AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

June 22, 2015

U.S. Senate Committee on Finance
Attn. Chairman Orrin Hatch
Ranking Member Ron Wyden
Sen. Johnny Isakson
Sen. Mark Warner
219 Dirksen Senate Office Building
Washington, D.C. 20510

RE: Chronic Care Working Group

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

On behalf of the 120,900 physician and medical-student members of the American Academy of Family Physicians (AAFP), I write in response to your letter dated May 22, 2015, in which you call for policy recommendations from stakeholders to help address the growing problem of chronic disease in the United States. The AAFP applauds your bipartisan leadership in continuing to shine a light on the challenges that patients with multiple chronic conditions experience. Without intervention, managing chronic illness will increasingly dominate the health needs of America. Along with the growth in the overall population, the number of older Americans will continue to increase as people live longer, and they will have more chronic conditions. The U.S. physician workforce must be prepared to manage care for a larger, more diverse, and older population with a growing number of chronic medical conditions.

Family Medicine Is at the Center of Chronic Care.

Aside from patients and their families, there is no group more involved in managing patients with chronic disease than family physicians. One out of every four physician-office visits in America takes place in a family physician's office. Managing patients with chronic illness goes to the very heart of family medicine. It is what we do every day. Family medicine is uniquely situated to help decrease the national burden of chronic illness, while improving quality and controlling the overall total cost of care.

Family physicians are trained to deliver and practice primary care, which the AAFP defines as "health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health settings." Family physicians not only diagnose and treat illness as it arises, but

also focus on the prevention and management of illness—including diabetes, hypertension, chronic kidney disease, and innumerable others. Family physicians do this by establishing continuing healing relationships with patients and overseeing and caring for all of their health needs—typically collaborating with other health professionals, and utilizing consultation or referral as appropriate.

Family medicine as a discipline also is concerned with the overall cost of care. Beginning with residency, training of family physicians must "incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate."[1] The AAFP also engages in ongoing efforts "to provide public education which emphasizes the responsibility of the individual patient for his/her personal health and for rising health care costs."[2] These efforts emphasize the positive effects of exercise, nutrition, highway safety, and the detriments of drug and substance abuse, obesity, and smoking. In short, improving health and simultaneously reducing health costs have always been central to the work of family medicine.

Therefore, the AAFP agrees with the Committee's Working Group that preventing, treating, and managing chronic illnesses are essential in order to meet the Triple Aim of improved population health, improved patient care, and lower costs. To help meet that goal, the AAFP makes the following policy recommendations **in bold** to the Working Group and to the Finance Committee.

1) Improvements to Medicare Advantage

Medicare Advantage (MA) plans offer beneficiaries an alternative to traditional fee-for-service Medicare. The acceptance and popularity of MA among beneficiaries are well documented, and the percentage of newly eligible beneficiaries choosing MA plans over traditional Medicare continues to increase. The AAFP considers MA plans to have several advantages over traditional fee-for-service Medicare:

- MA plans have aggressively pursued networks and delivery models that place a priority on the longitudinal relationship between patients and primary care physicians.[3] Incentivizing the establishment and maintenance of continuous relationships with primary care physicians is an important step toward improving the health quality and outcomes of any patient, but especially those patients with multiple chronic conditions. Fragmentation in care delivery leads to poorer outcomes and higher costs. The AAFP continues to be pleased with the pace at which MA plans are moving to embrace and implement the core principles of the patient centered medical home (PCMH) as the foundation of their primary care networks. We believe this is prudent and consistent with AAFP policy and those policies included in the recently enacted *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*.

- MA plans have implemented alternative payment models for primary care physicians. These alternative payment models range from blended payments to global payments

[1] Accreditation Council for Graduate Medical Education, ACGME Program Requirements for Graduate Medical Education in Family Medicine (2014), at 15.

[2] American Academy of Family Physicians, "Health Care Costs, Methods for Reducing," at http://www.aafp.org/about/policies/all/health-costs.html.

[3] All references to "primary care physicians" in this letter refer to physicians who practice family medicine, general internal medicine, and general pediatrics.

with upside and downside risk. While additional work is needed to ensure that the payment models used by MA plans are equitable for participating primary care physicians, the rapid transition away from fee-for-service is positive. The AAFP does not consider fee-for-service by itself to adequately support the continuous, connected, and comprehensive primary care that Medicare beneficiaries need. There will always be a role for fee-for-service, but its continued use only drives volume and contributes to widespread fragmentation in care delivery.

- MA plans have approached care delivery in a comprehensive manner that is unencumbered by the silos of traditional Medicare. This has allowed for a more complete and thorough analysis of care provided to any Medicare patient across the spectrum of care delivery—physician offices, hospitals, rehabilitation facilities, long-term care settings, etc. As a result, MA plans are better positioned to provide data to primary care physicians that enable greater coordination of care and management of patients with chronic illness.

The AAFP offers four recommendations on how MA plans can better support patients with multiple chronic conditions and their primary care physicians:

- **Congress should encourage MA plans to align care management functions within the primary care practice, rather than as a stand-alone function.** The AAFP appreciates the commitment that MA plans have made to care management, and their willingness to fund the services of care managers for primary care practices. We also believe that these services should operate within the physician practice, so that a personal care team manages the patient's care, rather than an anonymous health-plan employee. With years of practice transformation leadership, it is our experience that the value of care managers is realized when they are aligned with and embedded within the practice. This has been the case in all practice settings and all geographic regions. Care management functions operating outside the primary care practice are far less effective.

- **Congress should require MA plans to make more patient data available to primary-care physicians.** MA plans collect and analyze large volumes of data related to every patient or population of patients. This is important to the coordination of care of patients with multiple chronic conditions. Our concern is the lack of availability of this data at the level of primary care. Primary care physicians are best positioned to coordinate care for Medicare patients, especially those with one or more chronic conditions, but they need more usable data than currently is provided. The types of data needed would include summaries of treating specialists, hospitals visits, lab and imaging services provided, and complete prescription drug adherence information. Providing greater amounts of usable and applicable data to a patient's primary care physician would permit greater coordination of care, limit duplicative services, and facilitate improved health outcomes and lower costs.[4]

[4] This recommendation applies with equal force to the entire Medicare program—both MA and traditional fee-for-service. Medicare should require greater data transparency so a patient's family physician has timely and accurate data on care provided by other physicians, medication lists, pharmacy and rehabilitation services, as well as any potential hospital services provided to the patient. Data democratization is a key to both improving quality and lowering overall costs and we urge Congress to take immediate steps to free patient data.

- **Congress should require MA Plans to implement and reimburse for the new Medicare Chronic Care Management (CCM) code.** The AAFP believes that all MA plans, regardless of current programs they may operate, should be required to pay primary care physicians for the chronic care management (CCM) code (CPT 99490) established by Medicare and codified by Congress in MACRA Section 103 (see additional discussion below under Section 3).

- **Congress should encourage MA plans to place greater emphasis on caregiver education.** A caregiver is a friend or relative who provides unpaid care for someone with a chronic or disabling condition. Older patients with multiple chronic conditions often rely upon such caregivers for assistance, yet there are very few organized activities aimed at informing and educating them. The AAFP views this as a great deficiency in the Medicare program and would encourage MA plans to place an emphasis on these activities.

2. Alternative Payment Models

The AAFP believes that substantial transformations in the management of patients with chronic illnesses will be achieved only if accompanied by the adoption of innovative payment models that support the critical care-management activities that primary care physicians and their teams perform. The AAFP advocates for a blended payment model, under which a primary care practice is paid a "blend" of enhanced fee-for-service, incentives for quality performance, and a per-patient-per-month (PPPM) care management fee to cover care that falls outside of the traditional office visit (of particular importance in caring for patients with chronic illness). **To that end, the AAFP recommends that Congress establish in Medicare a risk-adjusted, per-patient per-month care management fee for primary care practices.** The AAFP believes that care management, including chronic care management, is better handled as a PPPM payment within a blended payment model rather than as a fee for service. Such a PPPM recognizes the important coordination of care offered by primary care.

The AAFP considers the following seven elements to be core activities that a risk-adjusted PPPM care management fee should be designed to pay for: (1) non-physician staff time dedicated to care management, (2) patient education, (3) use of advanced technology to support care management, (4) physician time dedicated to care management, (5) medication management, (6) population risk stratification and management, and (7) integrated, coordinated care across the health system. Most of these are non face-to-face activities for which current fee-for-service payment systems provide little to no support.

The Comprehensive Primary Care (CPC) Initiative, currently led by the CMS Center for Medicare and Medicaid Innovation (CMMI), is the most promising and concrete example of how increasing support for primary care can improve quality and reduce costs. The CPC initiative is a four-year, multi-payer pilot program currently taking place in 7 U.S. regions. Under the program (in place from Jan. 1, 2013 through Dec. 31, 2016), CMS and 37 other payers pay 500 participating primary care practices in seven geographic markets[5] a PPPM fee to support a core set of care-management functions. During the first 2 years of the program, the care

[5] The seven markets are: the state of Oregon; the state of Colorado; the state of Arkansas; the state of New Jersey; Tulsa, Oklahoma; the Hudson Valley of New York, and the Cincinnati-Dayton Region of Ohio and Kentucky.

management fee fell into a four-tier rate structure of $8, $11, $21, or $40 depending on the complexity of the patient, with the average management fee paid under the program of about $20 per patient per month. In years 3 and 4 the care management fees are reduced slightly, to be offset by opportunities to capture shared savings. CMS reports that the average practice utilizes 5 staff members to perform these additional functions.[6]

In January 2015, CMS released the first annual report of the early effects of the CPC initiative, based on data through September 2013.[7] In short, the initial findings demonstrate that supporting primary care practices to perform care management decreases utilization of higher-cost services such as hospitalizations, emergency department visits, and specialist visits. Although the evaluators recommended that the findings be viewed with caution based on the preliminary nature of the data, they also deemed the results "promising and more favorable than might be expected for the first 12 months of the initiative."[8] Moreover, the savings generated by care management activities successfully offset the cost, while also keeping patients out of more costly, higher-intensity settings.

The AAFP views this as a positive initial result. The evaluators stated that they "anticipated it may take 18 months to three years for practices to transform and to see effects on cost, service use, and quality."[9] The AAFP agrees. As participating CPC practices continue to transform the way they manage their patient panels, the AAFP believes that subsequent rounds of data that CMS releases will demonstrate more dramatic positive results. **We call on Congress to urge the Secretary of Health and Human Services to use current authority to expand this program and payment model across all of Medicare.**

It should be noted that the Medicare Payment Advisory Commission (MedPAC), in its March 2015 report to Congress, also recommended that Congress establish a per-beneficiary payment for primary care (although without risk adjustment), in order to pay for care coordination and other "behind-the-scenes activities," which the Commission acknowledged "the fee schedule is not well designed to support."[10] This payment, which would not be risk-adjusted, is designed to replace the Medicare Primary Care Incentive Payment (PCIP), which expires at the end of 2015. MedPAC recommends this transition from a fee-for-service add-on to a PPPM based on the recognition that "the fee schedule is an ill-suited payment mechanism for primary care," and envisions the payment as a temporary measure "until new and better payment and delivery system reforms are established."[11] While MedPAC itself acknowledges that the PPPM that it recommends is not nearly large enough to drive practice transformation (between $2-$3 per

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[6] Center for Medicare and Medicaid Innovation, CPC By the Numbers, *available at* http://innovation.cms.gov/Files/x/cpci-btn.pdf

[7] Mathematica Policy Research, Evaluation of the Comprehensive Primary Care Initiative: First Annual Report, January 2015, *available at* http://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf.

[8] *Id.* at xiv.

[9] *Id.* at xix.

[10] Medicare Payment Advisory Commission, Report to the Congress, March 2015, at 106.

[11] *Id.*

patient per month), the recommendation is significant in that it is a movement from pure fee-for-service nature of the PCIP to a blended model.

3. Traditional Fee-for-Service Medicare

As the Working Group noted in the RFI, traditional fee-for-service Medicare has recently increased its focus on chronic care by implementing new billing codes in the physician fee schedule and by studying alternative payment models.

Specifically, in the fall of 2014, CMS established payment for chronic care management (CCM) through a new billing code, CPT 99490, payable under the Medicare physician fee schedule on a fee-for-service basis beginning on Jan. 1, 2015. The CCM code pays for various services, such as enhanced access to appointments, creation of a patient-centered care plan, and coordination with other providers.[12] The beneficiary must sign an agreement to have the services provided, and the service may be provided by only one practitioner. CMS established payment for the CCM code at $40.39, which may be billed once per patient per month and can be discontinued at any time by election of the beneficiary. Further, Congress has codified chronic care management in MACRA Section 103. The AAFP appreciates Congress's recognition of the indispensible value of non-face-to-face services provided by primary care physicians and their staff in support of beneficiaries with chronic conditions.

While the AAFP would prefer that Congress immediately establish a PPPM through a nationwide expansion of the CPC initiative, **as an intermediate step, Congress could add to Medicare's fee-for-service program another code for chronic care management, so primary care physicians can bill for outliers in terms of beneficiaries who require significantly more than the typical time per month, which cannot be easily accounted for otherwise under the current single code.** As it is, the CCM code describes chronic care management services of at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. Further, CMS has included only 20 minutes of clinical labor time as a direct practice expense input for this code. Without either an add-on code or any risk adjustments, Medicare is underpaying on practice expense for every patient who receives more than 20 minutes of chronic care management, which is the minimum referenced in the code descriptor.

The AAFP urges Congress to reform this incentive for minimal care. One way to do so would be the recognition of an "add-on" code to be used in conjunction with 99490. The Current Procedural Terminology manual already provides a model for such coding with its codes for complex chronic care management, 99487 and 99489. Another alternative is to value code 99490 in terms of typical inputs rather than minimal inputs. For instance, given the open-ended nature of the code (20 minutes or more), the AAFP believes CMS needs to include more than 20 minutes of clinical staff time in the direct practice expense inputs for the code. The current "one-size-fits-all" code that Medicare is using is not practical for the wide variety of Medicare beneficiaries with multiple chronic conditions.

Further, the AAFP recommends that Congress eliminate beneficiary cost-sharing for the CCM service code. Medicare currently covers a range of preventive services without cost

[12] Centers for Medicare and Medicaid Services, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015, 79 Fed. Reg. 67,547, at 67,721 (Nov. 13, 2014) ("CY2015 Final Rule").

sharing, including mammography, pap smear, prostate cancer screening, colorectal cancer screening, as well as the Medicare annual wellness visit. Chronic care management, however, does not fall under the Medicare preventive services umbrella, even though management also serves to prevent chronic conditions from worsening. Under the CCM code the beneficiary is responsible for a monthly co-pay of about $8, regardless of whether the patient sees the doctor in a separate face-to-face encounter. In the experience of AAFP members, for Medicare patients who lack supplemental coverage, this has led to beneficiary confusion and provider difficulty in collecting the beneficiary's share of the payment. Given the immensely high value of this service, the AAFP believes that chronic-care management should be available without beneficiary cost sharing.

4. Prescription Drugs

Proper medication management and adherence is essential both to the management of chronic illness as well as to patient safety. A patient with multiple chronic conditions must have an individual medication plan, and receive education and support from the primary care team, to ensure that the patient is capable of adhering to this personal medication plan.

Patients with multiple chronic illnesses are more likely to need frequent care in higher-cost settings, for example emergency or inpatient care. Such patients are more likely to receive fragmented care from multiple providers, who may not have access to the patient's complete medical record. Such fragmentation can lead to new prescriptions upon release from the inpatient setting that may create potentially harmful interactions with other medications, necessitating subsequent modification of the patient's care plan.

The AAFP recognizes that use of generic drugs can be an appropriate way to reduce costs in prescription benefit programs such as Part D—but only on a case-by-case basis and when directed by the patient's care team rather than a third party. Patients who are stable on drugs should not have to change to a new product based solely on economic considerations. Medicare Part D Plans and pharmacies that automatically fill prescriptions with generic substitutes in the name of cost containment can create medically negative unintended consequences, and compromise patient safety. In addition, medically negative reactions to automatically substituted generic pharmaceuticals almost invariably lead to additional preventable utilization of the health-care system. **Accordingly, the AAFP recommends that Congress incentivize insurers and pharmacies to work with prescribing physicians before engaging in generic substitution.**

5. Telehealth and Remote Patient Monitoring

The AAFP views both telehealth and remote patient monitoring as promising developments in primary care delivery. Telehealth describes a broad range of activities that primary care physicians and care teams can use to improve the delivery of care to patients with chronic illness, including remote office visits via teleconference. Remote patient monitoring allows pimary-care physicians or care teams to help monitor certain markers associated with chronic conditions such as diabetes (glucose), hypertension (blood pressure), and obesity or congestive heart failure (weight), without having to schedule an office visit. These activities are particularly impactful for patients in rural and frontier areas, patients who are homebound, or otherwise isolated. The AAFP believes that the explosion of personal technology now available to most Americans, combined with the need to tackle more chronic illness with fewer primary care physicians, creates unprecedented opportunities to expand access to care.

The Working Group should note that, of the obstacles that are preventing a freer flow of telehealth and related services, the obstacle of payment could be resolved through the AAFP's recommendation to establish an appropriately valued risk-adjusted PPPM care management fee, which would cover the additional costs of technology and staff. However, within the framework of the current Medicare fee-for-service system, the AAFP has four specific recommendations on how Congress can improve the use of telemedicine in Medicare and other federal health programs.

- **The facility fee for an originating site should cover a physician practice's associated costs.** A family physician's office can qualify as an originating site under current law. And family medicine practices are ideally suited to act as originating sites in their role as primary care providers—helping to facilitate the delivery of services from other providers (e.g. a social worker, nutritionist, or other physician) who are off-site. However, a family medicine practice that invests in the physical space and reliable HIPAA-compliant equipment for patients to receive services from providers offsite should also receive payment to cover the associated fixed and variable costs. In CY2015 this facility fee is $24.83.[13] While other originating sites (particularly hospitals and other institutional providers) may benefit from revenue bases and economies of scale that permit this investment, the AAFP does not believe that this fee is reasonably calculated to cover such costs in the case of the physician office. Accordingly, the AAFP urges Congress to direct that this payment be sufficient to ensure that it appropriately incentivizes primary care practices to participate as originating sites.

- **"Telehealth Services" should be defined broadly.** Current law generally limits "telehealth services" to professional consultations, office visits, and office psychiatry services, furnished via a telecommunications system. CMS defines such telecommunications systems as "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician."[14] CMS further explicitly states: "Telephones, facsimile machines, and electronic email systems do not meet the definition of an interactive telecommunications system."[15]

  The AAFP views telemedicine and telehealth services much more broadly. The AAFP considers telemedicine to encompass a range of processes and services intended to enrich the delivery of medical care and improve the health status of patients—not only virtual office visits, but also transmission of diagnostic images or video that a specialist reviews later (store-and-forward technologies that provide for the asynchronous transmission of health-care information), as well as remote patient monitoring. The AAFP believes that telemedicine also includes "lower-tech" methods of delivering health care such as an email or phone call. Relying on their training and experience, as well as their knowledge of their patients' needs, family physicians are ideally situated to employ a range of technological modalities to enrich the delivery of primary care, on a case-by-case basis. In recognition of this, the AAFP encourages Congress to define telemedicine and telehealth more broadly.

[13] *See* CY2015 Final Rule at 67,602.

[14] 42 C.F.R. § 410.78(a)(3).

[15] *Id.*

- **"Originating Site" should be defined broadly.** Current law requires that an eligible telehealth individual (i.e. the patient) be a Medicare beneficiary who receives a telehealth service furnished at an originating site. There are two requirements for originating site: first, the site must be one of eight enumerated providers.[16] And second, the site must be located in a rural health professional shortage area, or in a county that is not included in a Metropolitan Statistical Area. The AAFP would advocate for the removal of these restrictions on originating site.

  First, many AAFP members deliver care to their patients in the home via telephone, email, videoconferencing, and other means, based on a sense of professional obligation and a desire to provide excellent care. But Medicare and most payers do not reimburse physicians for these services since the patient's home does not qualify as an originating site. Thus, the AAFP urges Congress to incentivize physicians to deliver the right care, in the right place, at the right time—which in many cases includes consulting with patients who may not be able to leave the house.

  Second, in the intervening 15 years since Congress drafted and enacted the telehealth law currently in force, the use of communications technology in the workplace has grown exponentially. Not just clinical professionals but all types of American professionals now constantly rely on email, teleconferencing, videoconferencing, and other tools to conduct business and serve clients—whether they are based in a rural or urban setting. Many industries use email as a communication tool and meeting substitute even within their own office building. Acknowledging the continuing need for telemedicine for patients who live in rural and remote areas, the AAFP urges Congress to remove this now antiquated requirement that only rural-based patients can qualify for telemedicine services. In short, removing the site and place restrictions will greatly enhance the free flow of health services based on patient need.

- **Licensure should remain a matter principally of state regulation.** Finally, the AAFP acknowledges and appreciates Congressional leadership in proposing to remove obstacles to delivering telemedicine across state lines imposed by state medical licensure. The AAFP, however, opposes the concept of licensure on the federal level. To facilitate delivery of care across state lines, the AAFP encourages states to engage in reciprocity compacts for physician licensing, especially to permit the use of telemedicine.[17] The states, along with the Federation of State Medical Boards, are currently pursuing an Interstate Medical Licensure Compact, under which physicians would be eligible for expedited licensure in all participating states. To date, 9 states have enacted legislation to implement the Compact, and more are expected to follow suit. Given the progress on these efforts, the AAFP urges Congress not to regulate medical licensure.

[16] Defined under Section 1834(m)(4)(C)(ii) of the Social Security Act as: (1) the office of a physician or practitioner, (2) a critical access hospital, (3) a rural health clinic, (4) a federally qualified health center, (5) a hospital, (6) a hospital-based or critical access hospital-based renal dialysis center, (7) a skilled nursing facility, or (8) a community mental health center.

[17] In the limited case of existing patients (where the doctor-patient relationship has been established through a face-to-face visit), the AAFP does believe that policies should be established that allow a physician to provide care, via telehealth, in states where they may not have a license.

6. Serving the Needs of Chronic Patients in Rural and Frontier Areas

The National Rural Health Association notes that approximately 60 million Americans (20 percent of the US population) reside in rural areas. However, these rural populations have a higher incidence of health-related challenges, including heart disease, respiratory disease, disability associated with chronic conditions, and obesity. Disproportionately, unfavorable health outcomes have been linked to rural populations, such as higher asthma mortality rates and a more advanced stage at diagnosis of some cancers. The proportion of older Americans in rural areas is higher than that of the general population. As a consequence, rural physicians (usually family physicians) must treat patients with higher burdens of multiple and chronic diseases.

At the same time, America's rural and frontier areas are experiencing an alarming decline in the number of primary care physicians. Numerous observers have noted that the U.S. system of training physicians plays a significant role in the erosion of primary care, particularly in rural and frontier areas.[18] Despite mounting evidence and innumerable reports from independent expert panels documenting impending primary-care shortages and specialty maldistribution in the U.S. physician workforce, [19] the 50-year-old Medicare GME payment system continues to contribute to—rather than help solve—the nation's health-workforce problem. Accordingly, in addition to the recommendations on telehealth and remote patient monitoring, the AAFP makes the following recommendations to improve care for chronic patients in rural areas, through reforms to the graduate medical education (GME) system:

- **Congress should aggressively grow and make permanent community-based primary-care GME programs.** First, community-based GME programs more reliably produce primary care physicians in rural areas than legacy hospital-based GME programs. The most surefire way to produce primary care physicians in rural areas is not to give dollars to academic medical centers and merely hope that they train such physicians. The better approach is to give resources to programs which are designed to produce primary care physicians in rural areas. To that end, Congress has enacted (and in MACRA extended funding for) the Teaching Health Center (THC) GME Program. Under this successful primary care GME program, the Health Resources and Services Administration (HRSA) makes payments for direct and indirect GME expenses to community-based, ambulatory patient care centers that sponsor primary care residency programs.

  According to data provided to the AAFP from HRSA, as of July 1, 2014 (the start of the academic year currently coming to a close), the 556 residents currently supported by THC funds are all receiving training in accredited community-based programs in needed

[18] See, e.g., Institute of Medicine of the National Academies, Committee on the Governance and Financing of Graduate Medical Education, *Graduate Medical Education that Meets the Nation's Needs*, at 7-8 (July 2014) ("Although the GME system has been producing more physicians, it has not produced an increasing proportion of physicians who choose to practice primary care, to provide care to underserved populations, or to locate in rural or other underserved areas.").

[19] See, e.g., id.; also Council on Graduate Medical Education, *Advancing Primary Care*, at 3 (Dec. 2010) ("The current U.S. primary care physician workforce is in jeopardy of accelerated decline because of decreased production and accelerated attrition.").

primary care specialties: family medicine, general internal medicine, geriatrics, general pediatrics, as well as psychiatry, obstetrics/gynecology, and dentistry. Of these 556 residents, 374 (67.3 percent) are in family medicine. By comparison, one recent study in *Academic Medicine* found that even under a liberal set of assumptions, the production rate for primary care at teaching hospitals during the period 2006-2008 was only 25.2 percent.[20]

Second, community-based GME programs are more likely to produce primary care physicians who will practice in rural and underserved areas. During residency training, physicians develop ties to patients and to the community that make them more likely to remain there after training when they enter practice. The American Medical Association Physician Masterfile data confirms that a majority of family medicine residency graduates practice within 100 miles of their residency training location.[21] Almost half practice within 50 miles, and 19 percent practice within 5 miles. By comparison, a tiny fraction (fewer than 5 percent) of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.[22] Thus, the most effective way to get family physicians and other primary care physicians into rural and underserved areas is not to recruit them from academic medical centers but instead to train them in these underserved areas.

Third, community-based GME programs are more likely to produce physicians who understand how to manage chronic disease, as well as treat acute episodic illnesses. Hospitals are no longer the center of the nation's health-care delivery system as they were in 1965 when Medicare GME was created; thus, hospitals should no longer be the sole focal point for training physicians. According to *the New England Journal of Medicine*, for every 100 Americans who receive care in a physician's office, fewer than 4 are hospitalized—and far fewer still are hospitalized in an academic medical center. [23] In short, current GME policy is not keeping pace with changes in health-care delivery. A 2009 letter to Congress from the Council on Graduate Medical Education states: "There is currently an imbalance in the sites of training that does not allow adequate preparation of a physician workforce for either the place where most healthcare takes place (outpatient settings), or for the medically vulnerable populations who need care the most (those in rural and underserved areas)."[24] The 2014 IOM Report on GME confirms this, stating that "nearly all GME training occurs in hospitals—even for primary-care

[20] Candice Chen, M.D., MPH, et al., Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions, Academic Medicine, Vol. 88, No. 9, p. 1269 (Sept. 2013).

[21] E. Blake Fagan, M.D., et al., Family Medicine Graduate Proximity to Their Site of Training, Family Medicine, Vol. 47, No. 2, at 126 (Feb. 2015).

[22] Chen et al., at 1269.

[23] Larry A. Green, M.D. et al., The Ecology of Medical Care Revisited, N. Engl. J. Med., Vol. 344, No. 26 (June 28, 2001).

[24] Letter from Council on Graduate Medical Education (COGME) to the Committees of Jurisdiction, et al. (May 5, 2009), *available at* http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Publications/letter050509.pdf.

residencies—in spite of the fact that most physicians will ultimately spend much of their careers in ambulatory, community-based settings."[25]

Therefore the AAFP believes that investing much more heavily in community-based primary care GME is consistent with the national interest, while maintaining or expanding the status quo will continue to exacerbate the problem. **The AAFP recommends that Congress not only continue to add positions to the THC GME program, but also shift the financing of THC into Medicare.** In order for community-based GME to flourish, community-based programs must have the same stable source of funding that the traditional hospital-based GME programs rely upon.

- **Congress should add accountability measures to the GME program.** The AAFP recommends that Congress establish accountability measures that require sponsoring institutions that continue to receive Medicare subsidies to meet goals that are consistent with the nation's workforce needs, including those in rural areas. The taxpayer is paying for the nation's medical training; therefore, the taxpayer ought to receive a return on that investment, in the form of a properly balanced physician workforce that extends into rural and underserved areas. Currently, "teaching hospitals have . . . favored higher revenue-generating specialty training over primary care positions."[26] This results in a reduction in primary-care production, since "instead of responding to policy aims to correct shortage in the primary-care pipeline, *hospitals are instead training to meet hospital goals*."[27] Accordingly, Congress should establish accountability measures in hospital-based GME, just as it has in other Medicare payment systems, requiring sponsoring institutions to meet minimum thresholds in primary-care production.

  To that end, the AAFP recommends that all sponsoring institutions currently receiving Medicare GME funding should be required to allocate, at a minimum, 33 percent of their currently approved and funded full-time equivalent positions (as of their most recent closed cost report) to the training of primary-care physicians (family medicine, general internal medicine, and general pediatrics). If the current allocation of approved and funded FTEs exceeds 33 percent, the sponsoring institution must maintain that effort for 10 years to be eligible for new GME positions. Calculation of the primary care maintenance of effort should be based on the specialty status of the physician five years after the date of graduation from medical school.

  In addition, the AAFP recommends that any expansion of GME slots should allocate at least 50 percent of all new positions to primary care, and 50 percent of those positions being dedicated to family medicine, and they must be preserved as family medicine residency positions for 10 years at minimum.

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[25] Institute of Medicine of the National Academies, Committee on the Governance and Financing of Graduate Medical Education, *Graduate Medical Education that Meets the Nation's Needs*, p. 8 (July 2014).

[26] Nicholas A. Weida, et al., *Does Graduate Medical Education Also Follow Green?*, Archives of Internal Medicine, Vol. 170, No. 4, p. 389 (Feb. 22, 2010).

[27] *Id.* (emphasis added).

- **Congress should limit payment of all GME dollars to training for first-certificate residency programs.** Congress also should consider limiting all Medicare GME dollars to first-certificate training programs—the area of greatest public need. Of the 150 unique disciplines in medicine, all physicians initially train in one of 25 primary specialties—the so-called "first certificate programs" or "initial residency period"—before embarking on subspecialty training (known as a "fellowship"). The Medicare GME program currently finances training in both first-certificate programs and fellowships.[28] Because a typical fellow often will generate more than enough revenue to pay for the costs associated with the position, federal subsidies for fellowships are a poor use of scarce Medicare dollars.

  Since 1997, teaching hospitals have established thousands of new fellowship positions that do not receive Medicare support (positions funded above the cap imposed by *the Balanced Budget Act*). This is because physicians who have completed an initial residency are attending physicians—eligible for board certification, and accordingly may practice medicine without supervision, bill for their services, and generate substantial clinical revenue for a teaching hospital. This strongly supports the inference that the revenue generated by physicians in most fellowship training positions more than covers the corresponding costs. In short, fellowships are a profit center for teaching hospitals and do not need public subsidies. Meanwhile, repurposing Medicare GME support from fellowships to first-certificate residency positions would finance, in a budget neutral manner, over 7,500 new initial residency positions—greatly expanding residency training without relying on new federal funds.

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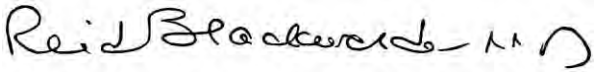
The AAFP thanks the Working Group and the Senate Finance Committee for its bipartisan leadership in exploring ways to improve the health of patients living with multiple chronic conditions. If you have any questions about this letter, or if we can be of further assistance, please do not hesitate to contact Andrew Adair, AAFP Government Relations Representative (aadair@aafp.org).

Sincerely,



Reid B. Blackwelder, MD, FAAFP
Board Chair

[28] Fellowships are funded at 50 percent for direct graduate medical education (DGME) and 100 percent for indirect medical education (IME).