Primary Healthcare Payments: Reform on Hazardous Grounds

Written by: Andrew J. Shirley, August 2014

Despite decades of warnings, an income gap that exists between many of the nation's advanced medical specialists and primary care physicians has been widening at a rapid pace. Many medical school residents are well aware of the disparity between primary and specialty care incomes and opt for areas of care outside of the primary care setting. More than 60 million patients are currently without a primary care doctor. At the same time, legions of specialists abound.

While most health care lobbyists fight to ensure annual funding for the Sustainable Growth Rate (SGR), the core instrument used to reimburse both primary and specialty physicians throughout the American health system is the Relative Value Unit or RVU. In 1985, The Consolidated Omnibus Budget Reconciliation Act enacted a Medicare fee schedule for services rendered. In 2010, more than 8,500 distinct physician services were listed. The RVU scale was designed to balance the inequality between care delivery fees by calculating geography, value of service and cost to deliver care.

Determined by the Specialty Society Relative Value Scale Update Committee commonly called the "RUC", reimbursement payment rates are set by 29 men and women who compare one physician RVU rate against that of another. The committee was organized and has been operated by the American Medical Association since the mid 1980s.

In my mind, nowhere else in government do we consent to allow approximately two dozen specialists with completely unchecked latitude, the ability to directly self-determine personal levels of income (more than 90% of RUC recommendations are approved). It might be the perfect Washington example of the fox guarding the henhouse. For example, try to envision a world where 29 hand-picked popular military figures gathered inside a room every five years to determine relative value of deployment and acts of service on a per action basis. Picture then, without a single word from the United States Department of Defense, Intelligence Committee, Armed Services Committee or White House Administration, the group then approves said rates and immediately begins to receive taxpayer funds.

While critics might argue that my comparison is not apples to apples in nature, I would say it undeniably connects in the one area that matters more than anything else – the life and death, health and safety activities that altruistic souls perform every day in order to protect Americans.

Bluntly put, the RUC is a moral hazard of the purest shape and form. Critics have charged that the process is ripe with conflict of interest. The Honorable Thomas Scully, a former Center for Medicare and Medicare Services chief administrator, once described RUC meetings in this detail: "Essentially, we sit down in a RUC meeting and say, "Here's $43 billion and growing, how do you want to divide it up? What is the relative value of weights between anesthesiologists, gastroenterologists, surgeons and primary caregivers? And set the relative values at what the physician community thinks the relative payment should be."

Essentially, health care payment funding is now a $60 billion taxpayer funded allotment given to 29 people with incredible sway over the *who*, *where* and *how much* of medicine in the RVU system.

Year after year, primary care doctors are left out of the conversion and medical students everywhere cast their vote accordingly – with their feet.

While primary care groups like the American Academy of Family Physicians and dedicated physician leaders like Congressman Michael C. Burgess, M.D. (R-TX) have fought for greater support for primary caregivers and greater awareness, it will be nearly impossible to compete in a system where the rules of the game favor one side of the scale so heavily. In 2010, only five RUC members were physicians from primary care fields.

Congressional Resolutions aimed to extend the SGR and patch over potential holes in payment continuity will do little to reform a physician community advisory group which fails to support primary caregivers. It is time for a true leader to eliminate unchecked leverage and rewrite the rules in an effort to: 1.) Discontinue the use of anonymous votes, 2.) Diversify the membership board, and 3.) Embolden CMS to take back the authority it relinquished in 1985. The future of healthcare in America depends upon it. ▪