



**Statement for the Record
of the
American College of Physicians
to
the Senate Finance Committee**

“Aligning Incentives: The Case for Delivery System Reform”

September 16, 2008

The American College of Physicians (ACP) is the largest medical specialty society in the United States, representing 126,000 internal medicine physicians and medical student members. ACP commends Chairman Max Baucus and Ranking Member Charles Grassley for holding this hearing on health system reform and aligning incentives to improve the quality of health care for patients. The College has been at the forefront of the effort to reform the health care system through its efforts to increase the number of primary care physicians and to reform Medicare payment systems to align incentives for physicians with delivery systems that can achieve improved outcomes for patients, such as the Patient-Centered Medical Home. We commend the Senate Finance Committee, under the leadership of Chairman Baucus and Ranking Member Grassley, for supporting policies to improve payments for primary care services, to provide additional funding to the Medicare Medical Home demonstration project, and to provide relief from payment cuts resulting from the flawed Sustainable Growth Rate (SGR) formula.

The Importance of Primary Care In Achieving Better Outcomes and Cost Savings

A fundamental goal of delivery system reform should be to recognize and support the value of primary care in improving outcomes; reducing preventable over-utilization of emergency rooms, hospitals and testing facilities; and achieving overall costs savings.

Evidence from over 100 references has found that primary care, such as care provided and managed by an internal medicine physician (internist), consistently is associated with improved outcomes and lower costs. ACP will soon be publishing a comprehensive and annotated literature review on the impact of primary care on quality and costs of care, which we will be glad to share with the Senate Finance Committee. Highlights include the following:

- 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.^{i ii iii}
- Primary care has the potential to reduce costs while still maintaining quality.^{iv v vi vii}
- States with higher ratios of primary care physicians to population have better health outcomes, including mortality from cancer, heart disease or stroke.^{viii ix}



- Individuals living in states with a higher ratio of primary care physician to population are more likely to report good health than those living in states with a lower such ratio.^x
- The supply of primary care physicians is also associated with an increase in life span.^{xi xii} An increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.^{xiii}
- Primary care physicians have also been shown to provide better preventive care compared to specialists, reflecting their ability to better manage the whole health of patients.^{xiv xv xvi}
- The preventive care that primary care physicians provide can help to reduce hospitalization rates.^{xvii xviii xix xx xxi} During the year 2000, an estimated 5 million admissions to U.S. hospitals involved hospitalizations that may have been preventable with high quality primary and preventive care treatment; the resulting cost was more than \$26.5 billion. 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.^{xxii}
- Hospital admission rates for five of 16 ambulatory care-sensitive conditions "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease," increased between 1994 and 2003, suggesting worsening in ambulatory care access or quality for those conditions.^{xxiii xxiv} Studies of certain 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.^{xxv}
- An increase of one primary care physician per 10,000 population in a state was associated with a rise in that state's quality rank and a reduction in overall spending by \$684 per Medicare beneficiary.^{xxvi} By comparison, an increase of one specialist per 10,000 people was estimated to result in a drop in overall quality rank of nearly nine places and increase overall spending by \$526 per Medicare beneficiary.

The Primary Care Physician Workforce is Facing Collapse

Despite strong evidence that primary care contributes to better outcomes for patients and overall cost savings, the primary care physician workforce is headed towards collapse.

Demand is growing, at the same time that few young physicians are choosing primary care and many established physicians are leaving primary care practice.

Primary Care Supply is Declining while Demand is Growing

- The U.S. population is expected to increase 18 percent between 2005 and 2025, to 349 million. 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 will increase 50 percent from 2000 to 2010.^{xxvii}

- This rapid growth in population and increased proportion of elderly people is expected to raise the number of ambulatory care visits by 29 percent by 2025. The increased child population is estimated to increase patient visits by 13 percent.^{xxviii}
- The number of patients with chronic diseases, who benefit most from the coordination of care and continuity in care that primary care physicians provide is also increasing. Nearly 45 percent of the U.S. population has a chronic medical condition and about half of these, 60 million people, have multiple chronic conditions.^{xxix} For the Medicare program, 83 percent of beneficiaries have one or more chronic conditions and 23 percent have five or more chronic conditions.^{xxx} By 2015, an estimated 150 million Americans will have at least one chronic condition.^{xxxi} 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.^{xxxii} Among nonelderly adults, the number who report having one or more of seven major chronic conditions has increased from 28 percent in 1997 to 31 percent (or 58 million) in 2006.^{xxxiii}

While the demand for primary care is increasing, there has been a dramatic decline in the number of graduating medical students entering primary care and an exodus of established primary care physicians from practice. Factors affecting the supply of primary care physicians include excessive administrative hassles, high patient loads, and declining revenue coupled with the increased cost for providing care.

- A 2007 study of fourth-year medical students' career decision making revealed that only 2 percent of students intended to pursue careers in general internal medicine.^{xxxiv}
- In 2007, only 14 percent of first-year internal medicine residents planned to pursue careers in general medicine. Among third-year internal medicine residents, only 23 percent planned to practice general internal medicine compared to 54 percent in 1998. From 1997 to 2005, the number of US medical graduates^{xxxv} entering family medicine residencies dropped by 50 percent.^{xxxvi}
- An increasing proportion of new primary care physicians are females, who tend to work fewer hours, further reducing the effective workforce. By 2025, half of all primary care physicians will be female.^{xxxvii}
- A 2008 study predicted a 20 percent shortage, and possibly 27 percent if the decline in primary care Match rates continues, of adult primary care physicians by 2025. This translates into a shortfall of an estimated 35,000–44,000 adult primary care physicians. Further, greater use of nurse practitioners and physicians assistants and increased primary care by specialists are not expected to make enough of an impact on this shortfall.^{xxxviii}

Established primary care physicians are also leaving practice at much higher rates than specialists. Approximately 21% of physicians who were board certified in the early 1990s have left internal medicine, compared to a 5% departure rate for internal medicine subspecialists.^{xxxix}



Many communities throughout the United States already are experiencing shortages of primary care physicians, and many more will soon join their ranks. For example, the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services estimates that 150,308 Montana residents lack access to a primary care physician, resulting in \$54,444,985 in annual expenditures on preventable emergency room visits. 339,747 residents of Iowa lack access to a primary care physician, resulting in \$183,880,125 in preventable emergency room admissions. A state by state estimate of the shortage of primary care physicians and the impact on preventable hospital admissions is available at [<http://nhsc.bhpr.hrsa.gov/about/reports/reauthorization/appb.htm>].

A shortage of primary care physicians will undermine efforts to expand health insurance coverage. A health insurance card will not assure access to care if there are not enough primary care doctors. ACP strongly supports the goal of providing all Americans with health insurance coverage, but as Massachusetts's recent experience has shown, policies to expand coverage must go hand-in-hand with policies to reverse the shortage of primary care physicians.

The Boston Globe reported on September 22 that many of those in Massachusetts, a state that has pioneered policies to expand health insurance coverage, must wait months to get an appointment with a primary care doctor:

“The wait to see primary care doctors in Massachusetts has grown to as long as 100 days, while the number of practices accepting new patients has dipped in the past four years, with care the scarcest in some rural areas. Now, as the state's health insurance mandate threatens to make a chronic doctor shortage worse, the Legislature has approved an unprecedented set of financial incentives for young physicians, and other programs to attract primary care doctors. But healthcare leaders fear the new measures will take several years to ease the shortage. Senate President Therese Murray, who championed the legislation, said that many of the roughly 439,000 people who obtained health coverage under the 2006 insurance law are struggling to find a doctor. ‘You can take a look at the whole state and you are not going to find a primary care physician anytime soon,’ she said in an interview. ‘It became apparent very quickly that we needed to do something.’

How Medicare Payment Policies Undermine Primary Care

Despite the overwhelming evidence that shows the ability of primary care physicians to improve the health of patients, the federal government undervalues the work of primary care physicians. Medicare payment policies have contributed to a U.S. health care system that has contributed to the shortage of primary care physicians and does not serve the interest of patients:

- Medicare pays little or nothing for the work associated with coordination of care outside of a face-to-face office visit. Such work includes ongoing communications between physicians and patients, family caregivers, and other health professionals on following recommended treatment plans;



- Low fees for office visits and other evaluation and management (E/M) services provided principally by primary care physicians discourage physicians from spending time with patients;
- Low practice margins make it impossible for many physicians, especially in solo and small practices, to invest in health information technology and other practice innovations needed to coordinate care and engage in continuous quality improvement;
- Medicare's Part A, B and D payment "silos" make it impossible for physicians to share in system-wide cost savings by organizing their practices to reduce preventable complications and avoidable hospitalizations.
- Medicare does not control volume or create incentives for physicians to manage care more effectively;
- The Sustainable Growth Rate (SGR) formula cuts payments to the most efficient and highest quality physicians by the same amount as those who provide the least efficient and lowest quality of care; penalizes physicians for volume increases that result from following evidence based guidelines; triggers across the board payment cuts that have resulted in Medicare payments falling short of inflation for hard-pressed primary care practices that are struggling to keep their doors open; and forces many physicians to limit the number of new Medicare patients that they can accept in their practices;

Redesigning Payment Policies to Align Incentives with Quality and Efficiency

ACP urges Congress to enact comprehensive reforms of Medicare payment policies to align incentives with quality and efficiency of care in a way that recognizes and supports the central role of primary care physicians in achieving better outcomes at lower costs. We are pleased to report that we are working with Senator Maria Cantwell, a member of the Senate Finance Committee, on a bill that would realign Medicare payment policies to support patient-centered primary care. The bill will also include loan forgiveness and scholarships for internists, family physicians, and pediatricians who agree to provide primary care in a facility or geographic area that is facing a critical shortage of primary care physicians. It is our understanding that Senator Cantwell will be introducing the bill early in the 111th Congress. Among the payment reforms that are being considered for inclusion in the bill are provisions to provide immediate payment increases for evaluation and management services provided principally by primary care physicians, changes to take into account the impact of primary care on reducing overall Medicare program costs, coverage and payment for specific services relating to care coordination by primary or principal care physicians, and transition to a new payment methodology for primary care practices organized as Patient-Centered Medical Homes (PCMHs). We recommend the following:

1. **Reform Medicare fee-for-service payments by providing immediate, sufficient and sustained payment increases for services provided principally by primary care physicians.** Such reforms should include:



- *Change Medicare fee schedule budget neutrality rules to take into account the impact of primary care on reducing total Medicare baseline spending (Parts A, B and D combined).* As noted above, there is solid evidence that primary care is associated with reductions in preventable hospital and emergency room admissions and overall lower costs of care. Currently, under Medicare's budget neutrality rules, any payment increases resulting from raising the work relative value units (RVUs) for primary care services must be offset by across-the-board reductions in payments for all physician services, including the same primary care services that are intended to gain from the payment increases in the first place. Such budget neutrality redistribution also increases opposition from physicians in non-primary care specialties to increased payments for primary care.

ACP specifically recommends that Congress amend section 1848 of the Social Security Act to increase the \$20,000,000 limitation that requires an adjustment to maintain budget neutrality by a dollar amount that is equal to the anticipated savings in Medicare Parts A, B (including Part B Services that are not included in the Medicare Physician Fee Schedule), and D for the designated primary care services and services and capabilities that promote patient-centered care Chronic Care Coordination. The existing budget neutrality limitation requires that if relative value unit (RVU) adjustments in a year cause payments to differ by more than 20,000,000 from the expenditures that would have occurred had no such RVU adjustments been made, a budget neutrality offset is applied to keep spending within the \$20,000,000 limitation. This proposal would require HHS to increase the \$20,000,000 limitation by an amount equal to anticipated savings from Medicare payment for the designated primary care services and capabilities as defined by the PCMH and Chronic Care Coordination, so that no budget neutrality offset would be required until the higher dollar limitation (\$20,000,000 plus an additional dollar amount equal to anticipated savings in Medicare Part A, B, and D) is exceeded. This change in budget-neutrality would *not* result in an increase in overall Medicare expenditures to fund primary care, but allow for higher payments for primary care to be funded at least in part through efficiencies achieved in other parts of Medicare.

- *Pay primary and principal care physicians for specific services associated with care coordination that are not currently reimbursed or covered by Medicare.* These services include: care plan oversight; evaluation and management provided by phone; evaluation and management provided using Internet resources; collection and review of physiologic data, such as from a remote monitoring device; education and training for patient self management; anticoagulation management services; and current or future services as determined appropriate by the Secretary that facilitate the ability of primary and principal care physicians to coordinate care for beneficiaries. Estimated savings from separate payment for such services should be applied to increase the budget neutrality adjustment under section 1848 of the Social Security Requirements as previously described.



- *Increase payment for evaluation and management services provided by primary and principal care physicians.* Specifically, ACP recommends that the Secretary be directed to develop a methodology, in consultation with primary care physician organizations, MedPAC, and other experts, to increase Medicare payments for designated evaluation and management services provided by primary and principal care physicians through a service-specific modifier to the established RVUs for such services, service-specific bonus payments or through such other methodology as determined by the Secretary. The Medicare Payment Advisory Commission made a similar recommendation in its March 2008 Report to Congress.

This methodology should include proposed criteria for physicians to qualify for such higher payments, including consideration of the type of service being rendered, the specialty of the physician providing the service, and demonstration of voluntary participation in programs to improve quality, such as participation in the Physicians Quality Reporting Initiative (PQRI) or practice level qualification as a Patient-Centered Medical Home. Aggregate funding for such designated evaluation and management services should take into account estimates of the impact of primary care on reducing preventable hospital admissions, duplicate testing, medication errors and drug interactions, Intensive Care Unit (ICU) admissions, per capita health care expenditures, and other savings in Medicare Parts A, B (including Part B services not included in the Medicare Physician Fee Schedule) and apply a portion of the aggregate estimate of such savings to fund the total aggregate dollars available to increase payments for such services.

- *Continue to provide performance-based bonus payments for physicians who voluntarily participate in the Physicians Quality Reporting Initiative.* The PQRI should provide higher payments to physicians who report on “high impact” measures relating to chronic diseases that have the greatest potential to improve quality and achieve efficiencies in health care expenditures and utilization.
2. **Transition Medicare payment policies toward a new payment system to align incentives for physicians with comprehensive, longitudinal, patient-centric, and coordinated care for patients delivered through a Patient-Centered Medical Home (PCMH).** ACP commends the Senate Finance Committee for its role in providing increased funding to allow for expansion of the Medicare Medical Home Demonstration Project in the Medicare Improvements for Patients and Providers Act. We believe that this demonstration project should be the first step toward transitioning to a new payment system for qualified PCMHs to align incentives with effective care coordination. Specifically, we recommend that no later than January 1, 2012, the Secretary should be required to propose and implement a new payment methodology for qualified PCMHs achieved through a voluntary recognition process or other equivalent process as determined by the Secretary, for the clinical work and practice expenses associated with providing care coordination services, consisting of the elements listed below. The Secretary should take into account the results of the



Medicare Medical Home demonstration, defined in Public Law 109-432, Section 204, in developing this alternative PCMH payment structure.

- Prospective, risk-adjusted per beneficiary per month PCMH fee for each beneficiary that chooses that practice as their PCMH to cover the work and practice expenses involved in providing care consistent with the PCMH model (e.g. increased access, care coordination, disease population management and education) that are not currently covered under the Medicare Physician Fee Schedule. Such prospective, risk-adjusted per beneficiary payment should be set at a level and magnitude that is sufficient to support the acquisition, use and maintenance of clinical information systems needed to qualify as a PCMH and that have been shown to facilitate improved outcomes through care coordination. Such payments should be made on a “tiered” per beneficiary per month fee that will provide for a range of payment depending on how advanced a practice’s capabilities are in having the information systems needed to support care coordination.
- The Secretary should consider the impact of qualified PCMHs on reducing preventable hospital admissions, duplicate testing, medication errors and drug interactions, and other savings in Medicare Parts A, B (including Part B services not included in the Medicare Physician Fee Schedule) and apply a portion of the aggregate estimate of such savings to determining the aggregate amount of payment for the PCMH fees that would then be provided to qualified practices. Should aggregate actual savings after three years be higher than the estimate, the Secretary shall apply a portion of such additional aggregate savings to fund the PCMH fee.
- Performance-based bonus fee determined by meeting or achieving substantial improvements in performance as specified clinical, patient satisfaction and efficiency benchmarks.
- Continued fee-for-service payment for evaluation and management services.

Last year, ACP worked with the American Academy of Family Physicians (AAFP) the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA) to jointly establish principles that define the PCMH. The PCMH is a delivery model that involves a patient with a relationship with a personal physician who works with a practice team to provide first contact, whole-person, continuous care. The PCMH model is based on the premise that the best quality of care is provided not in episodic, illness-oriented care, but through patient centered care that emphasizes prevention and care coordination. A PCMH practice must demonstrate that it has the infrastructure and capability to provide care consistent with the patient’s needs and preferences. The PCMH joint principles call for enhanced payment to support the practice transformation and increased value to the patient and the health care system.

ACP, AAFP, AAP, and AOA, as the four organizations that represent the vast majority of primary care physicians, worked with the National Committee on Quality Assurance (NCQA) to establish an independent process by which physician practices can be recognized



as a PCMH. The NCQA established process, the Physician Practice Connections-PCMH (PPC-PCMH) module, requires practices to meet core requirements and attain a minimum score to be recognized as a medical home. Practices that meet these core requirements and achieve at or above the minimum total score are identified as one of three progressive levels of PCMH. The highest level of medical home, a Tier 3 PCMH, is generally associated with the greater use of HIT.

Having a process by which an independent, third-party determines whether a physician practice is a PCMH is one reason why the model has gained considerable traction over the past few years. Assurance that practices are transforming to meet the full needs of patients has contributed to the decision of many employers, health plans, consumer organizations, policymakers, and other health care stakeholders to embrace the model. It is our understanding that CMS intends to use a recognition process to identify the medical home practices that participate in the Medicare medical home demonstration project authorized by Congress in 2006 and enhanced through the Medicare legislation that became law earlier this year.

In its June 2008 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that it establish a robust PCMH pilot project that focuses on practices that use significant HIT.

3. **Direct the Medicare Payment Advisory Commission to continue to study and recommend new Medicare payment policies to align incentives for all physicians, primary care and non-primary care physicians alike, with team-based care coordination, quality and effectiveness of care, patient satisfaction, and efficiency.** In addition to re-aligning incentives to support care managed by primary and principal care physicians, it is also important for Medicare to study and then institute payment reforms to create incentives for *all* physicians to provide high quality and efficient care to beneficiaries. This is especially true since much of the increase in spending on physician services is for diagnostic and treatment procedures that are typically provided by physicians in non-primary care specialties. Medicare needs to consider ways to pay physicians that will reward team-based care coordination, quality, effectiveness of care, patient satisfaction and efficiency instead of the volume of procedures and encounters.
4. **Repeal the Sustainable Growth Rate (SGR) and eliminate the accumulated payment deficit that otherwise would be applied to future physician payment updates.** None of the reforms proposed in this statement to align Medicare payment with improved outcomes and more efficient use of resources will work if physicians continue to face annual across-the-board cuts from the SGR. Such cuts fall particularly hard on primary care physicians, because they can least afford to absorb the cuts, they are unable to offset cuts by increasing volume, and they are being penalized for volume increase in other categories of physician services that are outside of their control. Implementation of payment reforms, such as those proposed in this testimony, to support the value of care coordinated by primary and principal care physicians may eliminate the need to have any kind of national volume target, since the payment system itself would provide incentives for physicians to achieve desired quality outcomes in the most efficient way possible. In the event that Congress determines that some kind of national volume target is still needed, then the



target should be designed in such way as to assure that payments are able to keep pace with rising costs, that primary care physicians are not penalized for volume increases outside of their control, that the target sets a realistic rate of growth in lieu of the current standard of per capita GDP, that the target take into account the impact of spending on primary care services in achieving efficiencies in the non-physician parts of Medicare, and that it protect payments for primary care physicians from payment reductions that will further undermine the supply of primary care physicians.

Conclusion

The American College of Physicians appreciates the opportunity to provide its input to the Finance Committee on the value of primary care physicians, health system reform, and the Patient Centered Medical Home. We believe that there is an urgent need to reform Medicare payment policies to support the critical role of primary care physicians in achieving better outcomes and lower costs and to reverse the decline in the numbers of physicians who are selecting primary care careers. ACP proposes that Congress mandate improvements in Medicare fee-for-services policies to create incentives for high quality, efficient, and patient-centered care while transitioning to new models of payment, such as the Patient-Centered Medical Home, to support team-based care coordinated by a primary or principal care physician. We look forward to working with members of the committee to adopt these proposals as Congress considers health reform during this legislative session and in 2009.

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