AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

August 10, 2011

The Honorable Patty Murray
United States Senate
Washington, DC

Dear Senator Murray:

Congratulations on your appointment to serve on the historic Joint Select Committee on Deficit Reduction. The Committee's wide-ranging responsibility is a challenging one and on behalf of the 100,300 members of the American Academy of Family Physicians (AAFP), thank you for accepting this critically important assignment.

The scope of your work is as broad as the federal government – everything from transportation to housing; from agriculture to energy; and from education to banking and finance. Our most immediate concern, of course, is the health of our nation's population. And while health care comprises 15-20 percent of the nation's economy, we recognize that you will have many more issues to consider than physician payment and training. And we know that the time you will have to review all the potential areas of reduction is very limited. However, health care is a major component of the increased costs found in the federal budget and so we hope you will find our suggestions for restraining health care costs helpful in your deliberations.

We ask that you support a proven health delivery model that would both save money and maintain quality by first, stabilizing Medicare payments to physicians by repealing the flawed formula based on the Sustainable Growth Rate (SGR) and specify a payment rate for the next 3 to 5 years, in order to allow time for the various demonstration programs and alternative health care delivery models to generate sufficient data to determine which payment methods make the best fiscal and quality sense. For this payment rate, AAFP strongly recommends that it stipulate at least a 3-percent higher rate for primary care physicians delivering primary care services.

Secondly, we advise against reductions in Graduate Medical Education (GME), since no matter how health care delivery is transformed, we will need additional primary care physicians. However, if reductions are necessary, we believe you should not include any cutbacks in GME payments for primary care education and training.

The evidence for the value of primary care in restraining health care costs and improving quality is very clear. For example, findings from the Dartmouth Health Atlas Data demonstrate good geographic correlations with having more primary care, particularly family medicine, and having lower Medicare

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costs and reduced "ambulatory care sensitive" hospitalizations—i.e., hospitalizations that should not happen if patients have good access to primary care. There is also growing evidence that experiments with the Patient-Centered Medical Home (PCMH) and Accountable Care Organizations (ACO)—particularly those that emphasize improved access to more robust primary care teams—can reduce total costs by 7-10 percent, largely by reducing avoidable hospitalizations and emergency room visits.

Primary care is just 6-7 percent of total Medicare spending, so primary care based payment experiments are recouping the entire costs of care in those settings, not just the added investments. These findings hold true in integrated systems like Geisinger, insurance experiments like Blue Cross Blue Shield of South Carolina, Community Care of North Carolina for Medicaid, or individual system efforts like Johns Hopkins. The key factor across all of these is increased investments in the primary care setting. Based on the early results of these experiments, we believe that increasing primary care payments so that they represent 10-12 percent of total health care spending to improve access to a broader array of services will more than offset the cost of the investment.

An evaluation of a primary care-based ACO by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care (a division of the AAFP) is showing that over the longer term, these investments could offset inpatient costs by 50 percent or more.

The evidence shows that to achieve the savings that Congress is looking for, and to improve the quality of health care delivered to millions of patients in the country, payment must include investment in primary care. The U.S. has built a health care system that focuses on acute care at the expense of preventive care, coordination of care and chronic disease management. This imbalance means that we rely on the fee-for-service which rewards volume and disregards care management and cognitive medical skills provided by primary care physicians.

As Congress attempts to re-balance our fiscal situation, re-balancing our health care delivery system is a necessary component.

If we can provide further assistance to you or your staff as you undertake this important assignment, please contact us through the director of government relations, Kevin Burke, at 202-232-9033 or by e-mail at kburke@aafp.org.

Sincerely,

Lori Heim

Lori Heim, MD, FAAFP
Board Chair