AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Talking Points on Pilot to Test Modernization of Primary Care GME

Primary Care Needs to Train in the Community

- Over 90 percent of primary care services are delivered in outpatient ambulatory care settings. Yet the training for primary care physicians is still quite hospital dominated and the funding is hospital-dependent.

- For hospitals, residents provide valuable clinical services that result in significant savings. This labor cost incentive provided by the staffing benefits [of having residents in the hospital] has been a longstanding constraint on hospitals' willingness to reduce residents' time in the inpatient setting, cited by many experts including the Commonwealth Fund, the IOM, COGME and the Blue Ridge Academic Health Group (*Ludmerer and Johns, 2005*).

- The education of primary care physicians must be modernized -- so that much more of the training is in non-hospital settings. Funding this endeavor must be de-linked from inpatient hospital services, as they bear no relation to the costs and needs of training in the community setting.

- Modernization of this training would lead to production of the type of primary care physician needed now and for the future. Emphasis will be placed on care coordination, implementation of the patient-centered medical home, and caring for the population of the community as opposed to responding to an episode of acute care.

- Congress has stressed on more than one occasion the importance of accomplishing more training in non-hospital settings.

Why a Pilot?

- This pilot is necessary to test ways to modernize primary care training. The pilot would test various modes of providing funding to entities whose mission is solely the education and training of primary care physicians

- The pilot will determine the degree to which four organizational models are successful in increasing the quantity and type of primary care physicians necessary to meet current and future population needs.

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- Under the funding method to be tested, the funding, decision-making, control, and flexibility will be placed with the organization whose sole mission is training primary care physicians.

- The educational entity will be accountable for the funding dollars, and directly responsible to the accrediting body for producing the type and quality of primary care physicians.

- This pilot, if successful, could demonstrate the best methodology to solve myriad of regulatory problems associated with the training of primary care physicians, including didactic versus patient care training; volunteer preceptor; and others that keep cropping up, when one tries to fit 21st century training into a mid 20th century model.

- A five year pilot will allow CMS and others to judge the effectiveness of these models in their responsiveness to community needs and the accrediting bodies.

What is the impact on hospitals?

- The necessary inpatient training will be accomplished by the educational entity purchasing such training from participating hospitals. For those hospitals that have actually used their GME dollars for primary care training, they will actually gain income from the medical education entity.

- The proposal is budget neutral as residency training is already paid for under the Medicare program. The pilot would shift less than $50 million per year to the pilot project.

- Current regulatory issues, including new rules regarding the accreditation of new programs, which has caused the closure of at least one family medicine residency program (in Maine), would be resolved as moot.

Why Medicare SHOULD Pay for This Mode of Training

- MedPAC in its most recent public meeting (Oct. 09) discussed the current problem of what our training system is producing. They will be entertaining issues such as alternatives to the IRB formula (linking the dollars to Medicare volume), and movement away from inpatient training (how to count ambulatory training). In the words of the Commission Chair, Glenn Hackbarth, “the training system is not producing what society needs. It doesn’t seem to be self-correcting; it cries out for intervention.”

- Strengthening the primary care workforce will promote ambulatory and preventive approaches to health services with the associated decreases in hospitalizations and Emergency Room use. This will contribute to better health for Medicare beneficiaries and cost savings for the Medicare Trust Fund.

- An argument that is made that Medicare should not pay for GME separate from the hospital because of smaller Medicare patient loads is specious. The litmus test should not be how many Medicare patients they see in the hospital while training, but rather

what patients will they be able to serve when they are out in practice. Clearly physicians in both family medicine and internal medicine will be seeing a great deal of Medicare patients in their practices.

- Congress made the decision years ago that Medicare should fund the training of physicians for the public good. Congress also recognized in the Balanced Budget Act of 1997 (BBA) that training in non-hospital settings was of key importance, especially for rural and underserved areas, and incentives should be put in place to fund that training. Primary care physicians are a critical piece of the physician workforce – key to caring for Medicare beneficiaries. Primary care training should not be given short-shrift in training funds just because the old formula hasn't kept up with the times and changes in modes of training and patient care.

- GME funding model unchanged since initiation to serve Medicare Patients 1965. While hospital-based GME funding model hasn't changed, practice of medicine has transitioned to more emphasis on outpatient ambulatory care.

Conclusion

- Over 90 percent of services of primary care physicians are provided is in an outpatient clinic or other non-hospital community-based entity. Yet dollars to fund primary care training continue to flow through hospitals.

- Hospitals are conflicted by desire to keep residents (and dollars) in hospitals versus deploying into community-based offices for optimal training.

- Educational entities are being established with the purpose of innovating to meet community needs for increased quality and quantity of primary care physicians. At least four unique models have been identified across the country.

- But the GME funding flow being tied to hospitals has prevented these models from being adequately tested. Testing these models is the only reasonable way to collect data that can inform future GME policy decisions.

- A pilot is needed to test these innovative, market-based models that are trying to respond to community need.