diseases Society of America
- The Endocrine Society

The Cognitive Care Alliance, CCA

September, 2015: Formation of the Cognitive Care Alliance, CCA

- SGIM as founding member
- Governance
    - Chair: John Goodson
    - Executive director: Erika Miller
    - Executive board: SGIM, AGA, ACR, AAN

Saving the Cognates: The pathway to an evidence-based Medicare PFS

Step 1: Research to define the content of new and established patient evaluation and management (E/M) services

Step 2: Rework the definitions and valuations

--More balanced gradations

--Appropriate valuations

--Improved documentation requirements

CCA letter to House, Sept 2017

COGNITIVE CARE ALLIANCE

September 7, 2017

The Honorable Tom Cole
Chair
Subcommittee on Labor, HHS, Education, and Related Agencies
Committee on Appropriations
United States House of Representatives
Representatives
Washington, DC 20515

The Honorable Rosa DeLauro
Ranking Member
Subcommittee on Labor, HHS, Education, and Related Agencies
Committee on Appropriations
United States House of

Washington, DC 20515

Dear Chairman Cole and Ranking Member DeLauro:

"The existing E/M codes fail to adequately describe the work demanded by cognitive medical practice and have not maintained their relative valuation with respect to other physician services within Medicare's physician fee schedule (PFS). These deficiencies are creating workforce shortages and burdening Medicare beneficiaries."

The growing interest in reforming the fee schedule

- **MedPAC:** "The Commission remains concerned within Medicare's fee schedule for the services of physicians…primary care remains undervalued…" (2014)
- **Urban Institute** (December, 2016): "We suggest that CMS shift from its current approach common, which relies on specialty societies surveys and the RUC…, to empirical determination of time."
- ***Fixing Medical Prices***. Miriam Laugesen (Harvard Press, 2016)

Summary points

1. The RBRVS remains fundamental to all new payment models. MACRA is an adjuster.
2. E/M undervaluation remains a root cause for the decline of the primary care workforce.
3. CMS has provided a pathway to improved PC compensation with new service codes: IPPE, AWVs, TCMs, CCMs, and Prolonged services
4. CMS (Medicare) must end its codependence with the AMA's RUC and CPT Editorial Panel
5. Congress is the higher authority.

Thank you