Advocating for Family Medicine

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January 15, 2015

The Honorable Joseph Pitts
Chairman, Subcommittee on Health
Energy & Commerce Committee
Washington, DC 20515

The Honorable Frank Pallone, Jr
Ranking Member, Subcommittee on Health
Energy & Commerce Committee
Washington, DC 20515

The Honorable Cathy McMorris Rodgers
Energy & Commerce Committee
Washington, DC 20515

The Honorable Gene Green
Energy & Commerce Committee
Washington, DC 20515

The Honorable Morgan Griffith
Energy & Commerce Committee
Washington, DC 20515

The Honorable Diana DeGette
Energy & Commerce Committee
Washington, DC 20515

The Honorable Kathy Castor
Energy & Commerce Committee
Washington, DC 20515

The Honorable Peter Welch
Energy & Commerce Committee
Washington, DC 20515

Dear Chairman Pitts, Ranking Member Pallone and Reps. McMorris Rodgers, Green, Griffith, DeGette, Castor, and Welch:

The American Academy of Family Physicians (AAFP) and the undersigned organizations represented by the Council of Academic Family Medicine (CAFM) are pleased to provide the enclosed comments and supporting materials in response to your December 6, 2014 "Open Letter Requesting Information on Graduate Medical Education." We applaud your willingness to evaluate policies associated with the structure and financing of our nation's graduate medical education system.

We look forward to working with the Committee on this issue. Please do not hesitate to contact us if you require additional information on our response and policy recommendations.

Sincerely,

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1. What changes to the current graduate medical education (GME) financing system might be leveraged to improve its efficiency, effectiveness, and stability?

We continue to believe that federal investments in physician education and training are prudent and should be aligned with our national interests. Furthermore, we share in concerns that the United States will have an insufficient supply of physicians in the near future, especially in primary care specialties such as family medicine, general internal medicine, and general pediatrics. However, our opinions differ from many in terms of how to achieve these worthwhile objectives. It is our assertion that our current system—both in construct and financing—is contributing to the problem, not solving it. Stated more explicitly, we believe that simply expanding our current system will only exacerbate our current problems, not ameliorate them.

The methodology that determines how our nation pays for graduate medical education was created nearly 50 years ago and, with only minor exceptions, has not undergone any reforms or structural changes since that time. As a result, our current system is closely aligned with an education and financing model that is reflective of the century in which it was created and does not take into account modern-day practices.

Our current system has produced physicians and physician scientists who have transformed medical care, but it has failed to produce an appropriate physician workforce to provide care to the citizens of our country. This system lacks accountability and transparency. It rewards a select few states, while other states and regions struggle to produce a physician workforce for their residents.

The most important GME reforms the Committee should pursue are those that would decouple GME financing from the hospital payment system. This financing structure discourages training in the most acutely needed specialties and incentivizes training in those specialties that produce the highest revenue. In short, the current GME financing system has less to do with producing an adequate physician workforce and more to do with the financial benefits accruing to individual institutions.

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.

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.
    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.

2. There have been numerous proposals put forward to reform the funding of the graduate medical education (GME) system in the United States. Are there any proposals or provisions of proposals you support and why?

In September 2014, the American Academy of Family Physicians (AAFP), released the proposal, "Aligning Resources, Increasing Accountability, and Delivering a Primary Care Physician Workforce for America." This proposal was created in consultation with and supported by the Council of Academic Family Medicine (CAFM) organizations, and it represents the unified position of Family Medicine on GME financing and structure. The policy outlines five proposed reforms of our nation's GME system and its financing.

In addition, we are strongly supportive of several key provisions of the 2014 Institute of Medicine (IOM) report, "Graduate Medical Education That Meets the Nation's Health Needs." This report, which is similar to the AAFP's proposal, calls for greater transparency and accountability within the GME system, and it encourages changes to the payment methodology in order to move toward a system that relies less on the legacy hospital-based model used today.

There are several reports issued by the Council on Graduate Medical Education (COGME), the Medicare Payment Advisory Commission (MedPAC), and others that align with our reform recommendations. The following are our reform recommendations, including justification for why these reforms are needed and information about how they align with the recommendations of multiple advisory bodies.

Recommendation #1: Expand the number of residency positions for first-certificate residency positions, particularly in needed priority specialties, by limiting direct graduate medical education (DGME) and indirect medical education (IME) payments to the training for first-certificate residency programs, utilizing the savings for expansion.

Enacting this proposal would provide the necessary funding for the basic training of all physicians. It would continue to meet the needs of the public that Congress has supported through GME, namely the production of physicians to care for the nation's elderly and the U.S. population as a whole. This recommendation aligns with Goal 1 of the IOM report, which is to "encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost." ("Graduate Medical Education That Meets the Nation's Health Needs," July 2014) It also correlates with Recommendation 1 and Recommendation 4 of the IOM report. Recommendation 1 states that Medicare GME support should be maintained at the current aggregate amount while steps are taken to modernize GME payment methodologies. It also states that the current Medicare GME payment system should be phased out. Recommendation 4 states that the Medicare GME payment policy should be modernized.

Increasing the overall quantity of physicians will not resolve our current and future workforce needs. It is well documented that the number of physicians trained is not wholly dependent on Medicare financing. Since the establishment of the cap on funded positions in 1997, resident positions in programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) increased by 17.5 percent (academic year 2003-04 to academic year 2012-13), with the bulk of these positions in subspecialty disciplines that require fellowship training. Currently, a disproportionate percentage of physicians are being trained as subspecialists despite a greater public demand and need for primary care and other first-certificate disciplines. The sustainability of fellowship training programs usually does not require federal funding. These resources should be redirected to areas of greater need.

According to the 20th report of COGME, "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, 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." ("Advancing Primary Care," December 2010) For these reasons, we strongly support a greater investment in the training of primary care physicians (family medicine, general internal medicine, and general pediatrics) and believe such an investment is aligned with our nation's need for a workforce that will improve population health outcomes.

Recommendation #2: Align financial resources with population health care needs through a 0.25 percent reduction in the IME adjustment factor—from the current 5.5 percent to 5.25 percent—and allocate these resources to support innovation in graduate medical education.

Traditional Medicare GME funds hospitals to produce the physician workforce needed to care for the Medicare population and the U.S population as a whole. This hospital-centric method of training has not produced the quantity or quality of primary care physicians the nation needs. The percentage of training positions devoted to primary care is currently at historic lows and dropping. “Despite a cap on Medicare-funded positions, 9,100 accredited GME positions were created between 1998 and 2008. Growth was predominantly in subspecialty training and non-primary care core specialties.” (“Loss of Primary Care Residency Positions Amidst Growth in Other Specialties,” *Am Fam Physician*, July 2010) Amidst this growth, there was a net loss of more than 1,200 first-year family medicine resident and general internal medicine positions, as well as a loss of 65 such programs. Meanwhile, 133 internal medicine subspecialty programs opened.

This proposal aligns with Goal 2 of the 2014 IOM report: “Encourage innovation in the structures, locations, and designs of GME programs to better achieve Goal 1 (“Encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost.”). The IOM recommends using a portion of current Medicare GME funds (approximately 10 percent, increasing to 30 percent) to fund the following: new infrastructure; innovative demonstration projects; development of performance measures; new training slots (where needed); and program evaluation. It also recommends maintaining current Medicare GME funding (i.e., DGME and IME) but transitioning to a different payment system.

In two 2011 reports (“Ensuring an Effective Physician Workforce for America”, April 2011, Revised November 2011 ; “Ensuring an Effective Physician Workforce for the United States,” September 2011), the Josiah Macy Jr. Foundation called for a reexamination of the way that GME is currently governed, financed, and regulated. MedPAC (“Report to the Congress: Aligning Incentives in Medicare,” June 2010) 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.” 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.

Medicare’s rigid payment formulas for GME do not allow for the innovation needed to improve medical education in order to produce physicians with the appropriate training needed to meet the nation’s current and future health care needs. Medicare currently does not finance training in many ambulatory sites that are valuable and more closely aligned with modern medical practice. We need to change the traditional financing to new, innovative methodologies that would incentivize new training models, while keeping the stability of Medicare funding. Preparation for a rapidly changing educational and practice environment, and expansion of the training content and sites are needed.

This proposal encourages increased training in ambulatory, community, and medically underserved sites by implementing new funding methodologies to redirect existing GME funding directly to primary care and other shortage residency programs, educational consortia, or non-hospital community agencies, and to create the proper financial incentives for ambulatory and community-based training.

Recommendation #3: Create and fund a national body charged with evaluating the current health care workforce and making recommendations on future composition.

Currently, there is not a group organized by the government that is responsible and/or accountable for evaluating the health care workforce and producing recommendations on its composition. Specifically, there is not a "roadmap" for how the federal government should target its investment in GME. In addition, the system would benefit from a greater level of transparency regarding the number and type of physicians being trained, as well as the content and sites of such training. We should move from guaranteed financing of GME programs to a system of accountability and planned production goals.

This proposal aligns with several IOM goals, including Goal 4, "Clarify and strengthen public policy planning and oversight of GME with respect to the use of public funds and the achievement of goals for the investment of those funds," and Goal 5, "Ensure rational, efficient, and effective use of public funds for GME in order to maximize the value of this public investment." ("Graduate Medical Education That Meets the Nation's Health Needs," July 2014)

A diverse group of health professions organizations—including family medicine, pharmacy, nursing, the Association of American Medical Colleges (AAMC,) the American Medical Student Association (AMSA), several osteopathic organizations, and many others—has indicated their support for a national body charged with such activities.

Recommendation #4: 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.

Recommendation #5: 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.

The purpose of our fourth and fifth recommendations is to improve the balance between specialty and primary care training so that federal funds are directed to institutions that will increase primary care training positions by regulating the distribution of new residency positions between primary care and non-primary care positions, and will maintain current primary care positions nationally.

The AAFP and CAFM recommend that in order to be eligible for any new GME positions in the future, all sponsoring institutions and teaching hospitals currently receiving Medicare

and/or Medicaid funding for graduate medical education be required to allocate, at minimum, 33 percent of their currently approved and funded full-time equivalent positions (FTEs) (as of their most recent closed cost report) to the training of primary care (i.e., family medicine, general internal medicine, and general pediatrics) physicians. If their current allocation of approved and funded FTEs exceeds 33 percent, the sponsoring institution and/or teaching hospital must maintain that effort for 10 years in order 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.

If any workforce proposal is to restrain the growth in health care spending successfully, it must support programs that build the primary care workforce. To build an adequate national primary care workforce, it is important for all institutions to be committed and accountable in its production. We believe institutions should demonstrate a commitment to the training of an adequate primary care workforce before being allowed to increase non-primary care training positions. To be clear, while we know that production of family medicine and other primary care physicians is not the only national physician workforce need, it is the most acute. The need to rightsize the primary care workforce is driven by two factors: (1) addressing questions of access, and (2) improving the nations' bottom line. An appropriately sized primary care workforce will reduce the growth in health care expenditures and increase quality outcomes.

3. Should federal funding for graduate medical education (GME) programs ensure training opportunities are available in both rural and urban areas? If so, what sorts of reforms are needed?

Yes. We believe that GME programs should ensure training opportunities in both rural and urban areas. This belief is consistent with the background and recommendations of the July 2014 Institute of Medicine (IOM) report, "Graduate Medical Education That Meets the Nation's Health Needs."

The IOM report clearly states the problem, which is that approximately 19 percent of the U.S. population lives in rural areas, but only 11 percent of physicians practice in these areas and only 2.9 percent of medical students envision practicing in rural or small-town environments.

The report goes on to note that there are a number of factors that have some bearing on the problem.

- Simply producing more physicians, as many have suggested, has little impact on the problem. The evidence suggests that while the "capacity of the GME system has grown in recent years, it is not producing 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."

- The locations of a physician's medical school and GME training are predictive of practice location. In addition, the longer the duration of training in a particular geographic area, the more likely a physician is to practice in that area.
- Under the current system, the geographic distribution of Medicare-funded GME training slots is essentially frozen based on the location of residencies in 1996.

Family Medicine recommends the following solutions:

- Reauthorize the Health Resources and Services Administration (HRSA)-administered teaching health center (THC) grant awards. 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. 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.
- We agree with the following IOM statement: "The Medicare GME program clearly needs an organizational infrastructure for strategic policy development and implementation, and program oversight." ("Graduate Medical Education That Meets the Nation's Needs," July 2014) The governing body should have appropriate content expertise, including expertise in underserved populations (both rural and urban), performance measurement, and quality improvement.
- The American Academy of Family Physicians (AAFP) and the Council of Academic Family Medicine (CAFM) believe in the need for accountability for the public's investment in GME. To that end, ready-to-use performance metrics (e.g., an increase in GME graduates choosing to practice in rural clinical settings and underserved urban areas) could be used for GME payment purposes.

4. Is the current financing structure for graduate medical education (GME) appropriate to meet current and future health care workforce needs?

No. The current financing structure is too closely aligned with hospital-based care and services. The ecology of medical care was first demonstrated by Kerr White, MD, and colleagues in the 1960s ("The Ecology of Medical Care," *N Engl J* Med, November 1961) and was updated using contemporary data in 2001 by The Robert Graham Center for Policy Studies in Family Medicine and Primary Care ("The Ecology of Medical Care Revisited," *N Engl J* Med, June 2001). The Graham Center estimated that on average each month, out of 1,000 people in the United States, 327 people consider seeking health care services. Of the 327 people who consider seeking care, 217 go to a physician (113 of these go to a primary care physician), 21 go to a hospital clinic, 14 receive home health care, 13 go to the emergency department, 8 are admitted to a hospital, and fewer than 1 go to an academic health center.

If this is the case, why do we centralize training in the care site least sought by patients? More importantly, why do we provide financial incentives to those sites least used by our population? Despite these facts, GME dollars continue to flow through hospitals. As a result, the need to provide an optimal training environment conflicts with a hospital's desire to maximize revenue. We believe that it is time to decentralize or "dehospitalize" our GME system. Our training system should be more closely aligned with our delivery system, which is no longer hospital centric. Michael Whitcomb, the former senior vice president for medical education at the Association of American Medical Colleges (AAMC), echoed this sentiment in a 2006 article when he stated that, "clerkships based on the inpatient services of major teaching hospitals no longer provide the optimal range of experiences for students to learn clinical medicine." ("Ambulatory-based Clinical Education: Flexner Revisited," *Acad Med*, February 2006)

The Institute of Medicine (IOM) report also commented on the relationship between GME financing and hospitals' priorities regarding physician training: "By giving the funds directly to teaching hospitals, the payment system discourages physician training in the clinical settings outside the hospital where most people seek care. Primary care residency programs are at a distinct disadvantage because of their emphasis on training in ambulatory care settings. Hospitals' control over the allocation of GME funds may also encourage the overproduction of specialists in disciplines that generate financial benefits for an individual institution rather than for the health care system overall." ("Graduate Medical Education That Meets the Nation's Health Needs," July 2014) The IOM is not alone in their concerns. A May 2009 Council on Graduate Medical Education (COGME) letter noted that "financial concerns have affected the majority of teaching hospitals' decisions about selection of training positions." This point was also raised in a 2010 *Archives of Internal Medicine* article, which stated that "teaching hospitals have also favored higher revenue-generating specialty training over primary care positions." ("Does Graduate Medical Education Also Follow Green?," *Arch Intern Med*, February 2010)

i. Should it account for direct and indirect costs as separate payments?

a. If not, how should it be restructured? Should a per-resident amount be used that follows the resident and not the institution?

b. If so, are there improvements to the current formulas or structure that would increase the availability of additional training slots and be responsive to current and future workforce needs?

The creation of two distinct payments for GME was steeped in the best practices of the time. We want to appreciate the fact that inpatient care has associated costs that are not present in the ambulatory setting. At the same time, we want to be very clear that, in our opinion, the use of an "add-on" payment to a hospital-based payment system creates perverse incentives that have contributed to the current workforce challenges in the United States. The IOM suggests a single payment per resident, adjusted for geographic variations in costs. This is an appealing proposal, and we are inclined to agree that this may be the best path forward. However, we continue to believe that this may be an "and" situation versus an "or" situation.

The American Academy of Family Physicians (AAFP) and the Council of Academic Family Medicine (CAFM) recommend three major reforms of the financing structure.

1. In order to be eligible for any new GME positions in the future, all sponsoring institutions and teaching hospitals currently receiving Medicare and/or Medicaid funding for graduate medical education should be required to allocate, at minimum, 33 percent of their currently approved and funded full-time equivalent positions (FTEs) (as of their most recent closed cost report) to the training of primary care (i.e., family medicine, general internal medicine, and general pediatrics) physicians. If their current allocation of approved and funded FTEs exceeds 33 percent, the sponsoring institution and/or teaching hospital must maintain that effort for 10 years in order 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.

2. Federal support should be limited to first-certificate training programs. Currently, there are more than 114,000 resident physicians training in more than 150 specialties and subspecialties. Even though there are more than 150 unique disciplines in medicine, all physicians initially train in one of 25 primary specialties—often referred to as "first-certificate programs" or the "initial residency period." These programs are foundational to other subspecialties, meaning that a physician seeking a subspecialty must first complete training in one of the first-certificate programs.

The federal government, through the Medicare program, finances training in first-certificate residency programs and fellowships. Under current law, fellowship positions are funded at 50 percent for direct graduate medical education (DGME) and 100 percent for indirect medical education (IME). While there is value in training physicians in subspecialties, the concept of the government financing such training is what we believe is unnecessary. Because physicians who have completed an initial residency are eligible for board certification, they are, in practicality, allowed to practice medicine and bill for their services, which raises the question of why they require financial assistance with the cost of their training.

Trends in graduate medical education support the self-sustainability of fellowship programs. Specifically, we know that since 1997, thousands of new fellowship positions have been created that do not receive financial support from Medicare, clearly demonstrating that the revenue generated is sufficient to support these positions, thus eliminating the need for federal support.

To this end, the AAFP and CAFM recommend that Medicare DGME and IME funding be limited to FTE positions in first-certificate residency programs. We further recommend that all funding currently dedicated to fellowship training positions be repurposed for first-certificate residency positions and distributed on an annual basis, consistent with our "Increasing Accountability" policy recommendations. Implementation of this recommendation would, by our calculations, result in more than 7,500 new first-certificate training positions.

3. Current and future funding is tied to accountability and transparency requirements for all programs. Expansion of GME is a priority for most, if not all, sponsoring institutions and teaching hospitals. The need for such expansion is being accelerated by the growth and aging of the U.S. population. The most immediate need is in primary care, but there are other specialties that face shortages as well. To best meet the needs of our current and future population, the AAFP and CAFM recommend that a policy be implemented that requires all sponsoring institutions and teaching hospitals seeking <u>new</u> Medicare- and/or Medicaid-financed GME positions to meet minimum primary care training thresholds as a condition of their expansion. We also recommend that current "over cap" positions not be eligible for new GME funding, because financial support for those positions has already been demonstrated.

   The AAFP and CAFM believe that any expansion of GME slots should be allocated on a 50/50 basis with at least 50 percent of all new positions going to primary care (i.e., family medicine, general internal medicine, and general pediatrics) and 50 percent going to other primary residency (i.e., first-certificate) programs. Of the 50 percent of new positions dedicated to primary care, at least 50 percent must be dedicated to family medicine, and they must be preserved as family medicine residency positions for 10 years at minimum.

ii. Does the financing structure impact the availability of specialty and primary care designations currently? Should it moving forward?

Yes, there is a direct influence. Because there is no deliberate strategy to address specific workforce shortage specialties, sponsoring hospitals frequently choose to preferentially sponsor residencies in specialties and subspecialties that result in more revenue. Again, there is a lack of accountability and transparency related to the choice of specialty training that institutions sponsor. The current financing system does not hold sponsoring hospitals accountable for training a workforce with a strategically desirable specialty mix.

Yes, there should be strategic and deliberate direction of scarce federal funding to where it is most needed, with an emphasis on primary care specialties. By restructuring GME funding to go directly to the sponsoring organization on a per-resident basis, the temptation for hospitals to use GME funding as financial support for other, noneducational purposes will be avoided. Establishing a federal body to make recommendations regarding workforce composition should help determine the direction moving forward. Federal funds should be appropriately directed toward institutions in ways that will both increase primary care training positions and maintain current primary care training positions.

5. Does the current system incentivize high-quality training programs? If not, what reforms should Congress consider to improve program training, accountability, and quality?

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 hospital centric. 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 21st 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 Institute of Medicine (IOM) has recommended that Congress needs to reconfigure the GME funding stream to support a better mix of primary care physicians with hospital-based specialists. The IOM’s recommendation to create a single Medicare GME fund with two subsidiary funds makes a great deal of sense to Family Medicine. This division of the single

spending stream allows for federal investigation into residency program transformation. In our view, this is a positive step toward determining effective performance measures and how to better fund high-performance programs.

Congress also should direct a portion of the GME funds to be paid to community-based residency programs. Teaching health centers (THCs) are one model of such residency programs. This redirection of payment will help increase accountability in the GME program, since the responsibility of community-based residency programs is clearly to produce more primary care physicians.

Another way to accomplish this rebalancing between subspecialties and primary care is to eliminate federal funding for fellowships in subspecialties. Currently, medical students are accepted into a residency program that provides exposure to many types of medical experiences in one of 25 specialty areas and issues a "first certificate" of training. Upon completion of this first-certificate training program, the resident is eligible for board certification and is allowed to practice medicine. However, many residents continue their training in specific subspecialties for which the residency awards a fellowship. Offering these follow-on fellowship programs is very attractive for hospitals, because they often generate revenue in addition to GME funding. We recommend that federal GME funding of specialty and subspecialty fellowships be eliminated and the savings be applied to additional first-certificate training programs. It is estimated that this step would eliminate funding for 9,000 fellowship positions (most, if not all, of which would still generate revenue for the sponsoring hospitals). The savings produced would support approximately 7,500 new positions in the initial residency period.

Family Medicine also agrees with the IOM's recommendation to combine the indirect medical education (IME) and direct graduate medical education (DGME) funding and to base payments to organizations sponsoring GME programs (whether or not they are hospital based) on a "national per-resident amount (PRA) (with a geographic adjustment)." ("Graduate Medical Education That Meets the Nation's Health Needs," July 2014)

6. Is the current system of residency slots appropriately meeting the nation's health care needs? If not, please describe any problems and potential solutions necessary to address these problems.

The current system does not meet our nation's health care needs. While our current system excels at preparing highly trained subspecialists and physician researchers, 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.

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.

7. Is there a role for states to play in defining our nation's health care workforce?

Yes, most definitely. It is critical for states to strategically define and financially support development of a health care workforce to meet local needs. The appropriate mix of primary care specialties and other specialties should be influenced by local study and design. We support the goals of the Institute of Medicine (IOM) report, including Goal 5, which states that Medicaid GME funding should remain at each state's discretion but should adopt the same accountability and transparency standards as Medicare. ("Graduate Medical Education That Meets the Nation's Health Needs," July 2014)