AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

January 19, 2015

The Honorable Kevin Brady
Chairman, Subcommittee on Health
House Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Brady:

On behalf of the American Academy of Family Physicians (AAFP), which represents 115,900 family physicians and medical students across the country, thank you for the opportunity to submit our comments on the *Hospital Improvements for Payment (HIP) Act of 2014* Discussion Draft. The AAFP's comments are set forth below.

1. **Medicare IME Dollars Should Be Preserved for Graduate Medical Education.**

Medicare pays hospitals for patient discharges under the inpatient prospective payment system (IPPS) for inpatient hospital stays, and the outpatient prospective payment system (OPPS) for outpatient stays. The Discussion Draft would establish under Section 1886(t) of the Social Security Act a new unit of payment known as hospital prospective payment system (HPPS) for certain short stays, beginning in FY 2020. Starting on October 1, 2019, hospitals would bill Medicare under the HPPS for "short term hospital stays," defined as those hospital stays that "(1) have an actual length of stay less than 3 days; (2) are classified to a MS-DRG that has a national average length of stay that is less than 3 days; and (3) is classified to a MS-DRG that is among the most highly ranked discharges that have been denied for reasons of medical necessity by RACs."[1]

Currently, Medicare pays hospitals for indirect medical education (IME) expenses only if those hospitals have residents in an approved graduate medical education (GME) program. Under the Discussion Draft, to compute the HPPS base payment rate—which Medicare would pay to all hospitals, including those that are not teaching hospitals—the

[1] Ways and Means Section-by-Section Summary, at 2.

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Secretary is directed to take into account current aggregate IME spending. Based on discussions with Subcommittee staff, the AAFP understands that beginning in FY 2020, this computation will cause current IME spending to be spread across all Medicare-participating hospitals, including those without residents, thus diverting IME dollars away from the purpose of supporting medical education.

Given the challenges that the United States faces with primary-care physician shortages, as well as the maldistribution of physicians both geographically and across specialties, the AAFP believes that any IME dollars that the Subcommittee would direct outside of teaching hospitals ought to be used instead for other GME programs—in particular primary-care GME in community settings.

2. Any Redistribution of IME Dollars Should Fund Community-Based Primary-Care GME Programs.

Despite mounting evidence and innumerable reports from independent expert panels documenting impending primary-care shortages and specialty maldistribution in the U.S. physician workforce,[2] the 50-year-old Medicare GME payment system continues to contribute to—rather than help solve—the nation's health-workforce problem. In short, the United States desperately needs more primary-care physicians (those who practice family medicine, general internal medicine, and general pediatrics), and in particular, primary-care physicians in rural and other underserved areas.[3] Accordingly, the AAFP urges the Subcommittee not to redirect excess IME dollars to non-teaching hospitals, but to direct them toward community-based GME programs, which hold the greatest promise for solving the physician workforce problem.

First, community-based GME programs more reliably produce primary-care physicians than legacy hospital-based GME programs. The most surefire way to produce primary-care physicians is not to give dollars to academic medical centers and merely hope that they train physicians in primary care; the better approach is to give resources to programs which are designed to produce primary-care physicians. To that end, Congress has enacted the Teaching Health Center (THC) GME Program.[4] Under

[2] 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."); 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.").

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

[4] See Public Health Service Act, § 340H.

this successful primary-care development program, the Health Resources and Services Administration (HRSA) makes payments for direct and indirect GME expenses to community-based, ambulatory patient care centers that operate primary-care residency programs.[5] Absent Congressional intervention, however, that program will expire on September 30, 2015.

According to data provided to the AAFP from HRSA, as of July 1, 2014 (the start of this academic year), the 556 residents currently supported by THC funds are all receiving training in accredited community-based programs in understaffed primary-care specialties: family medicine, internal medicine, geriatrics, pediatrics, as well as psychiatry, obstetrics / gynecology, and dentistry. Of these 556 residents, 374 (67.3 percent) are in family-medicine programs. 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.[6] Since the THC program will expire on September 30, 2015, and federal funding for teaching health centers will cease, the AAFP urges the Subcommittee to devote all excess IME resources to the THC program as soon as possible. By way of example, the AAFP estimates that a 0.25-percent reduction of the IME adjustment rate (from 5.5 percent to 5.25 percent) would free up $300 million in annual medical-education spending, which under the current THC cost structure would fund the training of roughly 2,000 FTEs per year.

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. American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.[7] 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.[8] Thus, the most effective way to get family and other primary-care physicians into rural and underserved areas is not to recruit them from academic medical centers but instead to <u>train them in these underserved areas</u>.

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[5] By way of example, The Lone Star Community Health Center in Conroe, Texas, receives funding under the THC program, and is training 9 residents in family medicine in the 2014-2015 Academic Year.

[6] 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).

[7] 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).

[8] Chen et al., at 1269.

Finally, community-based GME programs are more likely to produce physicians who understand how to manage patient panels, rather than 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.[9] In short, 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)."[10] Aside from the enactment of the soon-to-expire THC program, little has changed in the GME landscape since this letter was authored. The 2014 IOM Report on GME confirms this, stating that "nearly all GME training occurs in hospitals—even for primary-care residencies—in spite of the fact that most physicians will ultimately spend much of their careers in ambulatory, community-based settings."[11]

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.

3. Congress Should Add Accountability Measures to the GME Program.

As you consider additional reforms to the traditional hospital-based 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 needs. 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. Currently, "teaching hospitals have . . . favored higher revenue-generating specialty training over primary care positions."[12]

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

[10] 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.

[11] 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).

[12] 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).

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*."[13] 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 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.

4. Limit payment of all GME dollars to training for first-certificate residency programs

Congress also should limit 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.[14] Because a typical fellow 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

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

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

and need public subsidies no more than a Fortune 500 corporation would. Meanwhile, repurposing Medicare GME support from fellowships to first-certificate residency positions would finance over 7,500 new initial residency positions—greatly expanding residency training without relying on new federal funds.

Thank you for your leadership and for your consideration of the AAFP's comments. If the AAFP can be of further assistance, please do not hesitate to have your staff contact Andrew Adair (aadair@aafp.org), Government Relations Representative.

Sincerely,

Reid B. Blackwelder, MD, FAAFP
Board Chair