

June 27, 2011

The Honorable Barack Obama
Office of the President
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Obama:

On behalf of the Council of Academic Family Medicine (CAFM), which represents the membership of The Society of Teachers of Family Medicine, The Association of Departments of Family Medicine, The Association of Family Medicine Residency Directors, and The North American Primary Care Research Group, and in conjunction with The American Academy of Family Physicians (AAFP), we write to help inform your important bipartisan discussions on proposals to address the federal deficit. We appreciate the difficulty of the task you have undertaken, and offer our perspective as medical educators and practicing family physicians regarding a key portion of the Medicare program, graduate medical education (GME), which supports the training of physicians for the nation.

We recognize the need to control the growth of federal spending, restore our vital economy and revise the status quo in health spending. We are very much aware of the questions that have arisen over the value and accountability of Medicare Graduate Medical Education (GME) spending. We propose the recommendations below for changes to the Medicare GME that we have supported for many years. However, the manner and the purpose behind changes to Medicare GME are critical. We hope this letter will provide you, and your colleagues in this endeavor, specific recommendations that will address the rising costs in the health care system, yet at the same time improve care for our patients and the nation.

Recommendations

1. Any reductions in Medicare GME should be tailored in a manner that would allow for the advancement of primary care training to enhance the production of a workforce that will be able to restrain future health care costs.
2. Use this opportunity to provide incentives for changes to Medicare GME to allow for innovations in primary care training to help build the well-trained primary care workforce the nation needs.

The current Medicare GME system is outmoded, based on the historic trends in health care extant in the 1960s when hospital-based training was the norm. While we support modifications in that system to address the changing health care environment and the needs of our patients, we also suggest that Medicare GME has been a national success story in producing well-trained physicians to care for the US population. Caution should be used to modify the structure of this funding mechanism in ways that will improve our health care system by producing needed family physicians and other primary care physicians well-trained in new models of care, able to work in teams and support practices grounded on evidence-based medicine. We hope any changes and reductions in Medicare GME spending will support these goals, while not destroying an important public good for the sake of deficit reduction. Medicare GME should take the lead in providing payment incentives for the development of new models of care that will improve health outcomes for Medicare beneficiaries at significantly reduced costs. Medicare GME funding for primary care physician training, should be protected from deficit

reduction so that the production of a robust primary care workforce – one that has been shown to correlate well with lower Medicare costs -- is preserved and strengthened.

Restraining Health Care Costs with Primary Care

The evidence that primary care restrains health care costs and improves quality is very clear when that care is delivered in a team-based Patient Centered Medical Home (PCMH). Findings from the Dartmouth Health Atlas Data demonstrate good correlations between having more primary care, particularly family medicine, and having lower Medicare costs and reduced “ambulatory care sensitive” hospitalizations—i.e., hospitalizations that might be avoided by patients with access to primary care. There also is growing evidence that experiments with PCMH and Accountable Care Organizations (ACO)—particularly those that emphasize access to more robust primary care teams—can reduce total costs by 7-10 percent, largely by reducing avoidable hospitalizations and emergency room visits.

Primary care is just 6-7 percent of total Medicare spending, so patient-centered medical home experiments are recouping the entire costs of care in those settings, not just the added investments. These findings hold true in integrated systems like Geisinger, insurance experiments like Blue Cross Blue Shield of South Carolina, or individual system efforts like Johns Hopkins. The key factor in all of these examples is increased investments in the primary care setting.

Basis for Reform of Medicare Graduate Medical Education

The Medicare Payment Advisory Commission’s (MedPAC) June, 2008 report recognizes that “patient access to high quality primary care is essential for a well-functioning health care delivery system” (pg.14). The report recommends that “policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them.” Lastly, the Commission recognized that “medical education subsidies could also be used to help pay student loans for clinicians committed to primary care specialties.”

In its June, 2010 report, MedPAC continues to address this issue, stating “Currently, Medicare’s payments for GME generally subsidize the specialty choices of both teaching hospitals (in their program offerings) and residents (in their career choices). The resulting physician mix of specialties is unlikely to ensure that the nation has an efficient supply of health professionals for well-functioning delivery systems, as evidenced by falling shares of physicians practicing primary care after their residencies.”

According to the Council on Graduate Medical Education (COGME), in its 20th report (December 2010), “there is compelling evidence that health care outcomes and costs in the United States are strongly linked to the availability of primary care physicians. For each incremental primary care physician (PCP), there is 1.44 fewer deaths per 10,000 persons. Patients with a regular primary care physician have lower overall health care costs than those without one.”

If any budget proposal is to restrain the growth in health care spending successfully, it must also support programs that build the family physician and primary care workforce.

Incentivizing Educational Change to Promote a Properly Balanced Physician Workforce

CAFM and AAFP have long supported the need for significant reform of GME funding under Medicare. We believe that changes to entitlement programs such as Medicare GME should be

utilized to incentivize changes that would lead to a properly balanced physician work force, as recommended in the 20th COGME report. Such a workforce will promote cost restraints in Medicare spending.

Significant innovations in Medicare GME funding of training are needed in the United States. Currently Medicare GME does not properly incentivize the development of the primary care training in new models of care, such as patient centered medical homes, federally qualified health centers, and other ambulatory settings. In addition, the training of primary care physicians tends already to be underfunded by Medicare GME payments, due to historic deficits in counting primary care resident FTEs who trained outside the hospital.

We support the Congressional intent of Medicare GME that asserts the training of physicians is a societal good, and we recommend that CMS should provide financial incentives, through its various programs, for the development of an accomplished, well-trained, and state-of-the-art physician work force – one that is suited to practice most efficiently and effectively in our new health care system. These models of care can only develop appropriately if medical students and resident physicians are trained in these settings, and this can only occur when there are financial incentives for proper curriculum development and faculty development programs. These incentives are needed to support the development of faculties with special expertise to champion and teach health care delivery redesign.

Thus, we recommend that Medicare GME funding provide incentives for the development of new training models. We support the recommendation of the Medicare Payment Advisory Commission (MedPAC, June 2009), which states, “reforming medical education will be a key component to transforming the nation’s healthcare delivery system from one that historically is focused on care of acute illness to one that values patient centered care, quality improvement, and resource conservation.” To this end, we recommend changes to Medicare GME that would support innovation in primary care graduate medical education. To accomplish this, Medicare GME should provide financial incentives to:

1. Support primary care training in all sites where care is delivered.
2. Provide structured GME payments for primary care residencies to directly fund the entity where education is the primary mission – not the hospital.
3. Increase payments for primary care training to support added costs of training in community based (nonhospital) settings, as well as to offer incentives to medical students who chose a primary care career.
4. Provide incentives for training in rural and under-served areas.

We believe it important that all funding mechanisms in Medicare recognize the importance of education, both for the training of an appropriately equipped physician work force, and for the future success of deficit reduction and better health care outcomes. Payment incentives are needed to promote a more balanced educational model than the traditional model in which all Medicare payment for medical education is allocated to hospitals. It is our hope that the provision of such financial incentives for new models of education by Medicare GME would be an incentive for the development of a system of GME payments by private insurers as well.

Conclusion

We hope that as your deficit reduction talks continue, you take away two principles for reform of Medicare graduate medical education. The first is that any cuts to Medicare GME be targeted in ways that would support the advancement of primary care training, to produce a workforce able to restrain rising health care costs, rather than solely for a short term reduction of the federal

deficit. The second is to use this opportunity to provide incentives for innovations in primary care training to help build the well-trained primary care workforce the nation needs and which will restrain future health care costs. If we can provide further assistance, please contact the CAFM Director of Government Relations, Hope Wittenberg, at hwittenberg@stfm.org, or the AAFP Director of Government Relations, Kevin Burke, at kburke@aafp.org.

Sincerely,



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