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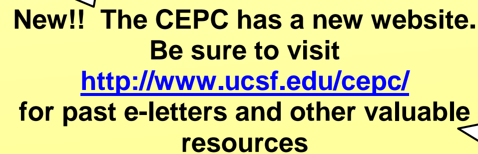

In This Issue
- **Featured Article: *Interview with Dr. Allan Goroll***

FEATURED ARTICLE

Interview with Dr. Allan Goroll

A groundbreaking article on primary care payment is:

Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. J Gen Intern Med 2007;22:410-415.

In this e-letter, Dr. Goroll adds his personal comments. The article is included in this e-letter.

Allan Goroll is Professor of Medicine at Harvard and a practicing primary care general internist at Massachusetts General Hospital. He is co-author of Primary Care Medicine: Office Evaluation and Management of the Adult Patient (Lippincott Williams and Wilkins, 5th edition, 2006). Dr. Goroll and associates have proposed an entirely new primary care payment mechanism which physicians and policymakers concerned with primary care are encouraged to study.

Tom Bodenheimer (TB) asked Dr. Goroll (AG) a few questions about the proposal:

TB: It is widely accepted that primary care cognitive office visits are reimbursed at far lower rates than procedural and imaging services taking the same amount of time. Some reformers hope to change the Resource-Based Relative Value Scale (RBRVS) fee-for-service payment system in order to create a more equitable balance between cognitive (also called evaluation and management or E&M services) and procedural services. You, on the other hand, are proposing that the entire fee-for-service payment system for primary care be scrapped. Please explain.

AG: RBRVS needs to be replaced, not modified because it is fundamentally flawed. While it was originally designed to fix the imbalance between paying for procedures and E&M work, it failed to do so.

TB: What are the specific flaws in the RBRVS system?

AG: First, it is based on encounters and discrete units of service, and primary care is all about comprehensive care, not face-to face visits. Some people have suggested that we could keep the RBRVS system and add a new code for a management fee for patients with chronic conditions. However, that does not change the "maximizing productivity" (more and more visits) emphasis of the current system, which distorts practice, demoralizes patients and physicians, and discourages students from choosing careers in primary care.

Second, RBRVS locks proceduralists and primary care physicians into a destructive zero-sum budgetary

relationship, because all Medicare physician payment is lumped into one budgetary pool. Every time Medicare approves payment for a new procedure that is widely used, it reduces the dollars available for other services, including E&M.

Third, the Relative Value Unit (RVU)-determining body, the RUC (AMA's Relative Value Scale Update Committee) does not provide adequate advocacy for primary care or timely updating of RVUs for E&M codes. The committee, made up of representatives from each specialty has very few seats for primary care. The result is marked failure to adequately update and revalue E&M services while richly valuing new procedures.

Fourth, quality improvement in medicine is about improving outcomes; RBRVS rewards amount of service (quantity), not outcomes (quality). Even if we attach a performance-based bonus (Pay for Performance or "P4P") on top of the RBRVS system to encourage good outcomes, we still have a payment system that overwhelmingly rewards volume and not quality.

Fifth, fixing the flaws in RBRVS would trigger a zero-sum-game intramural struggle with our specialty colleagues, which could drag on for years. We do not have years to fix this problem. The best strategy is to leave our proceduralist colleagues alone; let them continue with RBRVS and the RUC process (it seems to work fine for most of them) and let's work on an independent payment system for primary care that encourages the outcomes desired by the profession and the public.

TB: Could you briefly summarize the proposal in the JGIM article?

AG: We propose that primary care practices be paid an annual risk- and needs-adjusted comprehensive payment per patient, payable monthly. This payment would take the place of the current fee-for-service payments under RBRVS, and would support both the income of the physicians and the expenses of the practice, including the non-physician practice team and computerized information technology. 15-20% of the payment would be paid as a bonus for achieving mutually agreed upon quality, safety, and efficiency outcomes, risk adjusted so there is no disincentive to care for sick patients.

TB: What has been the response to this proposal?

AG: It has been overwhelmingly positive, people asking "Where do I sign up?"

a. There is almost unanimous agreement that RBRVS needs to be shelved for primary care and that paying a management fee is not sufficient to reverse the meltdown in primary care.

b. There is very strong support for our model, expressed in terms of great interest in field testing it around the country in all-payer demonstration projects over the next 2-3 years.

c. There have been no significant objections so far from the specialist community as long as we are not arguing for revaluing their RVUs.

d. One concern is that the practices would need to qualify as "medical homes" to qualify for our payment system, and many primary care practices would have a difficult time meeting the qualifications; these practices will need new monies to establish themselves as medical homes.

TB: Would your model create savings for Medicare or for overall health care expenditures in the US?

AG: There is concern that the net investment in primary care practice required for setting up medical homes and operating our payment model (estimated net 3% increase in total Medicare spending) might not be offset by savings derived from improvements in quality, safety, and outcomes. That is why we argue for field testing of our model as the next step, to rigorously test the hypothesis that saving 3% is readily achievable when we invest in primary care.

TB: Thanks for doing this groundbreaking work. I hope recipients of this e-letter will read the JGIM article and send feedback.

Thank you to all of our e-letter reviewers: Spencer Blackman, Kate Colwell, Sean Gaskie, Margaret Handley, Norman Hearst, Khati Hendry, Susan Hogeland, Janet Lai, Yoshi Laing, Joe Roll, Anne Rosenthal, and William Shore.

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