EDITORIAL

Comprehending Coordinated Comprehensive Care: The Devil is in the Dollars

David G. Fairchild MD, MPH[1] *and C. Mel Wilcox MD*[2]

[1]Division of General Medicine, Department of Medicine, Tufts-New England Medical Center and Tufts University School of Medicine, Boston, MA, USA; [2]Division of Gastroenterology and Hepatology, University of Alabama at Birmingham, Birmingham, AL, USA.

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We ignore the downward spiral of general Internal Medicine at our peril. Fewer graduates are choosing primary care residencies and practicing generalists liken their jobs to a hamster on a treadmill.[1] Anyone who has tried to recruit a clinical General Internist lately will attest to the dwindling supply. Meanwhile, demand grows each year. The graphic display of changes in residency positions illustrated by the Blue Ribbon Panel of the Society of General Internal Medicine (SGIM)[2] is a wake up call to those who believe General Internists will play an important role in caring for the growing number of elderly.

The policy monograph developed by the Blue Ribbon Panel of the Society of SGIM outlines principles that would promote a coordinated care model for general Internal Medicine.[2] The model proposes General Internists should be more than simply the provider of first (primary) care; they should be the chief executive of a health care team providing efficient, electronic health record (EHR)-supported, longitudinal care that improves health and prevents disease. Like Mom and apple pie, it is hard to disagree with these principles.

All of us would agree that enhancement of technology to support our practice via an EHR would pay major dividends and provide a mechanism to assess quality. However, outlining a "straw man" as a model to work from would have helped to make the proposed model less conceptual and more operational. For example, what kind of team do we need and how many participants should be involved? What are the designated roles of such individuals and how can we financially justify the team? Could the use of nurse practitioners and other health professionals further advance the model?

Irrespective of how the new model would be constructed, the important recurrent theme in the document, and an obvious key to realizing the vision of coordinated care, is that current payment systems must be modified. The current reimbursement system for general Internal Medicine has 2 underlying flaws representing a significant barrier to achieving the vision of coordinated care. First, overall reimbursement to General Internists is currently too low to support true high-quality coordinated care. Practicing General Internists have increased productivity not only because of the rising volume of patients, but because of declining reimbursement and salary. Continuing to increase clinical productivity to make up for shortfalls in reimbursement rates will be progressively more difficult as the population ages, however, as more patients will require longer visits to manage multiple and complex medical issues. This brings us to the second underlying flaw in the system. Visit-based reimbursement mechanisms are not aligned with the goals of providing comprehensive care—much of which could be provided outside of the traditional doctor–patient visit. Whereas some payers will pay for telephone calls with patients and web-based doctor "visits," most do not.

Interestingly, it seems that the General Internists in retainer-medicine ("concierge") practices are the only General Internists who are happy these days. They charge patients an annual fee to pay for services not otherwise covered by insurance, allowing them to provide more comprehensive care—albeit to a smaller number of patients than the average General Internist.

The payment system suggested by Goroll et al.[3] draws significantly from the retainer medicine model. Starting where the SGIM Blue Ribbon Panel left off, Goroll and colleagues suggest a comprehensive care model based on payment of a monthly risk-adjusted retainer fee for each patient in a comprehensive care practice. If, as they suggest, the net of these monthly retainer payments is significantly larger than the current collection of fee-for-service payments, then this payment methodology would overcome both of the fundamental flaws inherent in our current payment system (i.e., reimbursement that represents a net increase from current levels and is not tied to the office visit). No doubt, such a retainer payment system would enable General Internists to invest in EHRs, assemble the health care team, and provide comprehensive care to their patients—fulfilling the principles outlined in the SGIM monograph.

Without moving back to capitation, a per-member-per-month payment to support coordinated care would likely improve our system. However, there are potential pitfalls as one looks beyond general medicine. For example, how confident are we that by spending more time with patients, General Internists can wring out enough savings to offset the net increase in the comprehensive payment? If General Internists cannot generate savings from enhanced medical management, should they expect a reallocation of funds from specialists to cover the increases?

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Some may favor a reexamination of the financial worth of procedural activities. Yet, many subspecialists play a key role in the successful management and outcome of complex patients, enriching the quality of life. Further, it is unlikely that subspecialists will lie down quietly and let the monies flow from the subspecialty procedural to nonprocedural-based Internists without a fight. Certainly, the generalist's struggle to increase payments in the RBRVS system indicates that reallocating payments from specialists to generalists will be neither quick nor easy.

Goroll grapples with the scenario where a subspecialist effectively becomes the primary caregiver based on an overriding complex chronic medical condition (e.g., end stage renal disease [ESRD]). In this case, the patient may be better served staying with the subspecialist rather than the General Internist. How should such physicians be incorporated in this model? Would the General Internist here play more of a "subspecialist" role? Depending on the practice, could the subspecialist have a coordinated care team just like an Internist with similar financial arrangements and have the General Internist in such a scenario be a consultant?

In the case of a patient with ESRD, the retainer payment could be made to the specialist instead of the generalist. But how would the retainer payment be allocated in the case of a generalist who tends to refer frequently? What safeguards would protect against a generalist who simply amasses patients, collects the coordination retainer fee, but instead of coordinating care simply orchestrates referrals (shifting the time and cost of care to specialists)? Who would decide how many patients a generalist should have? Unless panel sizes are limited in some way or there are strict performance standards, then we may find ourselves back where we are now with physicians rushing patients through the office to enhance the bottom line. Performance measures would be critical to monitor the success of any such system.

We also cannot forget that an important driver of our health system is the patient, and many desire to see subspecialists. Patients will want to preserve the opportunity to seek expert guidance on selected conditions given the increasing complexity of diagnostic testing and management. In fact, in some settings, referral to a subspecialist may be more cost effective than evaluation by a primary care physician.

Clearly, before any change, pilot studies would be instrumental in defining the feasibility, appropriate size of staff, and the impact on quality. Perhaps with such pilot studies, quality measures could be better delineated and policies developed to protect against "gaming" the system.

In summary, lack of alignment between the current primary care payment mechanism and the elements required to provide high quality comprehensive continuity health care represents a fundamental flaw in our health care system. This has had a deleterious effect on our ability to attract the best and brightest to general Internal Medicine. Many Internal Medicine house staff seek subspecialty training because of the problems they see in general Internal Medicine, the reimbursement advantage of the subspecialist, and the perception of a decline in the overall management domain of the General Internist.

The SGIM policy monograph and the comprehensive payment methodology paper by Goroll et al propose a bold rethinking of what it means to be a General Internist. These papers accurately describe the current problems facing the field of general Internal Medicine and propose solutions addressing the lack of alignment between payment mechanisms and the goals of General Internists. We cannot solve the general Internal Medicine problem in isolation, however. To be successful, any new model for coordinated care must also create incentives to provide care that is highly integrated between specialist and generalist. Reforming payment mechanisms will be critical to driving this change and aligning incentives. These 2 papers help us comprehend the potential of coordinated comprehensive care. Can we realize the potential? We believe the answer is yes, but the devil is in the dollars.

Corresponding Author: *David G. Fairchild, MD, MPH; Division of General Medicine, Department of Medicine, Tufts-New England Medical Center and Tufts University School of Medicine, Boston, MA, USA (e-mail: dfairchild@tufts-nemc.org).*

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