



AMERICAN COLLEGE OF PHYSICIANS  
INTERNAL MEDICINE | *Doctors for Adults*®

**Assuring universal access to health coverage and primary care:**

***A Report by America's Internists  
on the  
State of the Nation's Health Care 2009  
and  
Recommendations for Reform***

**February 2, 2009**

**INTRODUCTION**

**In January, 2006, the American College of Physicians warned in its annual State of the Nation's Health Care report<sup>1</sup> that primary care was nearing collapse in the United States.** ACP is the largest physician specialty organization in the United States, and second largest physician membership organization, representing more than 126,000 internal medicine physicians and medical student members.

**Despite ACP's widely circulated 2006 report and the best efforts by many key stakeholders in response, we find that primary care is in even greater crisis than it was three years ago.** The Institute of Medicine recently reported that 16,261 additional primary care physicians are now needed to meet the demand in currently underserved areas.<sup>2</sup> Two recent studies project that the shortages of primary care physicians for adults will grow to more than 40,000.<sup>3 4</sup>

**The primary care shortage is escalating at a time when the need for primary care physicians is greater than ever.** Our aging population will further increase the demand for general internists and family physicians. In addition, increasing numbers of patients with multiple chronic diseases will also increase the demand for primary care.

**Even though decades of research tell us that primary care is the best medicine for better health care and lower costs, the current U.S. health care system fails to support policies and payment models to help primary care survive and grow.** More than 100 studies, referenced in ACP's recent paper, *How is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?*, demonstrate that primary care is consistently associated with better outcomes and lower costs of care.<sup>5</sup>

**Today, we are calling on President Obama and the new 111<sup>th</sup> Congress to take immediate, sustained and dramatic steps to accomplish two essential and inter-related goals:**

- **Provide affordable and accessible health care to all Americans.**
- **Provide every American with access to a primary care physician.**

**Expansion of health insurance coverage is essential.**

We must assure that:

- Those who may lose their coverage because of the economic recession are able to keep it;
- States have the resources needed to provide continued access and coverage under safety-net programs like Medicaid;
- All eligible children have access to the State Children’s Health Insurance Program.

These measures need to be followed by a comprehensive plan to expand coverage, starting with the most vulnerable Americans, and leading to coverage for all Americans, without regard to income or place of employment.

**Expansion of the primary care physician workforce is equally essential.**

There are not enough primary care physicians to meet the existing and growing needs of the currently insured U.S. population. Unfortunately, this also means that there are not enough primary care physicians to meet the needs of the tens of millions of uninsured Americans who stand to gain coverage if President Obama and Congress are successful, as we hope they are, in ensuring coverage for all.

This report provides findings to support ACP’s view that expansion of the primary care physician workforce must go hand-in-hand with expanding coverage.

It recommends achievable and measurable goals for reversing the primary care shortage and increasing primary care workforce capacity.

**It proposes specific policies that the federal government must take to achieve a simultaneous expansion of coverage and expansion of primary care workforce capacity. Our recommendations include:**

- Programs to help people keep health insurance coverage during the economic downturn followed by a comprehensive plan to achieve affordable coverage for all.
- Medicare payment reforms to make primary care competitive with other specialty choices;
- Transition to a new payment and delivery system for primary care modeled on the Patient-Centered Medical Home;
- Programs to train and eliminate student debt for physicians committed to providing primary care in facilities and areas of the country experiencing shortage;

- Reduction in administrative requirements imposed on primary care physicians and their patients;
- A call for President Obama to issue an Executive Order on Primary Care so that all federal agencies are working together in a seamless and coordinated manner to expand the primary care workforce.

We also propose additional reforms to improve the quality and efficiency of health care for all patients, not just those seen by primary care physicians.

## **FINDINGS**

### **1. There is an urgent need to provide health insurance coverage to the uninsured.**

- Based on the most recent Census Bureau estimates, 46 million Americans lacked health insurance coverage for at least a portion of calendar year 2007.<sup>6</sup>
- Because of the economic recession, the ranks of the uninsured are likely to grow.
- People without health insurance are more likely to live sicker and die younger.<sup>7</sup> The Institute of Medicine has estimated that more than 18,000 adults lose their lives annually because of lack of health insurance coverage.<sup>8</sup>

### **2. Health reforms to expand coverage will *fail* to improve outcomes and lower costs unless programs are created to reverse a growing shortage of primary care physicians.**

- Persons who do not have access to health insurance coverage are less likely to have a physician as a regular source of care.<sup>9</sup> They are also less likely to comply with recommended treatments, to take their medications, and receive recommended preventive services. Accordingly, as more persons obtain health insurance coverage as a result of health care reform, they will appropriately seek to form a relationship with an internist, family physician, or pediatrician to serve as their regular source of care.
- The number of visits to primary care physicians will increase as coverage is expanded. A study by the Association of American Medical Colleges estimates that universal coverage would increase overall demand for physician services by 25 percent.<sup>10</sup> Although AAMC did not calculate the percentage increase in demand by primary care or specialty, it is likely that a disproportionate share of the increased demand will come in the form of increased visits to primary care physicians. As a result, the United States will likely require an even greater expansion of primary care workforce capacity than the 25 percent overall increased demand for services projected by AAMC.

- Increases in the numbers of patients with chronic illnesses will accelerate the demand for primary care. According to *Health Affairs*, “In 2005, 133 million Americans were living with at least one chronic condition. In 2020, this number is expected to grow to 157 million ... Currently, most chronic illnesses care takes place in primary care physician practices ... Compared with specialist-only care, primary care offers high quality care at lower cost for patients with chronic conditions.” The authors support the development of multidisciplinary teams in primary care and public health and recommend that the U.S. adopt the goal of “half of U.S. clinicians practice in primary care.”<sup>11</sup>
- Most established primary care physicians are currently working at full capacity and will be unable to absorb the increased number of patient visits that will accompany coverage expansions. A rapid expansion of primary care capacity will accordingly be needed.

Included with this report is a very preliminary illustration of how many more primary care physicians will be needed to meet the needs of Americans who would become insured under President Obama’s health care reform proposal. The illustration suggests, for example, that we would need 6,700 more primary care physicians if Medicaid was expanded to cover everyone up to 150 percent of the Federal Poverty Level, and over 14,000 more primary care physicians to meet the needs of everyone who might be covered under the Obama plan. (This illustration is not intended to be a substitute for a more rigorous methodological evaluation by an expert advisory group reporting to the federal government, as discussed later in this document, of how many more primary care physicians and other clinicians will be needed to meet the needs of all those who would become eligible for coverage).

- This increased demand will come at a time when primary care physician workforce capacity is actually declining as many established primary care physicians are retiring or changing their careers to non-primary care fields and as fewer young physicians are choosing primary care.
  - As noted earlier, a December 2008 IOM report stated that 16,261 additional primary care physicians are currently needed to meet the demand in currently underserved areas, where federally funded safety net programs struggle to fill the gaps.<sup>12</sup>
  - *The Journal of the American Medical Association* recently reported that only 2 percent of fourth-year medical students plan to go into primary care internal medicine.<sup>13</sup>

- Two recent studies of workforce capacity project that there will be a shortage of 40,000-44,000 primary care physicians for adults, assuming current rates of health insurance coverage.<sup>14 15</sup>
- Nurse practitioners and physicians assistants represent an important part of the primary care workforce, but there will still be a critical shortage of tens of thousand of primary care physicians. A recent study published in *Health Affairs*<sup>16 15</sup> estimates a shortage of between 40,000 and 44,000 primary care physicians for adults, assuming current rates of insurance, even accounting for the contributions of nurse practitioners and physician assistants:

“The availability of more NP/PAs is uncertain. These practitioners’ involvement in office-based practice appears modest today ... probably fewer than half of NP/PAs are in office-based primary care. Large numbers work in emergency rooms, hospital clinics, intensive care units, and inpatient services. Our analysis of National Ambulatory Medical Care Survey (NAMCS) data indicates that 42 percent of patient visits to NP/PAs in office based practices are in offices of specialists – not generalists. NP graduate numbers fell from 8,199 to 5,920 between 1998 and 2005 and may decline further as master’s-level NP programs are replaced by clinical doctoral programs by 2015.”

**3. The price tag associated with covering more people will be much higher, and the outcomes of care much lower, if expanded coverage is not accompanied by policies to achieve a rapid expansion of primary care workforce capacity.**

- ACP recently released a comprehensive, annotated summary of more than 100 studies, conducted over the past two decades in the United States and abroad, that shows that the availability of primary care is consistently associated with better outcomes and lower costs of care.<sup>17</sup>
- Highlights of studies summarized in ACP’s literature review include the following:
  - The preventive care that primary care physicians provide can help to reduce hospitalization rates. In 2000, an estimated 5 million admissions to U.S. hospitals, with a resulting cost of more than \$26.5 billion, may have been preventable with high-quality primary and preventive care treatment. Assuming an average cost of \$5,300 per hospital admission, a 5 percent decrease in the rate of potentially avoidable hospitalizations alone could reduce inpatient costs by more than \$1.3 billion.<sup>18</sup>

- States with higher ratios of primary care physicians to population have better health outcomes, including decreased mortality from cancer, heart disease, or stroke.<sup>19 20</sup>
  - Each 10<sup>th</sup> percentile increase in primary care physician supply is associated with a 4 percent increase in odds of early-stage breast cancer diagnosis.<sup>21</sup>
  - An increase of just one primary care physician is associated with 1.44 fewer premature deaths per 10,000 persons.<sup>22</sup>
  - An increase of 1 primary care physician per 10,000 population in a state was associated with a rise in that state's quality rank by more than 10 places and a reduction in overall spending by \$684 per Medicare beneficiary.<sup>23</sup>
  - Medicare beneficiaries in fair or poor health were 1.82 times more likely to experience a preventable hospitalization if they resided in a primary care shortage area. Living in a primary care shortage area was an independent risk factor for a preventable hospitalization, even after controlling for other factors such as income, age, and race.<sup>24</sup>
  - Medical treatments for the 6 percent of Medicare beneficiaries who die each year comprise almost 30 percent of Medicare expenditures. More primary care visits in the preceding year were associated with fewer hospital days at end of life and lower costs. In 2001, nine primary care visits cost Medicare \$3,000; nine days in the hospital cost Medicare \$11,000. More primary care visits were also associated with fewer in-hospital deaths and fewer preventable hospitalizations for those with congestive heart failure and chronic obstructive pulmonary disease.<sup>25</sup>
  - Increased proportions of primary care physicians across all U.S. counties was associated with significantly fewer hospital admissions (5.5 percent), outpatient visits (5 percent) emergency department (ED) visits (10.9 percent), and total surgeries (7.2 percent).<sup>26</sup>
  - Similarly, a paper published by the ACP in the *Annals of Internal Medicine* that compared U.S. health care with care in other industrialized countries found that the best performing health care systems abroad, unlike the United States, are built on a strong foundation of primary care.<sup>27</sup>
- 4. Patients, employers, and taxpayers will suffer if health care reform does not expand the primary care physician workforce capacity at the same time as coverage is expanded.**

- For the newly insured, there will be long wait times to get an appointment with a primary care physician, if they are able to find one at all.
  - In a growing number of communities, it may become impossible for people who do not currently have a relationship with a primary care physician to find an internist, family physician or pediatrician who is taking new patients. Not because established primary care physicians do not want to accept the newly-insured into their practices, but because they have no time left in an already over-scheduled day to take on any additional patients.
  - Patients of established primary care physicians who already are working at full capacity, but who still try to accept more of the newly insured into their practices, will experience a reduction in the qualitative time their doctor is able to spend with them. Wait times for appointments will increase. Despite insurance coverage, without changes in the way care is provided, physicians may have to further decrease the time they currently spend with patients in order to try to accommodate increased demand for services – which could have a negative impact on quality, access, and timeliness. Primary care physician “burn out” is likely to increase because of physician dissatisfaction with not being able to spend enough time with their patients or being able to see them in a timely manner. Such burn outs will likely lead more primary care physicians to consider getting out of practice, which will then put further stress on remaining primary care physicians in their community.
  - Massachusetts’ experience is a case in point of what can happen if coverage is expanded without expanding the primary care workforce. When health insurance coverage was recently expanded to nearly 95 percent of the state’s residents, some low income residents reported difficulty finding a physician or getting an appointment.<sup>28</sup> In fact, the wait to see primary care physicians in Massachusetts has reportedly grown to as long as 100 days.<sup>29</sup>
  - The higher price tag associated with coverage expansions that do not concurrently address the need to rapidly expand primary care physician workforce will be borne by taxpayers and employers in the form of higher taxes and by increases in premiums and cost-sharing for persons who have health insurance coverage.
- 5. Delivery system and payment reforms to support primary care are a prerequisite for a high performing health care system with universal access and coverage. Accordingly, expansions of coverage must be accompanied by other health care delivery system and payment reforms designed to increase primary care workforce capacity and improve the outcomes and efficiency of care rendered.**
- Quality of care in the United States is highly variable and inconsistent. Americans receive approximately 50 percent of recommended care.<sup>30</sup>

- Health care spending in the United States is higher than in any other industrialized country.<sup>31</sup>
- Current levels of expenditures are not sustainable for the federal government, businesses, and patients. Spending on health care in the United States has been rising at a faster pace than spending in the rest of the economy since the 1960s.<sup>32</sup> In 1965, when the Medicare program was enacted, aggregate national health care spending was \$42.3 billion, accounting for 5.9 percent of total domestic spending in the United States. By 2007, national health care spending amounted to \$2.2 trillion or 16.2 percent of GDP, which translates to \$7,421 per person.<sup>33</sup> By 2017, health care spending is expected to reach \$4.3 trillion (\$13,101 per person) and amount to 20 percent of the GDP.<sup>34</sup>

The Congressional Budget Office (CBO) projects that without any changes in federal law, spending on health care will reach 25 percent of GDP in 2025, 30 percent by 2035 and 49 percent in 2082.<sup>35</sup> The Director of CBO has declared that the rate of growth in health care spending is the single most important factor determining the nation's long-term fiscal condition.<sup>36</sup>

Economist Uwe Reinhardt projects that a family that today has a gross wage base of \$60,000 might see it grow by 3 percent per year over the next decade, to \$80,600 by 2017. For the same family, total health spending might grow by 8 percent per year over the same time frame, to \$33,700 by 2017. For this worker, 41 percent of the family's gross wage base would be taken up by health care alone, before any deductions for taxes or fringe benefits.<sup>37</sup>

- Other countries have achieved better outcomes and lower costs in large part because primary care is the keystone of their health care systems. Investment in primary and preventive care can result in better health outcomes, reduce costs, and may better ensure an adequate supply of primary care physicians.<sup>38</sup>

## **POLICY RECOMMENDATIONS**

### **1. President Obama and Congress should enact legislation to rapidly expand health insurance coverage, leading to coverage for all Americans.**

- As a first step, the economic stimulus package should provide temporary assistance to states to maintain existing Medicaid eligibility, benefits and access to clinicians. It should also provide assistance to individuals who will lose coverage during the economic downturn.
- The State Children's Health Insurance Program should immediately be reauthorized and provided sufficient funding to cover all eligible children.



- Such initial steps must be followed by enactment of comprehensive legislation to provide all Americans with access to affordable coverage. Such legislation should:
    - Set a date when all Americans will have access to affordable coverage guaranteed by the federal government.
    - Provide sufficient, income-based subsidies, in the form of advanced refundable tax credits, for eligible persons to buy coverage through a group purchasing program modeled on the Federal Employee Health Benefits Program.
    - Provide incentives for states to expand the Medicaid program to include all persons with incomes up to 100 percent of the federal poverty level, with the additional cost borne by the federal government.
    - Provide access to a core package of essential benefits, including primary care and preventive services.
- 2. Reforms to expand the primary care physician workforce go hand-in-hand and should be implemented simultaneously with reforms to expand coverage.**
- Given the fact that it takes a minimum of seven years to train a primary care physician (medical school and residency combined), the United States cannot afford to delay implementation of policies to attract more new physicians to primary care and to sustain those already in practice. Therefore, in order to avert the deepening projections of primary care physician shortages, policies to expand primary care workforce capacity need to be implemented *immediately* to influence the career choices of medical students and physicians already in residency programs, and the retirement and career decisions of primary care physicians already in practice.
  - Expansion of coverage for any subset of the uninsured population must be accompanied by a simultaneous, sufficient, and sustained set of policies to assure that there will be enough primary care physicians available to take care of them.
    - For instance, if legislation were enacted to expand coverage to all uninsured Americans under 150 percent of the federal policy level by January 1, 2010, the primary care workforce might need to be increased by over 5,000 primary care physicians just to meet the needs of this share of the newly covered, based on the illustration discussed earlier.
- 3. No later than June 30, 2009, President Obama and Congress should charge an appropriate federal agency to convene an advisory group of experts on primary care workforce, including representatives of national membership societies representing primary care physicians, nursing, physician assistants, consumer and patient advocacy groups to develop specific and measurable**

**goals on the numbers and proportions of primary care physicians and other clinicians needed to meet current and increased demand for primary care including those associated with expansions of coverage.**

- This advisory group should also identify specific metrics to evaluate the impact (success or failure) of each policy that is implemented to expand the primary care physician workforce, including measures of medical student and new physician choice of specialty, measures of the career plans of established physicians, and measures of patient access to primary care. Such metrics should be reported to Congress, the public, and all appropriate federal agencies no later than September 30, 2009, for implementation beginning in calendar year 2010.
- Such metrics might include:
  - The numbers of medical students who express a commitment to choose a residency program in internal medicine, family medicine, and pediatrics and an intention to go into primary care at the completion of residency, starting with the 2009 third and fourth year medical student classes.
  - The numbers of physicians completing their third year residencies in internal medicine, family medicine, and pediatrics who select a primary care practice rather than a non-primary care, non-patient care career path, starting with physicians who will be completing their residencies in 2009.
  - The numbers of established primary care physicians who demonstrate a commitment to remain in practice rather than retiring prematurely or choosing another career path.
  - The percentage of persons, including newly-insured ones, who register in surveys that they are able to get an appointment with a primary care doctor in a timely manner without great difficulty or are able to find a primary care physician who is accepting new patients.
  - The ratio of primary care physicians to other specialists. For example, it has been recommended that the U.S. set a national policy goal that half of all U.S. clinicians practice in primary care.<sup>39</sup>
  - The percentage of nurse practitioners and physician assistants who choose to practice in primary care areas rather than subspecialties.
- 4. Programs to increase primary care workforce capacity will need to be continued for as long as is necessary, and expanded as needed, to assure the necessary and measurable increases in capacity.**
- Programs should be recalibrated should the impact in any year, beginning in 2010, indicate that the policies are not having a big enough impact on achieving

*measurable* gains in the numbers of young physicians and medical students choosing primary care, sustaining primary care physicians already in practice, assuring adequate patient access to primary care, and other metrics of primary care workforce capacity.

**5. The federal government should specifically take the lead in designing and implementing policies to provide for simultaneous, sufficient, and sustained policies to result in immediate and measurable increases in primary care workforce capacity. Such policies should include:**

- Reform of Medicare payments so that the career choices of medical students and young physicians are largely unaffected by considerations of differences in earnings expectations. This will require immediate increases in Medicare fee-for-service payments to primary care physicians, starting in the current calendar year, followed by continued annual increases in payments for primary care physicians.

Medical students and young physicians should make career decisions based on their interests and skills, instead of being influenced to a great extent by differences in earnings expectations associated with each specialty. Yet there is extensive evidence that choice of specialty is greatly influenced by the undervaluation of primary care by Medicare and other payers compared to other specialties.<sup>40</sup> One author suggests that achieving a national goal of 50 percent of clinicians practicing in primary care will require “improving the payment gap between primary care physicians and specialists such that the generalist-to-population ratio increases.”<sup>41</sup>

Currently, the average primary care physician earns approximately 55 percent of the average earnings for all other non-primary care physician specialties. [ACP analysis based on data from two sources: Medical Group Management Association--2008<sup>42</sup> and Merritt Hawkins – 2008 Review of Physician and CRNA Recruiting Incentives – Top Twenty Searches<sup>43</sup>].

To eliminate differential income as a critical factor in medical student/resident choice of specialty, the average net income for primary care physicians would need to be raised to be competitive with the average net income for all other specialties.

- The level of payment for services provided principally by primary care physicians must be increased to be competitive with other specialty and practice choices, taking into account any additional years of training associated with specialty training programs.
- A target goal for raising primary care reimbursement to make it competitive with other specialty and practice options should be established

by the federal government based on, in part, an analysis of the current marketplace and the price sensitivity of physicians with respect to projected income and choice of specialty.

- For instance, Medicare and all other payers would need to increase their payments to primary care physicians by 7.5-8 percent per year over a five-year period, above the baseline for all other specialties, to bring the average of the median earnings for primary care physicians to 80 percent of those for all other specialties, all other factors being equal. Achieving 100 percent parity would require annual increases of 12-13 percent over five years.
- Such market competitiveness targets could also be adjusted to take into account expansion of existing programs and development of new ones to reduce or eliminate student debt for physicians selecting primary care careers, so that the combined differential between debt and expected earnings is comparable to other specialty choices.

Other countries have made investments to increase pay to primary care physicians to make them competitive with other specialties, and have found such investments to be effective in attracting more physicians to primary care. The new contract for the English National Health Service “helped increase recruitment into primary care and was advantageous to family physicians, whose incomes increased 58 percent between 2002-03 and 2005-06.”<sup>44</sup>

- Transition to new payment models for primary care.
  - Such models should: provide payment for services not currently reimbursed such as care provided between face-to-face visits (e.g., e-mails, scheduled phone visits, care coordination).
  - Practices that organize to deliver patient-centered care through the Patient-Centered Medical Home (PCMH) model should be paid a monthly, risk-adjusted care management fee for each eligible patient; plus fee-for-service payment for face-to-face encounters with patients; plus performance-based payments for reporting on quality, patient satisfaction and efficiency metrics. A shared savings component might also be included. The total payments for PCMHs should be high enough to fully cover the costs – including physician and other clinical staff work and health information systems associated with care management – and result in an overall and substantial gain in net revenue to primary care physicians in such practices. Total compensation for PMCH should support the goals of making primary care more attractive and competitive and also furthering the PCMH itself.

- PCMHs will be accountable for demonstrating to an independent body, through a voluntary process, the essential core capabilities to support patient-centered care and for measuring and reporting their performance on an ongoing basis.
  - The current Medicare Medical Home Demonstration, which is limited to eight states, should be expanded to a national pilot.
  - CMS should set a timeline for expeditiously transitioning to a new payment model for all practices nationwide that have voluntarily sought and received recognition as Patient-Centered Medical Homes following completion of the Medicare demonstration/pilot.
- States should receive dedicated federal funding to:
  - Implement PCMH demos for Medicaid, SCHIP, and all-payer programs.
  - Raise payments to primary care physicians to increase participation in state Medicaid and SCHIP programs and to reduce ethnic and racial disparities in treatment. A recent study by the Center for Studying Health System Change found that "racial and ethnic disparities in primary health care are in part systemic in nature, and the lower resources flowing to physicians treating more minority patients are a contributing factor. In particular ... if Medicaid payments to physicians were on par with those paid by Medicare, disparities in reported difficulties between physicians whose patient panels were made up of greater versus smaller proportions of minorities would diminish, often substantially. Low payments may be leading primary care physicians to reduce the time spent with patients and more generally diminish their ability to function effectively as their patients' medical home."<sup>45</sup>
- Increased funding for scholarship and loan repayment programs under Title VII and the National Health Services Corps (NHSC), should be made available to increase the number of physicians who are trained in a primary care specialty and who commit to a reasonable primary care service obligation in exchange for graduating without medical education debt. Many U.S. medical graduates are interested in such programs, but there are not enough awards available. For example, the NHSC scholarship program already receives seven to 15 applicants for every award available.<sup>46</sup>

ACP is encouraged that the economic stimulus package being considered by Congress provides \$600 million to address shortages and to prepare our country for universal healthcare by training primary healthcare providers, including doctors, dentists, and nurses, as well as helping to pay medical school expenses

for students who agree to practice in underserved communities through the National Health Service Corps.

Congress should also increase funding for primary care training programs funded under the Title VII program and create new pathways to eliminate debt for physicians who are trained in primary care and agree to a service obligation in a critical need facility or geographic area. Specifically, Congress should establish and fund new scholarships and loan repayment programs to eliminate debt for physicians who are trained in a primary care specialty and who agree to serve in such capacity in critical shortage facilities or areas. This new program should provide up to \$30,000 per year in scholarship or up to \$35,000 per year in principal and interest repayment on loans for each year of primary care service in a critical shortage facility or area, respectively. Critical shortage is defined as a geographic area, physician practice, or other facility that the Secretary determines has a critical shortage of primary care but that does not qualify under the Health Professionals Shortage Area designation in current law.

- A systematic review and elimination of unnecessary, redundant, and ineffective paperwork requirements imposed by CMS and other federal agencies, especially those that fall disproportionately on primary care physicians. Such policies should include:
  - Simplifying the Medicare physician enrollment process;
  - Improving physician ability to help beneficiaries obtain needed prescriptions through Medicare Part D;
  - Ensuring physician interaction with regional Medicare Administrative Contractors (MACs); and
  - Studying the use of real-time Medicare claims adjudication.
- Require standardization and streamlining of insurance credentialing, billing, claims review, and other administrative procedures that fall disproportionately on primary care physicians associated with private sector health plans that participate in the Federal Employee Health Benefits Program, Medicare Advantage, or that may be offered through a Health Insurance Exchange as proposed by President Obama. Reducing the administrative burden will free physician practices to further focus on clinical care, improve physician satisfaction, and, lower overall health care costs. Physicians should, among other things, have the ability to:
  - Contribute the information health plans need for credentialing to a single source – from which individual plans can draw – rather than providing the same information to numerous payers;

- Access information on which a health plan covers a patient and the benefits the coverage affords in real-time through a single electronic platform;
- Use standard processes to navigate payer authorization-related programs, including those for prescription drugs and radiology services; and
- Receive payment for services that meet a health plan's conditions for payment at the time of the service.

The mechanisms to achieve these administrative efficiencies have been or are being developed. A requirement that private health plans that participate in federal programs use these mechanisms will help to streamline these programs while providing an example that health plans insuring a commercial population can follow.

**6. To assure that all federal agencies are working together in a seamless manner on development and implementation of programs to increase the primary care physician workforce capacity, President Obama should issue an Executive Order on Increasing Primary Care Workforce Capacity, within the first six months of his presidency.**

- This executive order should direct all federal agencies with an impact on health care in the United States to develop and implement policies to increase primary care workforce capacity in the United States to meet the needs of the currently insured, people who will become newly insured as a result of health reform initiatives to expand coverage, and the growing demand for primary care associated with an aging population with increased incidence of chronic illnesses. It should specifically require that all federal health-related agencies:
  - Develop, describe and initiate plans to encourage or require private sector entities that contract the federal government to provide care to patients funded or subsidized by the federal government – including health plans that participate in the FEHBP and the Medicare Advantage programs or the new Health Exchange proposed by President Obama – to implement policies to increase primary care physician workforce capacity.
  - Develop, describe and initiate plans to support innovative models for delivering primary care including the Patient-Centered Medical Home.
  - Develop, describe and initiate a research agenda to facilitate an understanding of the factors affecting choice of specialty, the demand for primary care, and policies to assure a sufficient primary care workforce capacity.

- Develop, describe and initiate payment reforms to make primary care competitive with other career and practice options and create measurable objectives for assessing the impact of such reforms on increasing primary care workforce capacity.
  - Develop, describe and initiate plans to reduce ineffective, duplicative or inefficient regulatory and paperwork requirements on primary care clinicians.
  - Develop, describe and initiate plans to assist physicians, especially those in smaller practices, to acquire the capabilities and health information systems to manage and coordinate care including health information technology.
- Develop and describe a timeline for implementing all such programs.
  - Develop and describe goals for each program and metrics for evaluating success.
  - Develop and describe a process for recalibration of such programs should they prove to be having an insufficient impact on increasing the primary care workforce capacity.

A draft summary of the proposed Executive Order to Increase the Primary Care Workforce Capacity is included with the materials accompanying this report.

**7. Federal spending on primary care – including the initial costs associated with higher payments to primary care physicians – should be considered to be investments in the infrastructure for a high performing health care system.**

- Hundreds of studies show that primary care is associated with better outcomes at lower cost. Primary care can be expected to produce overall savings to taxpayers compared to the poorer outcomes and higher costs that will result if there is an insufficient number of primary care physicians.
- Estimates of the costs associated with funding primary care should therefore include consideration of the impact of primary care on reducing preventable hospital admissions; emergency department utilization; unnecessary, duplicative or preventable imaging studies and other tests; and other avoidable costs.
- Accordingly, the federal investment in primary care should not fall under the usual pay-as-you go rules and should be funded in a way that does not fall within the usual budget neutrality rules for Medicare physician payments.

Included with this report is a document that discusses the different options available to fund primary care payment increases, the advantages and disadvantages of each, and ACP's recommendations.



**8. Congress and the Obama administration should also implement payment, delivery, workforce and other reforms to improve health care for all patients, not just those seen by primary care physicians. Although ACP strongly believes that policies to support primary care must be a linchpin of health care reform, policies are also needed to improve care for all patients, including those seen by internal medicine subspecialists, surgeons, and other specialties. Such policies should include:**

- Replacement of the Medicare Sustainable Growth Rate with a new method of updating physician payments to result in predictable updates that reflect increases in the costs of delivering care.
  - President Obama should specifically agree to remove drugs from the SGR formula.
  - Congress and the new administration should also agree to rebase Medicare baseline spending to eliminate the accumulated payment deficit created by the SGR.
- Fund independent research on the comparative effectiveness of different treatments. ACP has developed a detailed policy paper with recommendations on the organization and funding of comparative effectiveness research. It is available upon request.
- Promotion of transparency in reporting on the quality and cost of care based on the principles in the Consumer-Purchaser Disclosure Project.
- Support for pilot-testing a variety of innovative delivery and payment systems that emphasize team-based care, coordination of care, and prevention of illness by primary care and specialist physicians.
- Reductions in unnecessary paperwork and regulatory requirements in all specialties and types of practice.
- Improvements in the accuracy of physician payments under the Medicare fee schedule, including a better process for identifying potentially over-valued and undervalued services and improvements in the practice expense methodology.
- Improvements in the Medicare Physician Quality Reporting Program to make it a more effective and efficient program for improving health care outcomes.
- Support and incentives to physicians to acquire health information technologies with the necessary functionality to provide patient-centered, improve clinical outcomes, and facilitate transparency and accountability through the automatic reporting of performance measures.

- Workforce policies to assure an adequate supply of other specialties and professions facing shortages, including some internal medicine subspecialties, general surgery and nursing.

## **Conclusion**

In 2009, the State of America's health care is poor. There are too many uninsured and underinsured people. We have too few primary care physicians. We spend more and get less in return than most other industrialized countries. We over task our physicians with unnecessary administrative burdens that are wasteful and increase the cost of providing care while under-recognizing the true value of patient-centered care delivered by primary care physicians.

The problems are big, so the solutions must also be big. Small steps will not slow the collapse of primary care and certainly will not reverse it. Small steps will not provide all Americans with health insurance coverage.

ACP applauds President Obama for his commitment to achieving a better health care system for all Americans. We believe that this commitment is shared by members of Congress, Democrats and Republicans alike.

A better health care system must result in everyone having health insurance coverage, and everyone having access to primary care. Anything less than that is not acceptable. Primary care is the best medicine for better health and lower costs.

ACP looks forward to working with President Obama and Congress to achieve a high performing health care system with universal access to health insurance and universal access to primary care physicians.

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