AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

For the Record

to the

Senate HELP Committee
Subcommittee on Primary Care and Aging

Regarding

Primary Care Access

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The American Academy of Family Physicians (AAFP), which represents 105,300 family physicians and medical students, is pleased to submit the following statement for the record of the Health, Education, Labor and Pensions Committee's subcommittee hearing entitled, "30 Million New Patients and 11 Months to Go: Who Will Provide Their Primary Care"

According to the Institute of Medicine, primary care is defined as:

> *The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.*

Unfortunately, our current health care system is not consistent with this definition. Instead, the system is fragmented, uncoordinated, wasteful and expensive.

Every day, family physicians and other primary care doctors see the results of our poorly functioning system of care. Duplicative and unnecessary tests are ordered. Diseases remain undiagnosed and untreated until they result in acute conditions. Patients with multiple chronic illnesses are shunted from one specialist to another, each one of whom treats only one of the diseases. And far too little attention is paid to prevention and wellness services.

That is why the AAFP consistently has supported efforts to increase the role of primary care physicians in the delivery of health care. Primary care provides high-quality, coordinated, cost-effective care to patients employing a whole-person approach.

As such, efficient and effective health systems result when primary care physicians are the usual source of care for people. Family physicians and other primary care physicians can help patients prevent disease by improving their healthy behavior. They can aid them in managing their chronic diseases, especially when the patient has more than one chronic illness, and refer to a subspecialist, when necessary. And family physicians and other primary care physicians can help patients navigate the complex world of hospitals and other health institutions.

Health delivery reform requires considering how our dysfunctional health care system can become one that serves the patient by coordinating care over time to prevent disease, managing chronic conditions and providing immediate and targeted care for an acute condition when it arises.

Consequently, the availability of an adequate primary care physician workforce is essential to achieving these aims. Unfortunately, this workforce is stagnant, if not dwindling, which raises significant concerns about the viability of the nation's health care system.

The Commission on Graduate Medical Education (COGME) in its twentieth report (December 2010) offered specific recommendations and goals for building an adequate primary care physician workforce.

COGME cited 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 are 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.

As a result of a number of factors including compensation, practice environments, and experience in medical school, there is a shortage in the number of primary care physicians, particularly those with the ability to care for adults and their associated chronic disease burden. This shortage is especially critical now in the context of health care reform objectives that will increase the need for primary care physicians. As a result of passage of the *Patient Protection and Affordable Care Act* (ACA), as many as 32 million previously uninsured Americans will be eligible for coverage. Such an influx of previously uninsured and likely underserved individuals will undoubtedly increase the demand for primary care services nationwide.

At the present time, 32 percent of physicians in the U.S. are primary care providers, of which 12.7 percent are family physicians, 10.9 percent general internists, 6.8 percent general pediatricians, and 1.6 percent in general practice. The current U.S. primary care physician workforce is in jeopardy of accelerated decline because of decreased production and accelerated attrition. Decreased production from graduate medical education is a reflection of the choices made by young physicians and by teaching hospitals that are associated with a growing income disparity between primary care physicians and other specialties. Over the last several years, a variety of policies have been adopted to reduce this disparity and the new *Affordable Care Act* takes steps to reduce it even further. Decreased medical student interest in primary care is caused by multiple factors including heavy workload, insufficient reimbursement, the subtle persuasion in medical school away from primary care, and a lack of strong primary care role models.

Attrition also will be augmented as the primary care physician workforce continues to age. At the present, there are 242,500 primary care physicians in the U.S. and almost one quarter (55,000) are age 56 or older. The likelihood is that many of these physicians will retire within the next decade.

The AAFP believes policies and programs should be implemented to support the practice of primary care, and to increase the supply of primary care physicians. Fee-for-service payment for physician services is biased in favor of hospital-based and procedural services and does not provide appropriate incentives for the practice of primary care, or to increase the supply of primary care physicians. Policy changes should be dramatic to remedy these legacy biases and have immediate effect.

Specifically, policies should be implemented that raise the percentage of primary care physicians (i.e., family physicians, general internists, and general pediatricians) among all physicians to <u>at least</u> 40 percent from the current level of 32 percent, a percentage that is actively declining at the present time. The achievement of this goal should be measured by assessing physician specialty once in practice, rather than at the start of postgraduate medical training.

In order to achieve the desired ratio of practicing primary care physicians, the average income of these physicians must achieve at least 70 percent of the median income of all other physicians. Currently this average is in the 50 percent range. If primary care physicians are paid differently and better, in the context of the physician-led Patient Centered Medical Home, costs should decline. Investment in primary care office practice infrastructure will also be needed to cope with the increasing burdens of chronic care and to provide comprehensive, coordinated care. Payment policies should be modified to support both of these goals.

Accordingly, Congress, CMS, and private insurers should embrace reimbursement mechanisms that enhance primary care physician income including:

1. Preferential increases in fee-for-service payments for primary care services.
2. Support for coordination in primary care practices through per member per month care management fees.
3. Financial rewards for improvements in performance measures.
4. Reward the Patient-Centered Medical Home (PCMH) financially when its physicians meet the four essential functions (first contact access, patient-focused care over time, comprehensive care, and coordinated care) and the three corollary functions (family orientation, community orientation, and cultural competency) and when measures of process and quality are met and improved. The physician-led PCMH should be supported as the construct for the practice environment that achieves optimal care coordination and integration, for use of health information technology, for enhanced access, and for appropriate payment. Study levels of funding necessary to sustain the physician-led PCMH model and its impact on costs in settings other than physicians' offices.
5. Implement payment models that bundle payments for full-service accountable care organizations and incentivize the development of community health care organizations that provide the four essential functions of primary care through collaboration of primary care physicians, public health, care coordination organizations, and mental health organizations.

Medical schools and academic health centers should develop an accountable mission statement and measures of social responsibility to improve the health of all Americans. This includes strategically focusing and changing the processes of medical student and resident selection and altering the design of educational environments to foster a physician workforce of at least 40 percent primary care physicians and a health system that meets societal needs.

In order to accomplish the transformation of the educational environment, medical schools and academic health centers should:

1. Increase and sustain the involvement of primary care physicians through all levels of medical training;
2. Support student primary care interest groups;
3. Recruit, develop, and support community physician faculty members; and
4. Require student participation in rural, underserved, and global health experiences.
5. Expand medical school class size strategically to address the primary care physician deficit and maldistribution issues.
6. Reform admission processes to increase the number of qualified students more likely to choose a primary care specialty and to serve medically vulnerable populations.
7. Recruit and retain underrepresented minority students and faculty members.
8. Require block and longitudinal experiences of sufficient length that medical students clearly understand the essential functions of primary care and the medical home.
9. Collaborate with local communities and distribute resident training accordingly, support reductions in physician income disparities, and lead in the development of new models of practice like the physician-led PCMH.

The federal and state government contributions to this effort would include:

1. Providing increased incentives for physicians who practice primary care or other critical specialties in designated health workforce shortage areas.
2. Substantially enhancing funding for scholarships, loans, loan repayment, and tuition waiver programs to lower financial obligations for students who plan and pursue careers in primary care.

Graduate Medical Education (GME) payment and accreditation policies and a significantly expanded Title VII program should also support the goal of producing a physician workforce that is at least 40 percent primary care.

To accomplish this objective, Congress, the Administration, Department of Health and Human Services, and accrediting agencies should:

1. Change regulations to support more training in outpatient settings and experimentation with practice models to prepare residents appropriately for an evolving contemporary health care environment;
2. Strategically increase the number of new primary care GME positions and programs to accommodate the increased production of medical school graduates and respond to the need for a workforce composed of at least 40 percent primary care physicians;
3. Increase training in ambulatory, community, and medically underserved sites by promoting collaboration between academic programs and Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), and the National Health Service Corps (NHSC);
4. Implement new methods of funding to include GME funding that is not calculated according to Medicare beneficiary bed-days, and substantial expansion of Title VII funding specifically for community-based training.;
5. Provide financial incentives for GME that directs funding to primary care residency programs, educational consortia, or non-hospital community agencies to provide the proper incentives for ambulatory and community-based training;
6. Explore augmenting payments for primary care residents, including differentially higher salaries and early loan repayments, to decrease the negative impact of educational debt on primary care specialty choice;
7. Fund all primary care residency programs at least at the 95th percentile level of funding for all programs (using total direct medical education (DME) and indirect medical education (IME) payments as a basis); and
8. Reward teaching hospitals, training programs, and community agencies financially on the basis of the number of primary care physicians produced, to be determined by specialty *in practice* and not at the initiation of training.

Lastly, to enable policy development predicated on data and to address geographic and socioeconomic maldistribution of physician supply, Congress and the Administration should:

1. Ensure funding for the Healthcare Workforce Commission included in ACA;
2. Ensure funding of the National Health Service Corps at the $1.15 billion amount authorized by the ACA so that the NHSC can recruit more primary care physicians, provide greater support of scholarship recipients, create special learning opportunities and networks for scholarship recipients and early loan repayers, and forge formal affiliations with academic institutions and training programs;
3. Increase substantially the funding for Title VII, section 747, in Primary Care Medicine and Dentistry cluster grants;
4. Implement programs to increase funding by the Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), and private research enterprises for projects that stimulate primary care and community-based research and emphasize methodologies such as population-based ecological and cluster studies, qualitative behavioral studies, and comparative effectiveness research;
5. Increase funding for Community Health Centers (CHCs) that are committed to training students and residents; and increase funding for Area Health Education Centers (AHEC) programs to improve existing programs, support new programs, and support innovative

funding proposals that promote the practice of primary care in medically underserved areas.

The AAFP appreciates the opportunity to provide family medicine's views on the importance of an adequate primary care physician workforce in the development of an efficient and effective US health delivery system. In particular, we agree with the evidence that suggests that health system reform can be successful only if it is built on a base of primary care physicians. To this end, we recommend;

1. Elimination of the flawed sustainable growth formula in the Medicare physician fee schedule and support alternative delivery systems including the physician-led patient-centered medical home;
2. Full funding for the National Physician Workforce commission, Title VII and the National Health Service Commission;
3. Increased availability of scholarships and loan repayment for medical students choosing to practice as primary care physicians; and
4. Support for innovation in graduate medical education funding, including allowing GME dollars to "follow the resident" and reimbursement for residency sponsoring entities other than hospitals.

Thank you for the opportunity to provide recommendations on this critical topic