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MODERNIZING PRIMARY CARE GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Congress should support legislation to implement a budget-neutral pilot project to test locally based, innovative models for the distribution of Medicare Graduate Medical Education Funding (GME) for the training of primary care physicians. Representatives should cosponsor HR 3667, the *Primary Care Workforce Access Improvement Act* of 2011. Senators should consider sponsoring such legislation.

Description of the Pilot

This pilot project would test the effectiveness of local innovations in the way GME payments are made with the goal of facilitating the development of a robust primary care workforce. Currently, about 30 percent of the physician workforce is in primary care. Over time, the U.S. should have a physician workforce that is at least 40 percent primary care and uniquely trained to meet the needs of current and future patients.¹

Such a pilot is consistent with the recommendations of the Medicare Payment Advisory Commission (MedPAC) which states: "Reforming medical education will be a key component to transforming the nation's health care delivery system from one that historically has focused on care for acute illness to one that values patient-centered care, quality improvement, and resource conservation."² To accomplish this, the pilot would:

- Support primary care training in all sites where care is delivered
- Structure GME payments for primary care residencies to directly fund entities where education is the primary mission
- Increase payments for primary care training to support added costs of training in community-based (non-hospital) settings, as well as to offer incentives to medical students who choose primary care
- Provide incentives for training in rural and underserved areas

At least four models of governance, currently operating within family medicine, have been identified. Others may also exist. The pilot should test at least two situations of each of the models identified. These are:

1. A community-based independent corporate entity collaborating with two or more hospitals in operating one or more primary care graduate medical education programs (e.g., Siouxland Medical Education Foundation/Sioux City, IA, Family Medicine Residency of Idaho/Boise, ID, Montana Family Medicine Residency/Billings, MT).
2. A medical education entity established by two or more hospitals to develop and operate one or more primary care graduate medical education programs. The hospitals may be the sole corporate members, but the governing board has community representatives (e.g., Cedar Rapids, IA).
3. A hospital subsidiary or independent corporation operating one or more primary care graduate medical education programs for the hospital with community participation in the governance of the organization (e.g., Augusta, ME).
4. A medical education entity that is independent of any hospital, but collaborates with a hospital in operating one or more graduate medical education programs. The medical education entity may

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include a university or school of medicine (e.g., Madisonville, KY, Salina, KS, Lawrence, Massachusetts, Wayne State University, Rochester, MI, and Southern Illinois University, Quincy, IL).

Meeting the Primary Care Need

The current lack of a sufficiently strong primary care physician workforce has hurt our country and our patients. It results in increased costs and poorer health outcomes. As America attempts to increase the number of insured and the quality of care they receive, GME must ensure a workforce able to meet these societal needs. Both the number and proportion of primary care physicians needs to be substantially increased.¹ Funding of training has a profound impact on the development of a primary care workforce. Currently, Medicare GME does not foster the production of high quality and high numbers of primary care physicians – in fact, it hinders these twin goals. This is inconsistent with the mission of GME, which had its genesis in Medicare for the purpose of ensuring a sufficient workforce to care for the Medicare population.

Steps to Modernization

Residency experience in nonhospital and community-based settings is important because most of the medical conditions that practicing physicians confront should be managed in nonhospital settings.² Directing the funding stream to an entity whose principal role is the production of high-quality primary physicians, emphasizing training consistent with contemporary practice, and enhancing accountability for the product are all key steps toward modernization of the funding of primary care GME. The current GME payment system is hospital-oriented, reflecting the inpatient hospital model of care that was the practice norm when the program was established forty years ago. The outdated GME funding method and payment formula do not substantively compensate for the costs of training in nonhospital settings, where most primary care patient services are delivered and where most training should occur. Current national needs require methods that foster innovation, enhanced quality of the graduate, and accountability for the resultant product. Financial incentives inherent in current Medicare law and regulations strongly encourage teaching hospitals to confine their residents' learning experiences within a hospital.² Even with recent positive changes regarding counting resident time in the community, this remains the case.

Accountability for the “Product”

Current allocation of GME funds bears little relation to training or to the physician that is produced. It is solely based on estimates of the “extra costs” a hospital may incur from having residents train in that setting. In fact, there is currently no requirement that GME funds be used for education. A number of reports and articles have expressed concern that our health professionals are not learning certain skills necessary to work optimally in delivery systems that provide the kinds of care that best serve the public's needs.² Directing payment to the primary care training programs that, in concert with accrediting bodies, are responsible for residents' education, will achieve increased accountability more efficiently. This is what the above-described pilot will test.

Family medicine supports more consistency in the training of graduates. Such training should be predicated on competency-based curricula as well as a core set of skills, processes and knowledge. Training should:

- 1) be consistent with community needs,
- 2) support innovation to encourage enhanced quality and efficiency,
- 3) provide graduates with the ability to build and manage clinical practices – including practices delivering care in new models, such as the patient-centered medical home, and
- 4) be able to adjust to meet current and future patient needs and medical knowledge.

1. Advancing Primary Care: Twentieth Report of the Council on Graduate Medical Education, December 2010.

2. Report to the Congress: Improving Incentives in the Medicare Program, Medicare Payment Advisory Commission, June 2009.