- evaluating innovations to provide the best health care to patients
- engaging patients, communities, and practices to improve health

The majority of health care takes place in primary care practices, and yet, the majority of research funding supports research of one specific disease, organ system, cellular or chemical process—not for primary care.

Very little is known about important topics such as how primary care services are best organized, how to maximize and prioritize care, how to introduce and disseminate new discoveries so they work in real life, and how patients can best decide how and when to seek care

We call for additional funds to be allocated to primary care research

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References

1. Phillips RL Jr, Bazemore AW. Primary care and why it matters for U.S. health system reform. *Health Aff (Millwood)*. 2010;29(5):806-810.
2. Centers for Disease Control and Prevention/National Center for Health Statistics. Table 1, Physician office visits, by selected physician characteristics. In: *United States 2008 National Ambulatory Medical Care Survey and National Ambulatory Medical Survey.* Hyattsville, MD: CDC/NHCS; 2008.
3. Lucan SC, Phillips RL Jr, Bazemore AW. Off the roadmap? Family medicine's grant funding and committee representation at NIH. *Ann Fam Med*. 2008;6(6):534-542.

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Ann Fam Med 2011;469-470. doi:10.1370/afm.1310.

DEALING STRATEGICALLY WITH THE RUC TO BOOST FAMILY PHYSICIAN PAYMENT

Improving payment for the cognitive services family physicians provide undoubtedly is the most crucial and challenging issue the AAFP must resolve. The payment disparity between primary care and procedural specialties undermines every family physician who struggles to redesign and improve his or her practice in this economy, and it also drives medical students away from primary care.

The AAFP has been working on many fronts to rectify this payment disparity. One important part of that effort is to make sure the Centers for Medicare and Medicaid Services (CMS) receives recommendations on the relative values of Current Procedural Terminology (CPT) codes from experts who understand primary care. Unfortunately, that's not happening now to the extent necessary. The only body making recommendations to CMS is the AMA/Specialty Society Relative Value Scale Update Committee, commonly called the RUC.

From its inception in 1991, the RUC has been dominated by procedural specialties whose representatives don't fully understand the complexity of the cognitive services we provide. They also have a financial interest in keeping the values for procedural services high.

Furthermore, although the RUC's methodology functions well when it comes to valuing one procedural code against a similar one, the methodology is flawed when comparing cognitive services with procedural services. The methodology also values evaluation and management (E/M) visits the same as the E/M visits of other specialties, not taking into account the multiple comorbidities family physicians typically deal with in their patients.

As a result, the RUC often undervalues cognitive services while leaving overvalued procedures alone—an ongoing disaster for those in the Medicare fee-for-service system. Since fee-for-service will be at least a part of how family physicians are paid for some time to come, this has to change.

Two-Pronged Policy

For several years, AAFP policy on the RUC has called for 2 approaches. One approach is to reform the RUC itself with changes that include increasing the number of primary care seats; adding seats for external groups, such as consumers and employers, who would bring voices the RUC needs to hear; and instituting voting transparency for RUC members, who currently vote in secret.

But even if the RUC were reformed, it would still be limited because of the methodology it employs. Therefore, the second approach in the AAFP's policy is to advocate creation of an alternative, multi-stakeholder advisory group to provide recommendations to CMS in concert with recommendations from the RUC.

The AAFP has been open about our concerns with the RUC, working persistently through our RUC representatives and talking with AMA and RUC leaders to recommend solutions. We even wrote to CMS last year, urging changes in the RUC and the establishment of an alternative advisory group.

But we shifted strategy and went very public with our concerns on June 10, 2011 when we sent the RUC

a letter outlining the changes we want and, for the first time, setting a deadline for a decision—March 1, 2012.

Thinking Strategically

The AAFP Board of Directors thought long and hard before taking this bold new step. Some members and chapters, as well as some outside thought leaders, have called on the Academy to leave the RUC, and we've discussed this and other options for several years. Each time, we decided to remain in the RUC to keep pushing for change, with periodic reassessment of our participation.

In May, Board members discussed the situation in depth again. We were frustrated that our efforts weren't getting traction within the RUC, even though the public and policy makers increasingly understood the payment disparity's terrible implication for primary care. We knew that withdrawing from the RUC would be a dramatic gesture, but we kept coming back to this question: How would withdrawing advance our long-term strategy to improve payment for family physicians?

We knew that withdrawing would leave us with no way to keep pushing the RUC to change. For example, we were glad to support the bill recently introduced by Rep Jim McDermott, D-Washington, that would require CMS to hire independent contractors to augment the RUC's work, but the bill would do nothing to change the RUC itself. Furthermore, although withdrawing from the RUC might focus more attention on the bill, we weren't optimistic about the bill's chances in the Republican-controlled House.

We carefully discussed all of this during our May meeting and took the additional step of consulting with outside policy leaders and researchers to get their input.

In the end, we decided that withdrawing without sending the RUC a formal request for change would not benefit AAFP members. Our June 10, 2011 letter was that formal request.

The Second Front

In that letter, we also apprised the RUC of a separate but related action the Board took in May. The Board decided it was time to act on our second policy approach to the RUC problem. We funded the creation of a task force to explore the development of alternative methods for valuing primary care services in the current fee-for-service model. In addition to representatives from the AAFP, the task force includes representatives of other primary care groups, health policy makers, researchers, consumers and employers.

The task force will submit its recommendations to the AAFP Board within the next 6 to 9 months, and we anticipate sharing those recommendation with CMS. We've already met with the CMS administrator and his senior leadership team to discuss the task force, and they were very supportive of this direction. As a matter of fact, CMS observers will attend task force meetings in order to understand the thinking behind the recommendations when they receive them.

Lori Heim, MD
AAFP Board Chair