

# COUNCIL OF ACADEMIC FAMILY MEDICINE

Association of Departments of Family Medicine  
Association of Family Medicine Residency Directors  
North American Primary Care Research Group  
Society of Teachers of Family Medicine



June 22, 2015

The Honorable Orrin Hatch  
Chairman, Senate Finance Committee  
U.S. Senate  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member, Senate Finance Committee  
U.S. Senate  
Washington, DC 20510

The Honorable Johnny Isakson  
Co-Chair, Finance Committee Chronic Care  
Working Group  
U.S. Senate  
Washington, DC 20510

The Honorable Mark R. Warner  
Co-Chair, Finance Committee Chronic Care  
Working Group  
U.S. Senate  
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner:

On behalf of the Council of Academic Family Medicine (CAFM), which includes the Society of Teachers of Family Medicine (STFM), the Association of Departments of Family Medicine (ADFM), the Association of Family Medicine Residency Directors (AFMRD), and the North American Primary Care Research Group (NAPCRG), we write to respond to your request for best ideas to improve outcomes for Medicare patients with chronic conditions. We have two main goals in our response: the first is to identify ways to increase the primary care work force to meet the needs of our population – especially for the estimated eighty-one million people who will have multiple chronic conditions by 2020, the vast majority of whom are Medicare beneficiaries; the second is to recommend strategies to support the appropriate training of the primary care workforce and needed evaluation efforts as you institute innovative reforms related to Medicare practice.

## **Supporting an Appropriately Sized and Trained Physician Workforce**

Why is an increased primary care workforce needed? As you have cogently noted, “traditional Medicare still struggles to properly align incentives to providers who engage in labor and time intensive patient care coordination.” The same holds true for the Medicare graduate medical education program. Medicare needs to promote the production of community-based primary care physicians – who are trained in chronic disease management and population health. The Medicare Payment Advisory Commission (MedPAC), stated, “Despite the tremendous advances that our GME system has brought to modern health care, the Commission finds it is not consistently producing physicians and other health professionals who can become leaders in reforming our delivery system to substantially improve its quality and value.” (“Report to the Congress: Aligning Incentives in Medicare,” June 2010) Two specific areas of concern are workforce mix (including type, diversity, and distribution), and education and training in skills needed to improve the value of our health care delivery system, including evidence-based medicine, population health, team-based care, care coordination, and shared decision making.

The problem with the current physician training programs is not the quality of the programs, per se. While improvements and modernization are needed in many residency programs, the quality of the training generally is quite high, albeit focused too intently on hospital-based care. The fundamental problem is that the current system incentivizes the wrong mix of specialty training.

Because graduate medical education (GME) payments focus on training in hospitals, the result is an emphasis on hospital-based acute care specialties rather than on community-based specialties (e.g., family medicine, geriatrics) *that include training in chronic disease management and preventive health*. As the Council on Graduate Medical Education (COGME) noted in its 21<sup>st</sup> report, “many teaching hospitals have not recognized the need for a greater emphasis on primary care training.” (“Improving Value in Graduate Medical Education,” August 2013)

The current GME funding system does not meet our nation’s health care needs. While it excels at preparing highly trained subspecialists, it is failing to produce the number of primary care physicians the U.S. population needs and expects. Various studies and projections show a current primary care shortage that is predicted to get worse. With nearly 209,000 primary care physicians in the United States in 2010, it is projected that nearly 52,000 additional primary care physicians will be required by 2025. (“Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025,” *Ann Fam Med*, November/December 2012) Three factors affect this shortage: the growth in the U.S. population, the aging of the population, and expansion of insurance coverage.

However, a shortage of primary care physicians is only part of the problem. Another part is the uneven distribution of primary care physicians. The Health Resources and Services Administration (HRSA) estimates that nearly 20 percent of Americans live in areas that have an insufficient number of primary care physicians. At least part of the reason for this maldistribution is the location of physician training programs. According to The Robert Graham Center for Policy Studies in Family Medicine and Primary Care, 56 percent of family medicine residency program graduates practice within 100 miles of the residency program from which they graduate. (“Migration After Family Medicine Residency: 56% of Graduates Practice Within 100 Miles of Training,” *Am Fam Physician*, November 2013) Since most of the large academic hospitals are in major metropolitan areas, the current graduate medical education (GME) funding supports the development of physicians in these areas rather than in rural and underserved areas.

Data show that funding directed at large urban hospitals, as currently structured, is not the best way to create more primary care physicians or to meet the needs of rural and other underserved areas of America. There has been a 25% erosion of primary care production over the last decade that is the result of increased subspecialization training opportunities and closure of primary care training programs. Current funding, directed at hospitals without accountability for the product, is only producing 25% of graduates in primary care – including hospitalists. This is down from 32% 10-15 years ago. A 2013 Academic Medicine report finds that only 4.8% of all graduates of 759 sponsoring institutions practiced in rural areas and 198 of those 759 institutions produced no rural physicians. This percentage compares extremely unfavorably to the 19.3% of the population classified as rural by the 2010 census.

GME funding should be allocated in a manner that will encourage and increase training in ambulatory, community, and medically underserved sites. New methods of funding to include reallocation of existing GME funding that is not calculated according to Medicare beneficiary bed-days is needed. We believe GME funding should be provided directly to primary care residency programs, educational consortia that may include universities, or non-hospital community agencies and create the proper financial incentives for ambulatory and community-based training.

One example of the kind of training we believe should be supported by Medicare GME is the Teaching Health Center (THC) GME Program. Unlike the Medicare-sponsored GME positions, the THC program directly funds participating sponsoring organizations. Eligible entities include, among others: federally qualified health centers; community mental health centers; rural health clinics; health centers operated by the Indian Health Service; and other ambulatory centers that receive funds under Title X of the Public Health Service Act. By any measure, the Teaching Health Center Graduate Medical Education (THCGME) Program has been highly successful. Since its inception in 2011, there has been a rapid expansion in the number of THCs; more importantly, there has been an increase in the number of physicians being trained in primary care specialties. Currently, there are 60 THCGME programs operating in 24 states and training more than 550 primary care physicians and dentists. These programs are training physicians in the most-needed shortage specialties: family medicine; internal medicine; pediatrics; psychiatry; general dentistry; and geriatrics. In addition to providing meaningful and appropriate training opportunities for primary care physicians, these programs have expanded access to millions of underserved individuals in some of nation's most vulnerable communities, namely rural and urban.

We are sincerely grateful that Congress has reauthorized this program for two years as part of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA.) The current challenge is that—like small businesses that need predictable funding before making a long-term investment—some potential sponsoring organizations have been reluctant to apply for the THC grant awards in light of the uncertainty of future funding. In the next two years we hope that this Committee can put forward legislation that would create a path to permanency for this program, funded by Medicare GME dollars.

The American Academy of Family Physicians (AAFP), along with the Council of Academic Family Medicine (CAFM) organizations, has proposed five policies that we believe would improve our nation's GME system and its financing. These policies were included in the AAFP's comprehensive GME proposal, "Aligning Resources, Increasing Accountability, and Delivering a Primary Care Physician Workforce for America." We divided our policy proposals into two categories: Aligning Resources and Increasing Accountability. As you consider additional reforms we propose the following recommendations<sup>1</sup>:

1. Aligning Resources
  - a. Limit direct graduate medical education (DGME) and indirect medical education (IME) payments to the training for first-certificate residency programs.
  - b. Align financial resources with population health care needs through a 0.25 percent reduction in IME payments—from the current 5.5 percent to 5.25 percent—and allocate these resources to support innovation in graduate medical education.
  - c. Create and fund a body of experts at the federal and/or state level charged with making recommendations on workforce needs and the appropriate alignment of financial resources to meet those needs.
2. Increasing Accountability
  - a. Require all sponsoring institutions and teaching hospitals seeking new Medicare- and/or Medicaid-financed GME positions to meet minimum primary care training thresholds as a condition of their expansion.

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<sup>1</sup> For a more complete description of our GME reform policies and the context supporting them, please see <http://www.stfm.org/Advocacy/KeyIssuesandLegislation/ComprehensiveGMEReform>

- b. Demonstrate a commitment to primary care through the establishment of thresholds and maintenance-of-effort requirements applicable to all sponsoring institutions and teaching hospitals currently receiving Medicare and/or Medicaid GME financing.

Family Medicine recommends that Congress address both sides of the primary care physician shortage. Training institutions need to be accountable for producing the proportion of primary care physicians that the nation needs, and federal GME funding needs to include residency programs that are outside of the large academic hospitals and focus on team-based primary care in underserved areas.

### **Appropriate Investment in Research, Evaluation and Training**

Congress's task will not be done, however, with the right-sizing of the physician workforce. In order to see significant advances in the treatment of patients with multiple chronic conditions, increased resources must be dedicated to the science and methodology of chronic disease care. To provide the evidence needed for the care of patients with multi-morbidity primary care research investment in areas such as Practice-Based Research Networks (PBRNs), practice transformation, patient quality and safety in non-hospital settings, as well as the delivery of mental and behavioral health services in communities by primary care practices. And yet, the majority of research funding supports research of one specific disease, organ system, cellular or chemical process, and is not related to issues surrounding the total needs of a real life patient in primary care. Not only does the majority of health care take place in the primary care setting, this setting is the key interface between the patient and the primary care provider. The importance of what happens in that space is crucial to improving care, improving outcomes, reducing errors, and realizing meaningful patient-centered outcomes research (PCOR.) We see an unmet need for strong funding support for research that is conducted with and by primary care practices and their patients.

We recommend an investment of a portion of every Medicare dollar spent, to be directed to the Department of Health and Human Services' Center for Medicare and Medicaid Innovation, for the purpose of supporting and enhancing research in these areas.

As the Committee suggests in your stakeholder letter, Congress has recognized the importance of shifting payment incentives by emphasizing value over volume of care, most recently with the passage of MACRA. As part of this shift, understanding how to better organize health care to meet patient and population needs, recognizing the impact of social determinants of health, evaluating innovations to provide the best health care to patients, and engaging patients, their families, communities, and practices to improve health has become critically important, and research in these areas must keep pace. Even the current, relatively small portion of federal research dollars devoted to these areas is at risk. A strong, continued, stable research effort is needed. Below are some specific areas of research and effort that should be supported.

### **Practice Transformation**

Very little is known about important topics such as how primary care services are best organized, how new technologies impact care, how to maximize and prioritize care, how to introduce and disseminate new discoveries so they work in real life, and how patients can best decide how and when to seek care. We know from our members and our patients that the need is great to understand what works for patients and practices. Part of this transformation includes the establishment of and reliance on inter-professional teams for training and patient care. More research into best practices related to this integration is needed in both the training and practice arenas. Transforming primary care practices to be effective medical homes for our patients

should be a key priority – and one that can only be accomplished with studies in the primary care environment.

### **Patient Quality and Safety in Non-Hospital Settings**

We are all aware of the research related to the many improvements in patient care in hospital settings, and the continued work in this area. Our patients tell us that one of the key areas that is problematic for them is in the non-hospital setting. For example, the communication between specialist and patient and primary care provider is an area that needs work to understand how to improve. Improved methods for engaging patients in the management of their health conditions is another key area that needs further study.

### **Mental and Behavioral Health Provision in Communities and Primary Care Practices**

Research addressing best practices for integrated mental and behavioral health provision in communities and primary care practices, and ways to increase the uptake of these models in primary care practices is needed. As a 2011 Robert Wood Johnson policy brief states, “Comorbidity between mental and medical conditions is the rule rather than the exception. In the 2003 National Comorbidity Survey Replication (NCS-R), more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder had a comorbid mental health condition. Moreover, models that integrate care to treat people with mental health and medical comorbidities have proven effective, but despite their effectiveness, these models are not in widespread use.”<sup>2</sup> Typically mental health treatment is separate from primary medical care. More research is needed to identify best practices regarding integrated behavioral and mental health care in primary care, as well as identify barriers to adoption of these best practices into primary care practices and communities.

### **Training Future Investigators**

One piece critical to the successful engagement and development of primary care research is the constraint of not having an adequate cadre of well-trained researchers. We believe there is a need to deliberately promote this training. Funding additional researcher training programs for primary care researchers is an important area that needs to be enhanced in order to rapidly increase the development of the research needs we have presented in this letter.

We believe wholeheartedly in the axiom “you can’t engage primary care patients anywhere other than in primary care settings.” In addition, funding of such research needs to encompass the development of a pipeline of primary care researchers to enable a robust level of effort on primary care research needs. We need to support research and develop researchers in ways that are most meaningful and useful for patients, their community physicians, and their communities.

### **Conclusion**

We know that the overall health of a population is directly linked to the strength of its primary health care system. A strong primary care system delivers higher quality of care and better health for less cost. We offer two specific policy recommendations:

- Change the incentives and methodology of Medicare GME to produce more primary care physicians and to distribute them better in rural and underserved areas, and
- Invest strongly in the science needed to improve primary care and health outcomes for patients, to be paid for by a portion of Medicare expenditures.

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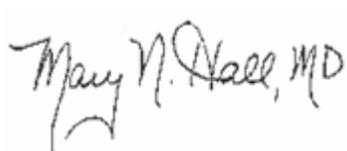
1. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf69438](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf69438)

Both of these areas are needed to create a robust primary care system for our nation -- one that delivers high quality of care and better health while reducing the rising cost of care.

We appreciate the opportunity to provide recommendations to the Committee and its Chronic Care Working Group. As stakeholders we look forward to continuing to engage with the Committee as it moves forward in considering its policy recommendations. We hope our ideas will resonate with you and that this is just the beginning of a continued dialogue.

If you would like more information, or have questions about our recommendations, please contact please contact Hope Wittenberg, CAFM Director, Government Relations, at 202-986-3309, or [hwittenberg@stfm.org](mailto:hwittenberg@stfm.org).

Sincerely,



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