

Reform of the Dysfunctional Healthcare Payment and Delivery System

**American College of Physicians
A Position Paper
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Executive Summary

The American College of Physicians (ACP), which represents over 119,000 physicians who specialize in internal medicine and medical students, recently released both a workforce policy paper, “Creating a New National Workforce for Internal Medicine: Recommendations of the American College of Physicians” and a January 2006 “State of the Nation’s Health Care” report. These documents provide substantial evidence of a looming crisis in primary care. The pool of primary care physicians (e.g. internists, family practitioners) is rapidly decreasing at a time when there is a growing demand for their services due to a rapidly aging population with increased incidence of chronic disease. This collapse of primary care will result in our health care system becoming increasingly fragmented, overly-specialized, and inefficient – and lead to lower quality, higher costs, reduced access and increased patient dissatisfaction.

Inadequate and dysfunctional payment and delivery policies are key drivers behind the impending collapse of primary care. Medicare, as the single largest purchaser of health care in the United States and as the standard for health plan payment policies in the private sector, has a particular responsibility to replace policies that are antithetical to primary care with policies designed to encourage and support its importance and growth. Examples of current Medicare policies that adversely affect primary care include:

- Undervaluing the evaluation and management (E/M) clinical services that are predominately provided by primary care physicians.
- Using methodologies to determine the relative value units (RVUs) for each service that overvalue some services/procedures to the detriment of other services in Medicare’s budget neutral system.
- Not paying for those services required to allow the primary care physician to provide patient-focused, longitudinal, coordinated care.
- Using a yearly fee update formula – the sustainable growth rate (SGR) – that projects annual cuts in physician fees of approximately 5 percent through 2011 and has a disproportionately adverse impact on primary care physicians.
- Providing incentives for volume of services with no regard to the quality or efficiency of the clinical service provided.

This policy paper builds on analyses and positions presented in recently released ACP position papers to develop a series of recommended changes to the current Medicare payment and delivery system that, if implemented, will improve the system and help mitigate the collapse of primary care. ACP recommends short term strategies to modify the current payment system until more fundamental reform can be enacted. The types of changes recommended include: ensuring that the value Medicare assigns to each physician service is accurate; providing separate Medicare payment for services that facilitate accessible and coordinated care; and transitioning

to a system that links a portion of Medicare payment to how well a physician adheres to evidence-based guidelines.

This policy paper also takes the position that these relatively modest modifications of the current physician payment and service delivery system will not be sufficient to permanently maintain and foster a thriving primary care workforce. ACP recommends that Congress replace the SGR formula with an alternative that is aligned with the goals of achieving quality and efficiency improvements and sustaining a sufficient supply of primary care physicians. Replacing the SGR would also maximize the impact of our recommendations to improve the current system. Further, ACP believes that a new model needs to be developed that recognizes the value of primary care delivery, is less likely to induce inappropriate service volume increases, and rewards care that is evidence-based and efficient. Thus, ACP calls on Congress to initiate a comprehensive study of reform options that meet these criteria. While ACP will analyze options and make recommendations for replacing the current physician payment and service delivery system in a future position paper, the College recently introduced a delivery model, the Advanced Medical Home, that it believes could achieve these goals if supported by appropriate financing. ACP recommends that CMS work with the College to further develop and test this model.

I. Recommendations to Ensure the Accurate Valuation of Physician Services

The College calls on policymakers to make immediate reforms in the way that Medicare determines the value of physician services under the Medicare Resource Based Relative Value Schedule (RBRVS).

Position 1: The Centers for Medicare and Medicaid Services (CMS) should substantially increase the work relative value units (RVUs) for evaluation and management (E/M) services based on evidence showing increased physician work.

Position 2: CMS should re-examine its methodologies for determining practice expense RVUs to ensure that the practice expenses assigned to specific services reflect true resource costs.

- CMS should implement a “bottom-up” methodology for using practice expense inputs to determine practice expense RVUs.
- CMS should facilitate a survey of all physician specialties to identify practice costs to include in the practice expense methodology.
- CMS should review its assumptions on the utilization and depreciation of service/procedure-specific equipment.

Position 3: CMS should establish a better process for identifying potentially misvalued RVUs and redistributing any savings into the budget neutral RVU pool.

- The Secretary should establish a group of independent experts to advise CMS in its process of reviewing RVUs.

- The Secretary should automatically review services that have experienced substantial changes in length of stay, site of service, volume, practice expense, and other factors that may reflect on the amount of physician work.
- The Secretary should automatically review the work RVU for recently introduced services after a specified period of time or based on other evidence that the work has changed over time.
- The Secretary should establish a process by which every service is reviewed periodically.

Position 4: CMS should request that the RVS Update Committee (RUC) examine its composition to assure that it is reflective of each specialty's relative contribution to providing services to Medicare patients.

Position 5: The College recommends that MedPAC examine modifying the RBRVS definition of work to more adequately reflect those processes related to the improving of clinical quality, efficiency and patient experience.

II. Recommendations to Provide Separate Medicare Payments for Services that Facilitate Accessible and Coordinated Care

The College calls on policymakers to make immediate reforms so that Medicare can pay physicians for providing patient-focused, longitudinal, coordinated care.

Position 6: CMS should provide separate payment for services employing e-mail, telephonic, and related technology that could facilitate timely communications between physicians and patients and reduce the need for face-to-face visits for non-urgent care.

Position 7: CMS should provide Medicare payment to physicians for the overall provision of defined care coordination/care management services, and/or provide specific codes for those activities that facilitate care coordination/care management services (e.g. care coordination across treatment settings, intensive care follow-up, use of patient registries and population-based treatment protocols, patient disease management training.)

Position 8: CMS should provide an add-on to Medicare payments for office visits that are facilitated by the use of HIT, such as electronic health records, electronic prescribing and clinical decision support tools, and reimburse accordingly. Furthermore, to ensure that the use of this technology is primarily to facilitate improved healthcare quality/safety, payment should be contingent on participation by physicians in reporting related data to approved quality improvement and measurement programs.

III. Recommendations to Add a Quality Component to the Medicare Payment System

Position 9: 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.

- The current payment system should be modified to allow new methods of reimbursement that reward those who follow evidence-based standards.
- Rewards should reflect the level of work and commitment to quality, which will differ among physicians and across specialties.
- Pay for performance (P4P) systems should rely on valid and reliable clinical measures, data collection and analysis, and reporting mechanisms.
- The value of health information technology (e.g. electronic health records, decision-support tools) should be financially recognized for its ability to assist physicians to do well on quality measures and report their progress.
- Potential P4P rewards should be significant enough to support continuous quality improvement, directed at positive rewards, not negative penalties, and be balanced between rewarding high performance and substantial improvement over time.
- Medicare P4P should enable physicians to share in system-wide savings (such as from reduced Part A hospital expenses) resulting from quality improvement.

IV. Recommendations to replace the sustainable growth rate formula (SGR) and introduce alternative payment and delivery models

Position 10: Congress must replace the sustainable growth rate (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 sustaining a sufficient supply of primary care physicians.

Position 11: Congress should enact legislation to require a comprehensive study and report on alternative Medicare physician payment and delivery models that would recognize the value of the patient’s relationship with a primary care physician, be less likely to induce inappropriate service volume increases, reward care that is evidence-based and efficient, reduce inappropriate geographic variations in cost and quality, and facilitate physician-guided care coordination of patients with chronic diseases. The study should be conducted by nationally recognized experts in health care financing and delivery (including experts on regional variations in cost and quality, quality improvement, and management of chronic diseases) and representatives of physician specialties that serve the most Medicare patients, including national medical specialty societies representing primary care physicians. The Medicare Payment Advisory Committee should review and comment on the study and report.

Position 12: Medicare and other payers should work with the ACP to design a new model for financing and delivering primary or principal care called the Advanced Medical Home.

- A pilot or demonstration of the Advanced Medical Home financing and delivery model should be implemented by CMS.

Introduction

“We learn early in our medical training about the importance and joy of having a continuous, ongoing and personal relationship with a patient, which is the hallmark of general internal medicine and family medicine. Unfortunately, we also learn ...that there is no economic future in primary care.” (Vineet Arora, MD, 2006)¹

A Looming Crisis in Primary Care

The American College of Physicians (ACP), which represents over 119,000 physicians who specialize in internal medicine and medical students, recently released both a workforce policy paper “Creating a New National Workforce for Internal Medicine: Recommendations of the American College of Physicians”² and a January 2006 “State of the Nation’s Health Care” report³ providing substantial evidence for a looming crisis in primary care. Primary care, the backbone of the nation’s health care system, is at grave risk of collapse due to a dysfunctional healthcare payment and delivery system. Immediate and comprehensive reforms are required to modify or replace this system that undermines and undervalues 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 incidence of chronic diseases. The consequences of failing to act will be higher costs, increased inefficiency, lower quality of care and increased patient dissatisfaction.

At a time when there is a growing demand for primary care physicians (e.g. internists, family practitioners) due to a rapidly aging population with increased incidence of chronic disease, the pool of these practitioners is rapidly decreasing.

- Demographic projections reflect an aging population for Medicare and the United States in general. Within only six years, the first of a wave of 76 million baby boomers will begin to be eligible for Medicare. The number of adults aged 65 and older, currently numbered at 36.3 million, is expected to grow 54 percent between 2000 and 2020. The population age 85 and over will increase 50 percent from 2000 to 2010.⁴
- Approximately two-thirds of Americans age 65 and older have multiple chronic conditions. Among adults ages 80 and older, 92 percent have one chronic condition, and 73 percent have two or more.⁵
- 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.⁶
- Primary care physicians and general internists in particular, are at the forefront of managing this increasing aging, chronically ill population. According to the Health Resources and Services Administration (HRSA) 2003 Changing Demographics Report, adult patients’ need for primary care physicians increases dramatically as they age.⁷
- There has been a dramatic decline in the number of graduating medical students entering primary care. In 2005, only 13 percent of first-year internal medicine residents planned to pursue careers in general medicine. Among third-year internal medicine residents, only 20 percent planned to practice general internal medicine compared to 54 percent in 1998.⁸

- Large numbers of physicians who had chosen a general medicine practice are leaving the field. A 2005 survey of internal medicine physicians who received their board certification in the early 1990s found that 21 percent of those who were practicing general (primary care) internal medicine have left internal medicine practice entirely, compared with only 5 percent of subspecialty internists who reported that they have left their subspecialty.⁹
- 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.¹⁰

The Collapse of Primary Care will Cause Higher Costs, Lower Quality, Reduced Access, and Increased Dissatisfaction

The primary care physician's ability to evaluate and clinically manage the whole patient in a patient-centered, longitudinal, coordinated manner has direct positive healthcare consequences. This is particularly true for the treatment of chronic conditions. The collapse of primary care will result in our health care system becoming increasingly fragmented, over-specialized, and inefficient – and lead to poorer quality, higher costs, reduced access, and increased patient dissatisfaction.

- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.^{11 12}
- Areas with more specialists have higher per capita Medicare spending,¹³ and that an increase in primary care physicians is associated with a significant increase in quality of health services, as well as a reduction in costs.¹⁴
- Studies of ambulatory care-sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care.¹⁵
- Cross national comparisons indicate that nations with stronger primary care infrastructures have lower rates of premature births, deaths from treatable conditions, and post neonatal mortality.^{16 17 18}
- Studies have repeatedly demonstrated that the vast majority of Americans prefer a sustained relationship with a primary care provider.¹⁹

Inadequate and Dysfunctional Payment and Delivery Policies Contribute to the Collapse of Primary Care

Inadequate and dysfunctional payment and delivery policies are key drivers behind the impending collapse of primary care. Medicare, as the single largest purchaser of health care in the United States and as the standard for health plan payment policies in the private sector, has a particular responsibility to replace policies that are antithetical to primary care with ones designed to encourage and support its importance and growth. Examples of current Medicare policies that adversely affect primary care include:

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