

**The Impending Collapse of Primary Care Medicine and Its Implications for  
the State of the Nation's Health Care:  
A Report from the American College of Physicians  
January 30, 2006**

**Executive Summary**

Primary care, the backbone of the nation's health care system, is at grave risk of collapse due to a dysfunctional financing and delivery system. Immediate and comprehensive reforms are required to replace systems that undermine and undervalue the relationship between patients and their personal physicians. If these reforms do not take place, within a few years there will not be enough primary care physicians to take care of an aging population with increasing incidences of chronic diseases. The consequences of failing to act will be higher costs, greater inefficiency, lower quality, more uninsured persons, and growing patient and physician dissatisfaction.

The American College of Physicians (ACP) is the nation's largest specialty society, representing 119,000 internal medicine physicians (internists) and medical students. Internists specialize in the prevention, detection and treatment of illness in adults. Our membership includes physicians who provide comprehensive primary and subspecialty care to tens of millions of patients, including taking care of more Medicare patients than any other physician specialty. Today, we are releasing sweeping policy proposals to avert a looming crisis in access to primary care medicine. Our proposals will fundamentally change the way that primary care is organized, delivered, financed, and valued.

**First, we are calling on policymakers to implement and evaluate a new way of financing and delivering primary care called the *advanced medical home*.** The advanced medical home is a physician practice that provides comprehensive, preventive and coordinated care centered on their patients' needs, using health information technology and other process innovations to assure high quality, accessible and efficient care. Practices would be certified as advanced medical homes, and certified practices would be eligible for new models of reimbursement to provide financing commensurate with the value they offer. These practices would also be accountable for results based on quality, efficiency and patient satisfaction measures. The advanced medical home would be particularly beneficial to patients with multiple chronic diseases—a population of patients that is growing rapidly and that consumes a disproportionate share of health care resources.

**Second, ACP calls on policymakers to make fundamental reforms in the way that Medicare determines the value of physician services under the Medicare fee schedule.** The current process for establishing relative values has resulted in payment rates that under-value office visits and other evaluation and management services provided principally by primary care physicians, and over-value many technological and

procedural services. Primary care is perhaps the most vital part of patient care. Access to primary care services provides higher quality care at lower costs. Medicare should begin paying physicians more for the time spent with patients evaluating and managing their care; for investing in health information technology to improve quality and for helping patients with chronic illnesses manage and control their diseases to avoid later complications. The program should begin paying primary care physicians for email and telephone consultations that can reduce the need for face-to-face visits and increase patients' ability to get medical advice in a timely manner. Medicare reimbursement policies should also recognize the value of the time that physicians spend outside the face-to-face visit in coordinating the care of patients with multiple chronic diseases, including the work involved in coordinating care with other health care professionals and family caregivers.

**Third, Congress and CMS should provide *sustained and sufficient financial incentives* for physicians to participate in programs to continuously improve, measure and report on the quality and efficiency of care provided to patients.**

Financial incentives under a Medicare pay-for-performance program (P4P) must be non-punitive (physicians who are unable to participate in the program should not be subject to negative updates), prioritized so that physicians are rewarded for achieving improvements for the top 20 conditions identified in the Institute of Medicine's "Crossing the Quality Chasm" report, recognize the critical role of primary care physicians in achieving such improvements, and be sufficient to offset physicians' investment in health information technology and other office redesign innovations required to measure and report quality. Pay-for-performance should be implemented along with reforms to change the way that physician services are valued and reimbursed, rather than grafted onto an underlying payment methodology that pays doctors for doing more, instead of doing better.

**Fourth, Congress must replace the sustainable growth rate (SGR) formula with an alternative that will assure sufficient and predictable updates for all physicians and be aligned with the goals of achieving quality and efficiency improvements and assuring a sufficient supply of primary care physicians.**

Because of low reimbursement levels, primary care practices are operating under such tight margins that they are unable to absorb cuts resulting from the SGR. The SGR has been ineffective in reducing the volume of inappropriate services and cuts payments to all physicians without regard to the quality or efficiency of care they provide.

**The Impending Collapse of Primary Care**

Primary care is on the verge of collapse. Very few young physicians are going into primary care and those already in practice are under such stress that they are looking for an exit strategy. According to the AMA's *Physician Characteristics and Distribution in the U.S.*, 35 percent of physicians nationwide are over the age of 55. Most will likely retire within the next five to 10 years. Unless steps are taken now, there will not be enough primary care physicians to take care of an aging population with growing incidences of chronic diseases. Without primary care, the health care system will become

increasingly fragmented, over-specialized, and inefficient—leading to poorer quality care at higher costs.

### *The Growing Demand for Primary Care*

- Primary care physicians, and general internists in particular, are at the forefront of managing chronic diseases, providing comprehensive care and coordinated long-term care. Yet, 45 percent of the U.S. population has a chronic medical condition and about half of these, 60 million people, have multiple chronic conditions.<sup>i</sup> For the Medicare program, 83 percent of beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions.<sup>ii</sup> Within 10 years (2015), an estimated 150 million Americans will have at least one chronic condition.<sup>iii</sup>
- Within the next decade, the baby boomers will begin to be eligible for Medicare. By the year 2030, one fifth of Americans will be above the age of 65, with an increasing proportion above age 85. The population age 85 and over, who are most likely to require chronic care services for multiple conditions, will increase 50 percent from 2000 to 2010.<sup>iii</sup>
- Approximately two-thirds of the 133 million Americans who are currently living with a chronic condition are over the age of 65. Among adults ages 80 and older, 92 percent have one chronic condition, and 73 percent have two or more.<sup>i</sup>
- In 2000, physicians spent an estimated 32 percent of patient care hours providing services to adults age 65 and older. If current utilization patterns continue, it is expected that by 2020, almost 40 percent of a physician's time will be spent treating the aging population.<sup>iv</sup>
- It is anticipated that the demand for general internists will increase from 106,000 in 2000 to nearly 147,000 in 2020, an increase of 38 percent.<sup>iv</sup>

### *Too Few Physicians Are Going into Primary Care*

The demand for primary care is increasing, while at the same time there has been a dramatic decline in the number of graduating medical students entering primary care.<sup>v vi</sup>  
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- Over the past several years, numerous studies have found that shortages are occurring in internal medicine.<sup>vii viii ix x xi xii</sup> Factors affecting the supply of primary care physicians, and general internists in particular include excessive administrative hassles, high patient loads, and declining revenue coupled with the increased cost for providing care. As a result, many primary care physicians are choosing to retire early. These factors, along with increased medical school tuition rates, high levels of indebtedness, and excessive workloads, have

dissuaded many medical students from pursuing careers in general internal medicine and family practice.<sup>xiii</sup>

- A recently-published study of the career plans of internal medicine residents documents the steep decline in the willingness of physicians to enter training for primary care. In 2003, only 19 percent of first year internal medicine residents planned to pursue careers in general medicine. Among third-year internal medicine residents, only 27 percent planned to practice general internal medicine compared to 54 percent in 1998.<sup>xiv</sup>
- More than 80 percent of graduating medical students carry educational debt. The median indebtedness of medical school students graduating this year is expected to be \$120,000 for students in public medical schools and \$160,000 for students attending private medical schools. About 5 percent of all medical students will graduate with debt of \$200,000 or more.<sup>xv</sup>

### **The Collapse of Primary Care will Cause Higher Costs and Lower Quality**

The declining interest in careers in primary care is important because the collapse of primary care will result in higher health care expenses and lower health care quality:

- When compared with other developed countries, the United States ranked lowest in its primary care functions and lowest in health care outcomes, yet highest in health care spending.<sup>xvi xvii xviii</sup>
- Studies have shown that primary care has the potential to reduce costs while still maintaining quality.<sup>xix</sup> Not only does early detection and treatment of chronic conditions play a vital role in the health and quality of life of patients, but it can also prevent many costly and often fatal complications when illnesses such as diabetes and cancer are diagnosed at a later stage. As expert diagnosticians, providing patient-focused, long-range, coordinated care, general internists play a significant role in the diagnosis, treatment and management of chronic conditions. It has been reported that states with higher ratios of primary care physicians to population had better health outcomes, including mortality from cancer, heart disease or stroke.<sup>xx xxi</sup>
- States with more specialists have higher per capita Medicare spending. An increase in primary care physicians is associated with a significant increase in quality of health services, as well as a reduction in costs.<sup>xxii</sup>



- Studies have also shown that expenditures for care for common illnesses such as community-acquired pneumonia were higher when provided by specialists than if provided by primary care physicians, with no difference in outcomes.<sup>xxx1</sup>

### **How Payment Policies Contribute to the Collapse of Primary Care**

Inadequate and dysfunctional payment policies, combined with high levels of medical student debt, are key drivers behind the impending collapse of primary care. Medicare, as the single largest purchaser of health care in the United States, has a particular responsibility to replace policies that are antithetical to primary care with ones designed to encourage and support its importance and growth.

- Primary care physicians provide the great majority of evaluation and management services. The average number of visits per week, in 1999, by specialty, are as follows:

- *Family practice – 122.9*
- *General pediatrics – 120.5*
- *General internal medicine – 106.5<sup>xxxii</sup>*

Percentage of outpatient visits, in 2004, by specialty:

- *Family practice – 19%*
- *General internal medicine – 27%<sup>xxxiii</sup>*

- Such evaluation and management (E/M) services are grossly undervalued by Medicare:
  - According to a recent analysis by the Medicare Payment Advisory Commission (MedPAC), over the past 10 years, the number of E/M services furnished grew slowly, relative to some other types of services, thereby *nullifying any gains in the relative value of E/M services* that initially resulted from implementation of the resource-based relative value scale (RBRVS) in 1992.
  - The physician work relative values for E/M services—which determines approximately 55 percent of the relative value that Medicare assigns to each service—have not been reviewed or increased for the past ten years, even though data from the National Ambulatory Medical Care Survey (NAMCS) show that *patients have more chronic conditions, are older, are more complex, have more diagnoses per encounter, more drug mentions per encounter, more diagnostic and screening services per encounter, and more counseling, education, and therapeutic services per encounter*. The diagnoses and drug mentions per E/M encounter have been higher for medical specialties than for surgical specialties.<sup>xxxiv</sup>
- Current processes for establishing work RVUs favor increases in the RVUs for services done by non-primary care physicians over those done by primary care.

MedPAC has asked that a private sector advisory group to CMS, the RVS Update Committee (RUC), examine its composition to assure balanced representation from all specialties, noting concerns expressed by primary care physicians about under-representation in the RUC. According to MedPAC, the existing processes also do not do a good job of identifying potentially over-valued RVUs. Services that are over-valued reduce the pool of dollars that can be redistributed to under-valued E/M services and may contribute to volume increases that nullified the initial gains for E/M services, as noted above.

- The sustainable growth rate (SGR) formula, which cuts Medicare payments to all physicians when expenditures exceed growth in the economy, has a disproportionately adverse impact on primary care physicians. Primary care physicians are hurt the most by SGR cuts because they already are paid less than other physicians. They also have low practice margins and fixed costs that make it impossible for them to absorb the cuts and have little or no way to offset cuts by increasing volume.
- The SGR also does not control volume, and is in fact inconsistent with the goal of improving quality and efficiency for the Medicare population. The SGR:
  - cuts the most “efficient” and highest quality physicians by the same amount as those who provide the least efficient and lowest quality care;
  - penalizes physicians for volume of services increases that may result from following evidence-based guidelines; and
  - cuts fees for categories of services with lower volume growth the same as those with higher growth. The Medicare Payment Advisory Commission reports that evaluation and management services and major surgical procedures have had lower volume growth than other diagnostic procedures.
- Medicare payment policies discourage primary care physicians from organizing care processes to achieve optimal results for patients because:
  - They are paid little or nothing for the work performed outside of the visit or procedure code.
  - Low fees for E/M services discourage spending time with patients.
  - Prevention is under-reimbursed or not covered at all.
  - Low reimbursement coupled with high practice overhead makes it impossible for many primary care physicians to invest in health information technology and other practice innovations.
  - E-mail and telephonic consultations that can improve timeliness and accessibility of care for patients and reduce the need for non-urgent face-to-face visits are not reimbursed by Medicare.

- Pay “silos” make it impossible for primary care physicians to share in system-wide cost savings that may result from better management and coordination of care. For instance, an internist who helps diabetic patients control their blood sugars may prevent occurrences of limb amputations. Each amputation that is prevented by an internist can save Medicare as much as \$30,000, mostly from reduced Part A hospital expenditures. Under current payment rules, however, a primary care physician cannot receive increased Part B reimbursement for quality improvements that lead to such savings in the Part A program.
- Medicare expenditures continue to increase rapidly but the evidence suggests that more spending doesn’t mean better quality. Studies show that areas with lower per capita costs often do better on quality indicators.<sup>xxxv</sup> Major improvements in quality and efficiency of care are not likely as long as Medicare continues to undervalue the services of primary care physicians and reward physicians for doing more, rather than doing better. A Medicare pay-for-performance (P4P) program potentially could help address some of the imbalances by rewarding physicians for achieving measurable quality improvement. But grafting P4P onto a system that rewards volume and acute care—over quality, prevention and coordination of care—is not likely to be successful. P4P could make things worse if it creates more practice hassles and expenses for primary care physicians without substantially increased reimbursement.

### **Recommendations for Averting a Collapse of Primary Care**

Because it takes a minimum of seven years to train a physician to go into primary care, it is imperative that policymakers take immediate, comprehensive and sustained action to avert the impending collapse of primary care:

- 1. Medicare and other payers should work with the ACP to design, implement and pilot test a new model for financing and delivering primary care called the advanced medical home.**
  - A. This model would fundamentally change the way that primary care and principal care (whether provided by primary care or specialty care physicians) are delivered to patients by linking patients to a personal physician in a practice that qualifies as an advanced medical home.
  - B. Comprehensive changes must be made in third party financing, reimbursement, coding and coverage policies to support practices that qualify as an advanced medical home.
  - C. Fundamental changes must be made in workforce and training policies to assure an adequate supply of physicians who are trained to deliver care in an advanced medical home model.
  - D. CMS should launch a national demonstration project to evaluate the advanced medical home.

Today, ACP is releasing “The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care,” a major policy paper approved by ACP’s Board of Regents on January 22, 2006. The paper proposes a new way to organize and deliver primary and principal care that addresses the fact that the U.S. health care system is poorly prepared to meet the current, let alone the future health care needs of an aging population.

The advanced medical home model is based on the premise that the best quality of care is provided not in episodic, illness-oriented, complaint-based care, but through patient-centered, physician-guided, cost-efficient, longitudinal care that encompasses and values both the art and science of medicine. Attributes of the advanced medical home include promotion of continuous healing relationships through delivery of care in a variety of care settings according to the needs of the patient and skills of the medical providers. Physicians in an advanced medical home practice are responsible for working in partnership with patients to help them navigate the complex and often confusing health care system. They provide the patient with expert guidance, insight and advice, in language that is informative and specific to patients’ needs. In the advanced medical home model, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to the needs of the patient.

A revised reimbursement system would acknowledge the value of both providing and receiving coordinated care in a system that incorporates the elements of the advanced medical home model. Further, such a system would align incentives so physicians and patients would choose medical practices that deliver care according to these concepts. Physicians would elect to redesign their practices because the model is supported by enhanced reimbursement for system-based care in the advanced medical home, rather than the volume-based, episodic, fee-for-service system currently in place. Patients would select an advanced medical home based on service attributes such as the patient-centeredness of a practice, improved access, and coordinated care – as well as value attributes as demonstrated by publicly available reports on quality and cost.

Pilot testing is crucial before the Advanced Medical Home model can be implemented nationwide. A demonstration project would permit exploration of the model’s applicability, reliability, strengths, weakness and identification of potential unintended consequences.

ACP asks that the Center for Medicaid and Medicare Services (CMS) conduct a national pilot program in 2007 to determine the feasibility, cost effectiveness and impact on patient care of the advanced medical home in a variety of primary care settings. This effort should specifically address the advanced medical home model, but would complement ongoing and planned CMS pilot programs such as the Medicare Physician Group Practice Project, the Medicare Care Management Performance Demonstration (MMA Section 649), and Medicare Health Support Pilot (MMA Section 721) and Medicare Health Quality Demonstration Program (MMA Section 646). ACP will also explore testing of this model with commercial payers.

2. **ACP calls on policymakers to make immediate reforms in the way that Medicare determines the value of physician services under the Medicare fee schedule.**
  - A. **CMS should substantially increase the work relative value units for evaluation and management services.**
  - B. **CMS should re-examine its methodologies for determining practice expense RVUs to reduce the disparities between evaluation and management services and other services.**
  - C. **CMS should establish a better process for identifying potentially over-valued RVUs that could be lowered and redistributed into the budget neutral RVU pool.**
  - D. **CMS should request that the RUC examine its membership composition to assure that it is reflective of each specialty's contributions to taking care of Medicare patients.**
  - E. **CMS should provide separate payment for separately-identifiable e-mail and telephonic consultations that could facilitate timely communications between physicians and patients and reduce the need for face-to-face visits for non-urgent care.**
  - F. **CMS should provide an add-on to Medicare payments for office visits that are supported by certified electronic health records and that are used by physicians to report data as part of an approved quality improvement and measurement program.**

Federal law requires that CMS conduct a review of the work RVUs for the Medicare physician fee schedule every five years. Organizations representing primary care physicians and medical specialists have developed data to support substantial increases in the work RVUs for E/M services, based on compelling evidence that the complexity and work associated with such services has increased since they were last reviewed ten years ago. The RUC is considering these recommendations. CMS should work with the RUC and assure that the five year review results in increases in the work RVUs for E/M services, commensurate with the evidence of increased physician work. ACP strongly supports the RUC process but recognizes that CMS has the final statutory responsibility to assure that the work RVUs approved through the five year review are accurate. ACP also supports MedPAC's request that the RUC examine its composition to assure balanced representation of all specialties, including primary care. ACP also supports a re-examination by CMS of the practice expense RVUs to reduce disparities in payments for E/M services and other services.

Even if the five year review results in substantial increases in the work RVUs for E/M services, budget neutrality offsets are expected to substantially reduce how much of an

increase in payments primary care physicians actually end up receiving. Therefore, Congress and CMS may need to take additional actions, including re-examining whether the existing RBRVS methodology, definitions, and payment rules need to be changed to assure sufficient and sustained increases in payments for primary care.

Medicare should also begin paying for e-mail and telephonic consultations with patients. ACP, in a series of papers on the “The Changing Face of Ambulatory Medicine,” has highlighted the positive use of telephone ([http://www.acponline.org/hpp/tel\\_care.pdf](http://www.acponline.org/hpp/tel_care.pdf)) and internet (<http://www.acponline.org/hpp/e-consult.pdf>) communications in improving the quality of patient care and increasing physician productivity. These non face-to-face services, which Medicare currently does not routinely reimburse, can improve quality by facilitating physician-patient contact that will allow for improved symptom recognition, diagnosis and follow-up care. These tools can also help physicians optimize their productivity in serving patients; allowing them to treat a wide array of non-urgent conditions and needs by phone or internet without the time and expense of an office visit, while reserving face-to-face care for patients most in need of intensive direct care.

Specifically, ACP urges CMS to establish separate payments for separately identifiable telephone (e.g. a call of the duration that the amount of physician time exceeds the amount of time that is currently included as post-E/M service work) and e-services that pertain to established patient problems unrelated to a face-to-face encounter that Medicare pays separately.

Finally, ACP recommends that Congress and CMS institute an add-on to Medicare payments for office visits that are supported by certified electronic health records (EHRs), when the EHR system is used by physicians in a CMS-approved quality improvement and measurement program. EHRs are critical to effective management of patients with chronic diseases and quality reporting and measurement programs. Recent studies suggest that the health care system could save tens of millions of dollars annually if EHRs were more widely adopted and used as part of an organized process for measuring and reporting quality. The high cost of EHR systems and the lack of an ongoing revenue stream to offset such costs remain a principal barrier to widespread adoption of EHRs, particularly in small primary care physician practices.<sup>xxxvi</sup> An add-on to Medicare payments for office visits could substantially accelerate adoption of EHRs by physicians in small practices. Such an add-on could be made contingent on (1) the EHR system meeting forthcoming standards from the Certification Commission on Health Information Technology to assure interoperability and functionality and (2) the practice’s participation in a CMS-approved quality measurement and reporting program, such as the Medicare Physician Voluntary Reporting Program. Congress and CMS could also limit the add-on to physicians in small practice settings. The National Health Information Incentive Act of 2007, H.R. 747, would mandate such an add-on for health information technology provided in small physician practices.

- 3. Congress and CMS should provide *sustained and sufficient financial incentives* for physicians to participate in programs to continuously improve, measure and report on the quality and efficiency of care provided to patients.**

- A. The current payment system should be replaced with new methods of reimbursement that reward physicians who follow evidence-based standards and take on the responsibility of coordinating care for patients with chronic diseases.**
- B. Rewards should reflect the level of work and commitment to quality, which will differ among physicians and across specialties.**
- C. P4P systems should rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms.**
- D. The value of health information technology should be recognized and supported financially.**
- E. Potential P4P rewards should be significant enough to support continuous quality improvement, directed at positive--not negative—rewards, and be balanced between rewarding high performance and substantial improvement over time.**
- F. Medicare P4P should enable physicians to share in system-wide savings (such as from reduced Part A hospital expenses) resulting from quality improvement.**
- G. Adding an additional portion of reimbursement on top of the current dysfunctional payment system will not achieve the desired results.**

ACP believes that Medicare pay-for-performance, if done correctly, can lead to improvements in reimbursement for primary care physicians while improving quality and lowering costs. The College has released a new position paper on “Linking Payments to Quality” ([http://www.acponline.org/hpp/link\\_pay.pdf](http://www.acponline.org/hpp/link_pay.pdf)) that provides a framework for developing and implementing a Medicare pay-for-performance program that would recognize and support the value of care coordination and quality improvement by a patients’ primary care physician. A key conclusion in this paper is that pay-for-performance must be done in conjunction with other reforms to fix Medicare’s dysfunctional payment system, including those described above, rather than grafting it onto a system that rewards volume and episodic care over quality and physician-directed care coordination.

ACP believes that a Medicare P4P program will have to be supported by a redistribution of funds among and across different geographic locations, health care professionals, and even among the College’s own members on the basis of quality. It is, therefore, critical that, in providing rewards for physicians who commit to redesigning their practices to support quality improvement, the level of work and commitment involved should be recognized through differential payments. Basing incentives on effort assures that physicians who expend a disproportionately large amount of time and resources trying to

improve quality and meet more complex measures, such as those who effectively manage patients with multiple chronic diseases, are recognized and rewarded accordingly. This is especially critical for the internist, whose ability to provide better care at lower costs through effective management of patients has been historically under-valued.

Redistribution of payments is only a small aspect of a larger issue that must be confronted before a system that rewards physicians for quality improvement can be effective: the dysfunctional physician payment system. As noted earlier, the current reimbursement system is fragmented and episodic in nature, leading to enormous inefficiencies. Physicians are paid a standard fee regardless of the quality of their care, which discourages innovations, coordination, and practice improvement. The current system must be replaced with new methods of reimbursement that reward those who follow evidence-based standards of care. Only then can internists be recognized as uniquely qualified to manage the care of more complex patients with multiple chronic diseases and comorbid conditions.

ACP realizes that designing a fair, credible, and effective P4P program is a challenging and complicated task. P4P is comprised of many aspects, including the development and selection of appropriate performance measures, the integration of acceptable methods of data collection and reporting, and an equitable determination of incentives. Within each of these categories are a set of unintended consequences that must be carefully monitored and reconciled. ACP also realizes that in the short-term, P4P programs may actually increase utilization of more effective but currently under-utilized treatments, thereby raising costs rather than reaping savings.

As new systems of payment linked to performance are being explored, it is crucial that the right measures are used, that data collection is accurate and reasonable, that appropriate and adequate financial incentives are provided, and that quality—not just cost reduction—is always the overriding measure of success. The access-to-care problems that disadvantaged and severely ill patients may encounter, if P4P programs lead physicians to avoid sicker or non-compliant patients, must also be carefully monitored

Physician adoption of quality improvement strategies upon which incentives are based, if done right, can result in higher-quality patient care leading to increased physician and patient satisfaction and help demonstrate that a well-trained internist, practicing in systems of care centered on patients' needs, provides the best value (i.e., cost and quality) in the health care system.

**4. Congress must replace the SGR with an alternative that will assure sufficient and predictable updates for all physicians and be aligned with the goals of achieving quality and efficiency improvements and assuring a sufficient supply of primary care physicians.**

As noted earlier, the SGR cuts payments to all physicians, but is especially detrimental to primary physicians in small practices who already are under-reimbursed and have very low practice margins. The SGR does not control volume and, in fact, cuts payments

without regard to the quality or efficiency of care provided by an individual physician. The SGR cuts also deprive physicians in primary care practices of the resources needed to invest in health information technology and quality improvements.

As a first step, Congress must enact pending legislation to reverse the 4.4 percent SGR cut that went into effect on January 1, 2006 and restore payments to no less than the 2005 levels.

Second, Congress must enact additional legislation this year that would avert more SGR cuts in 2007 and that would lead to a permanent replacement of the SGR formula. CMS, MedPAC and Congress should work with the ACP and other medical organizations to develop a long-term alternative to the SGR for enactment before the end of the current congressional session. Key principles for this longer-term solution include: separate physician fee updates from measures of per capita GDP, assure that the update formula is aligned with creating incentives for quality measurement and reporting, allow physicians to share in system-wide savings from quality improvement and coordination of patients with multiple chronic diseases, and reflect increases in physician practice costs, including resources associated with acquiring health information technology to support quality improvement. CMS and Congress should also work with ACP and other medical organizations to establish a process to address volume concern issues through a combination of encouraging adherence to evidence-based clinical measures through reporting and pay-for-performance, use of efficiency or cost of care measures, correcting mispricing of physician services under the Medicare fee schedules, addressing geographic variations in quality and cost through increased use of evidence-based guidelines and measures linked to financial incentives, and asking MedPAC to make recommendations regarding suspected inappropriate service/procedure-specific volume increases.

## **Conclusion**

Unless immediate and comprehensive reforms are implemented by Congress and CMS, primary care—the backbone of the U.S. health care system—will collapse. The consequences will be higher costs and lower quality as patients find themselves in a confusing, fragmented and over-specialized system in which no one physician accepts responsibility for their care, and no one physician is accountable to them for the quality of care provided. The state of the nation's health care in 2006 already is deficient, as evidenced by increasing costs, more uninsured persons, persistent gaps in quality, and the decline in the numbers of physicians going into primary care. But the state of the nation's health care in the near future will be far worse if the collapse of primary care is allowed to happen.

The recommendations being advanced today by the American College of Physicians offer a comprehensive strategy to redesign how primary care is financed and delivered to allow physicians to provide care that is centered on the needs of patients. ACP believes that our recommendations, coupled with reforms in medical education and relief from student debt, can reverse the decline in the number of physicians going into primary care. The

federal government must accept its responsibility to redesign Medicare payment policies to recognize the value of physician-guided care coordination through an advanced medical home, to increase reimbursement for undervalued evaluation and management services, to expand coverage and provide reimbursement for health information technology, and to link payments to quality in a way that is non-punitive and provides substantial increases--commensurate with effort—to those physicians who participate in quality improvement, measurement and reporting focused on the top 20 conditions described in the IOM’s Crossing the Quality Chasm report.

Such reform will help strengthen the state of the nation’s health care, now and in the future, by acknowledging and supporting the value and role of primary care physicians in delivering better care at lower cost.

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