AMERICAN ACADEMY OF
FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

December 23, 2008

The Honorable Barack Obama
Office of the President-Elect
451 6th Street, NW
Washington, DC

Dear Mr. President-Elect:

On behalf of the 93,300 members of the American Academy of Family Physicians, I appreciate your sustained commitment to advancing the ability of everyone in this country to access a health care system that is affordable and of the highest quality. Your nomination of Senator Tom Daschle as Secretary of Health and Human Services and Director of the White House office of health reform and your appointment of Dr. Jeanne Lambrew as Deputy Director of that office testify to your assembling an administration that embodies that commitment. We applaud your choice of such outstanding leaders in health care and we look forward to working with them to accomplish our mutual goal of improved health care for everyone in the nation.

Access to Health Care

Your long-standing interest in improving everyone's access to appropriate health care is commendable. Whether it is accomplished through the tax system or through direct support, the ability of everyone in the nation to find the health care they need regardless of their income in the setting that is most helpful and efficient will pay enormous dividends in better health and lower costs overall. However, without an adequate supply of primary care physician practices, beneficiaries will not be able to find the health care they need. When Massachusetts required everyone in the state to designate a practice as their usual source of care, state officials quickly learned that they did not have enough primary care physicians to meet the increased need.

Family physicians stand ready to support your Administration's efforts to make sure everyone in the nation can afford health care, and we ask that your Administration support the effort to assure an adequate number of primary care physicians to provide this care. Congress's Medicare Payment Advisory Commission (MedPAC)

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has proposed one way to do this. MedPAC's recommendation is that Medicare pay a 10-percent bonus for all primary care services offered to beneficiaries by qualified primary care practices. We propose to go a step further and recommend that the economic stimulus legislation include a 25-percent payment premium to primary care physicians who provide certain primary care services.

There is substantial evidence, consistent over 20 years, that the 200-percent payment disparity between primary care and subspecialty medicine is a predominant reason that fewer medical students are going into primary care. Since primary care is only 7 percent of the total Medicare budget, a 25-percent increase would raise total Medicare spending by only 1.75 percent. The Commonwealth Fund and World Health Organization both suggest in reports this year that the return on investment would be much higher. We suggest similar increases under Medicaid, particularly at a time when many primary care physicians lose money on care provided to Medicaid beneficiaries, and when states are poised to make cuts to the program.

We recommend this bonus as a down payment on the upcoming health reforms that should encourage physicians to remain in primary care practice and help residents and students appreciate primary care as a productive and desirable specialty. As the uninsured and underinsured populations begin to receive the advantage of federal support programs that make health care affordable, they will try to find physician practices that will offer them primary care services. Unless there is a clear, strong signal to current primary care physicians and residents, we are likely to see many more patients frustrated by their inability to find a physician practice that can offer them primary care. As a result, they will resort to using emergency rooms for routine care – an expensive outcome that will continue to crowd the ERs and produce uncoordinated care that could have been unnecessary if appropriate preventive and acute health care was available.

Patient Centered Medical Home

Family physicians are increasingly committed to transforming their practices to allow them to offer patients a team-based comprehensive medical home that coordinates their care among different providers in different settings. The patient-centered medical home model, which is a combination of the primary care model and the chronic disease management model of health care, is not business as usual. We believe that a patient-centered medical home is a more effective and efficient mode of health care delivery. It will mean that physician practices will have to change to become more accessible, more attentive to patients' needs, more flexible in providing care and more effective in tracking the quality of patients' outcomes.

The measure of the needed transformation can be taken by a practice's application to the National Committee on Quality Assurance (NCQA) through the Physician Practice Connections-Patient Centered Medical Home (PCC-PCMH) recognition program. A practice seeking this NCQA recognition needs to

complete an extensive and time consuming survey and provide documentation to validate responses. There are three levels (basic, intermediate and advanced) of medical home, depending on the practice's ability to meet nine standards and 166 measures. Completing this tool represents a significant investment of time (estimated at 60-80 hours) and resources. Such an investment is particularly difficult for those small practices that serve patients in rural and other underserved areas.

However, these rural and medically underserved areas need the preventive health care services and the management of chronic diseases that characterize the Patient Centered Medical home. Consequently, AAFP would recommend that the economic stimulus bill contain a funding program for small primary care practices serving patients in rural and underserved areas that apply for NCQA recognition as a patient-centered medical home.

Economic Value of Primary Care Physicians

As your team considers what to include in the pending economic stimulus legislation, we would note that, according to a study by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care, an individual family physician has a local annual economic impact of $700,000 to $1.5 million per year, depending on location [see: "Economic Impact of Family Physicians in Your State," October 2006]. However, the benefit for a community for having a family physician practice is lost when the local physician cannot afford to continue on the small margins with which the practice usually operates. Maintaining an effective family physician workforce helps the local economy as well as local health care. In many small and rural communities, health care and related services are now the most viable economic engine, and a community that loses its family physician loses both access and an important economic stimulus. Communities where bonus payments make it possible for a family physician to open an office gain twice.

Many of the reasons for the reduction in the primary care workforce are systemic and long-term. They will need to be addressed when your Administration and Congress turn to health system reforms. But in the meantime, as you and your advisors look to the importance of stimulating the American economy and making health care more affordable, you should consider the immediate signals that can be sent to family physicians and their local economies by including a bonus payment for primary care practices. Additionally, to help accelerate the transformation to the patient centered medical home, we urge assistance to encourage small practices in rural and underserved areas to undertake the NCQA evaluation process.

Thank you, again, for your commitment to America's family physicians and their patients. We are available at the convenience of your staff to further discuss inclusion of support for primary care practices in the economic stimulus proposal.

Your staff can contact us through Kevin burke, AAFP Director of Government Relations, at 202-232-9033 or by e-mail at kburke@aafp.org.

Sincerely,

James D. King, MD, FAAFP
Board Chair