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# Primary care's eroding earnings: Is Congress concerned?

Barely. Our study suggests that our best hope for change is to work with lawmakers who want to reform Medicare's Sustainable Growth Rate

## Practice recommendation

- Write your senator and congressional representative about the need for Medicare payment reform that addresses the primary care/specialist payment gap. Let them know, too, if you are no longer able to accept Medicare patients due to reduced payments.

## Abstract

**Purpose:** Despite increasing data demonstrating the positive impact primary care has on quality of care and costs, our specialty faces uncertainty. Its popularity among medical students is declining, and the income gap is growing between primary care and other specialties. Congress has the power to intervene in this impending crisis. If we want to influence lawmakers' actions, we need to know how they are thinking about these issues.

**Methods:** Using a set of questions covering several physician payment topics, we interviewed 14 congressional staff aides (5 aides on Medicare-oversight committees, 9 general staff aides) and one representative from each of 3 governmental agencies: the Medicare Payment Advisory Commission, Congressional Budget Office, and

Government Accountability Office.

**Results:** Interviewees revealed that issues in primary care are not high on the congressional agenda, and that Medicare's Sustainable Growth Rate (SGR) is the physician-payment issue on the minds of congressional staff members.

**Conclusion:** Attempts to solve primary care's reimbursement difficulties should be tied to SGR reform.

**T**he viability of primary care in the United States is in question, attributable in large part to declining provider payments in the face of rising medical school debt and fee-for-service pressures to increase patient volume.<sup>1-3</sup> Congress—which has authority over Medicare and its price-setting function for provider reimbursement overall—is seemingly unaware of the problems facing primary care, including barriers to payment reform. The future of our specialty may hinge on our ability to persuade Congress that these problems are dire. A growing body of evidence supports the essential and integrative function primary care plays in health systems, and its positive impact on quality of care and costs.<sup>4-6</sup>

**The confused order of things now**  
Advantages of primary care are proven.

Regions with higher ratios of primary care physicians relative to specialists have lower rates of hospitalizations, lower Medicare costs, and higher quality of care.<sup>7,8</sup> People with a primary care physician are more satisfied with their care and more likely to receive preventive services and better chronic disease management.<sup>9-11</sup> Most countries that have built their health care systems on a strong foundation of primary care demonstrate better health outcomes, fewer health care disparities, and lower costs.<sup>4,6</sup> Thus the waning of primary care presents risks to both personal and population health.

**Still, society undervalues primary care.**

Despite evidence of the benefits just cited, the income disparity between primary care physicians and specialists continues to grow, discouraging medical students from entering primary care careers.<sup>12</sup> The Medical Group Management Association shows that between 2000 and 2004, the median income for a family physician increased 7.5% to \$156,000; for invasive cardiologists, 16.9% to \$428,000; and for diagnostic radiologists, 36.2% to \$407,000. Adjusted for inflation, primary care income fell 10% from 1995 to 2004.<sup>13</sup>

**No wonder students shy away from primary care.** Though there is little public sympathy for the financial woes of primary care doctors, lower incomes are contributing to a drying of the primary care pipeline.<sup>14,15</sup> The number of US medical school graduates choosing family medicine residencies dropped by 50% between 1997 and 2005.<sup>16</sup> From 1998 to 2004, the number of internal medicine residents choosing careers in primary care plummeted from 54% to 25%.<sup>17,18</sup> This waning interest in primary care coincides, unfortunately, with the aging of the US baby boomers and an increasing prevalence of chronic disease.

**How Congress could help fix the disparity**

Medicare reimbursement has 2 components that Congress could amend to nar-

row the payment gap and help open the primary care pipeline: the Sustainable Growth Rate (SGR) and the Resource-Based Relative Value Scale (RBRVS) process.

**The SGR formula sets a target** for Medicare physician expenditures each year. Recently, physician expenditure growth has exceeded the target and, by law, the difference is subtracted from the fees paid to all physicians. According to the Medicare Payment Advisory Commission (MedPAC), much of the excess spending has come from rapidly increasing volumes of procedures used by specialists.<sup>19</sup> The SGR system therefore disproportionately penalizes primary care physicians because payments to all physicians are cut regardless of which specialties are responsible for excess spending.

**RBRVS is the system of relative values** applied to every procedure and office visit. The Relative Value Units (RVUs) for each procedure or office visit are multiplied by a conversion factor determined by the SGR formula. RVUs are largely governed by the Relative Value Scale Update Committee (RUC), which advises the Centers for Medicare and Medicaid Services (CMS) on revisions to physician reimbursement.

The RUC reviews the relative value scale at least every 5 years. Though primary care physicians provide about half of Medicare physician visits, they represent just 15% of the RUC's voting members.<sup>12</sup>

The committee's reevaluation process tends to raise some RVUs without sufficiently deflating others.<sup>20</sup> The resulting overall inflation of fees forces CMS to reduce payments equally to all physicians, meaning primary care is again disproportionately penalized. Moreover, both Medicare and private insurance companies follow the RUC's recommendations.

**Influencing Congress: Where to begin?**

As Congress escalates its deliberations on Medicare physician spending, we investigated how key legislators perceive issues in primary care and physician payment.

CONTINUED

**FAST TRACK**

**When adjusted for inflation, primary care income fell 10% from 1995 to 2004**

**TABLE**

**6 Questions we asked  
 the congressional staffers**

1. What are your views on the current state of primary care in the United States?
2. When considering legislation to improve health care in the United States, how—if at all—does primary care factor into your vision?
3. If there is legislative movement to change the Sustainable Growth Rate and Resource-Based Relative Value Scale systems in the next year, what should the goal be?
4. What is your sense of other health legislative assistants' understanding of primary care?
5. Who are you hearing from on issues of primary care? Who are you *not* hearing from?
6. What are the best sources to learn about these issues?

**FAST TRACK**

**Staffers from rural districts noted that constituents are having difficulty finding primary care doctors who take Medicare**

**Methods**

To better understand perspectives of congressional committees with jurisdiction over health care spending, we conducted semistructured key informant interviews in March 2007 with 14 health staff aides to members of Congress who have jurisdiction over Medicare. Interviews were done face to face and lasted 30 to 60 minutes.

The congressional committees with jurisdiction over Medicare physician payment are Senate Finance, House Ways and Means, and House Energy and Commerce. Each committee has 1 majority and 1 minority staffer specializing in Medicare part B, which includes physician payment. Of these 6 specialized staffers, 5 agreed to participate in semistructured interviews. Other staffers were contacted by using a purposeful sampling technique known as “snowballing” or chain-referral, whereby participants with whom contact has been made refer the researcher to other potential interviewees. This process yielded another 9 interviewees to total 14.

The aides identified several other information sources, and we interviewed 1 staff member each from 3 of these sources: MedPAC, the Congressional Budget Office (CBO), and the Government Accountability Office (GAO).

Interviews covered several topics,

including views on the state of primary care and physician payment (**TABLE**). Three researchers separately reviewed the interview notes to identify and compile themes.

**Results**

Of the 14 congressional staffers, 8 were Republican and 6 were Democrat; 5 were committee staff and 9 were general staff. Committee representation was fairly even among staffers: Senate Finance (4), House Ways and Means (5), and House Energy and Commerce (5). Range of experience on Capitol Hill was 3 months to 9 years.

**Some staffers are empathetic, others unaware.** Most respondents expressed concern about the decreasing number of students entering primary care careers and the potential impact on patient access to care. One staffer acknowledged, “the way our reimbursement system works, primary care is not an option for students...reimbursement is so low...the number of primary care physicians is going down relative to other specialties.”

Another participant added that most staffers “recognize a role for primary care. It’s also tough because of how strong the specialty community is.” One staffer advised, “The Alliance of Specialty Medicine goes along with the AMA, trying to represent a coordinated front...I don’t see this much coordination around primary care.”

A few staffers did not understand the definition of primary care or did not know which physician groups represent primary care.

**Legislation to improve US health care—and primary care.** Participants varied in their input on this subject. One staffer stated that primary care is “important but rarely singled out...usually the goal is broader reform so [primary care] is still a goal, but unstated.”

Some committee staff described the need to incentivize greater use of primary care and increase coordination

of care. A few proposed reevaluating RBRVS to help primary care, and they spontaneously raised the Medical Home concept as a way to encourage growth of primary care. The Medical Home involves pairing each Medicare beneficiary with a patient-centered practice that meets certain criteria including continuity with a personal physician, care coordination, quality assurance, increased access, and specific payment.<sup>21</sup> A pilot project in North Carolina that incorporates the Medical Home is saving the state about \$162 million annually.<sup>22,23</sup> One staffer championed primary care, but pointed out that a critical barrier preventing Congress from investing in it is the CBO, which is not convinced that primary care can save money over the long term.

### **The SGR dominates discussions on physician payment**

All respondents had a functional understanding of the SGR and desired reform, but few understood how the SGR contributes to the payment gap. Many staffers would like to do away with the SGR, but CBO estimates show that this would be cost-prohibitive.<sup>24</sup>

A few staffers believed that SGR reform may not happen until 2009, after the next president takes office. Some participants also predicted that SGR reform will not happen until more physicians refuse to see Medicare patients. To date, MedPAC has reported each year that there is no Medicare access crisis. Staffers from rural districts, however, affirmed that constituents are having difficulty finding primary care doctors who take Medicare.

Staffers uniformly agreed that nobody has the answer to fix the SGR. Several staffers commented on the complexity of the problem, pointing out that MedPAC's March 2007 SGR report did not achieve a consensus on how to restructure the rate. Many participants were disappointed with the MedPAC report and want solutions to fix physi-

cian payment that are more directed and "convincing."

Some expressed a need for "hands-on models and demonstration projects." Although these staffers have heard of models that would split the SGR by specialty or geography, they remain skeptical about such proposals without evidence of efficacy. Staffers were also wary of splitting the SGR by specialty, believing it would cause infighting among physicians.

**Staffers know far less about RBRVS than they do about the SGR.** One staffer admitted, "I won't pay attention until something is at a crisis point or we have a hearing or a vote." A few staffers asserted that there should be a more rigorous RUC review to examine what services are over- and undervalued.

**Government agencies are not asked to address primary care.** At the time of interview (March 2007), staff from MedPAC, GAO, and CBO said that Congress had not asked them to study issues in primary care. One CBO analyst asserted that "nobody's been able to demonstrate significant changes in volume or outcome [as a result of investing in primary care]...we need empirical data." The analyst also mentioned CMS demonstration projects as a way to gather data. According to a Capitol Hill veteran, the CBO believes that even if primary care extends a person's life, this may not necessarily save money.

### **Discussion**

Although most of the interviewed congressional staffers recognize the payment gap and understand that the number of physicians entering primary care is decreasing, Congress has not taken action to address these issues. Several factors explain this.

**SGR is the 800-pound gorilla.** When discussing physician payment, congressional staffers appear far more concerned with reforming the SGR than addressing problems in primary care. This perception is supported by the fact that

### **FAST TRACK**

**According to one Capitol Hill veteran, the CBO believes that even if primary care extends a person's life, this may not necessarily save money**

FAST TRACK

Research shows that primary care-oriented systems reduce preventable hospitalizations, which decreases costs

Congress has asked MedPAC and CBO to investigate the SGR, but has not asked them to examine issues in primary care. For Congress, the dilemma is to hold down physician spending while keeping physicians in the Medicare market. Staffers are dissatisfied with SGR reform proposals from MedPAC and are eager to learn about new possible solutions.

**No one perceives a crisis in access to Medicare providers.** According to annual MedPAC reports, the number of primary care doctors accepting Medicare patients is sufficient. Staff for members of Congress from rural areas, however, contend that some constituents cannot find a primary care provider who accepts Medicare.

**Congress is not convinced that primary care saves money.** Although some staffers believe that primary care can reduce costs, the CBO argues that this is not necessarily true. It is indeed difficult to prove cost savings from investing in preventive services because there is greater upfront cost, and extending people's lives could incur higher future costs. Research, however, shows that primary care-oriented systems reduce preventable hospitalizations, which decreases costs.<sup>4,5,7,8</sup> It seems that either the existing evidence is insufficient to convince the CBO or the evidence has not been communicated effectively.

**Strategic leverage moving forward**

The time is ripe for SGR reform because most staffers conveyed a desire for solutions. Because the SGR appears to take priority over primary care issues, it must be dealt with first. It is possible, however, for policy makers to address the SGR and RBRVS reforms while simultaneously investing in primary care. The SGR and RBRVS reforms could hold specialties accountable for their own volume growth and protect specialties with minimal volume growth.

**The Medical Home is a concept gaining recognition** among congressional staff and could involve restructured physician payment. In its Tax Relief and Health

Care Act of 2006, Congress mandated a 3-year Medical Home demonstration to be conducted across multiple demographic communities in up to 8 states. The concept encompasses "large or small medical practices where a physician provides comprehensive and coordinated patient centered medical care and acts as the 'personal physician' to the patient."<sup>25</sup> (The Medical Home is also a focus of The Patient-Centered Primary Care Collaborative [<http://www.pcpcc.net/>], a coalition of medical societies, employers, insurers, consumer groups, and others that is exploring the concept as a way to contain health care costs and also achieve fair remuneration for physicians.)

The demonstration must be carefully crafted to test the concept fairly. Even before the demonstration begins, Congress could ask the CBO and GAO to investigate existing evidence of primary care's cost-effectiveness. Support from the CBO is essential for Congress to invest in primary care.

**Other experiments are underway.** As of this publication, several major insurers are beginning regional experiments in raising fees for primary care visits in an effort to avoid greater costs down the road.<sup>23</sup>

**Access issue needs further study.** Our interviews revealed that while MedPAC asserts there is no primary care access issue, staffers from rural districts disagree. In fact, had Congress not overridden President Bush's recent veto of a Medicare bill to increase physicians' fees, doctors in urban areas would also have stopped accepting new Medicare patients.<sup>26</sup> Additional physician workforce studies are necessary to fully understand the current primary care physician supply. Also useful would be studies by Medicaid and Medicare that investigate thresholds at which physicians stop seeing patients with low-paying coverage.

**Advocacy is needed, too.** Congressional staffers appear to understand some of the difficulties in primary care, but give

priority to broader SGR reform. Further research and advocacy on the value of primary care and payment reform solutions will be necessary to establish primary care as a means to cost-effective, high-quality care in the United States. ■

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#### FAST TRACK

**Several major insurers are beginning regional experiments in raising fees for primary care visits in an effort to avoid greater costs down the road**