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COGME
Council on Graduate Medical Education

May 5, 2009

TO: The Honorable Kathleen Sebelius - Secretary of Health and Human Services
Dr. Mary Wakefield: Administrator – Health Resources Service Administration
The Senate Health, Education, Labor and Pensions Committee
The House Energy and Commerce Committee and its Health Subcommittee
The Medicare Payment Advisory Commission (MedPAC)
The Senate Finance Committee
The House Ways & Means Committee

FROM: The Council on Graduate Medical Education (COGME)

As the nation seeks to improve its health care delivery, the crisis in primary care looms as a major obstacle to achieving this goal. This challenge has been previously described by our committee and acknowledged by leaders of Congress. In that light, the members of COGME would like to share its key recommendations that relate to these critical issues in light of pending legislation on health care reform. These recommendations are based on the recognition that the re-invigoration of primary care is the basis for meaningful health care reform, and requires strategic investments to support primary care funding and training.

The primary care physician workforce (family medicine, general internal medicine and pediatrics) currently comprises 35% of all practicing physicians and is rapidly declining. Recent studies indicate that fewer that 20% of all US medical students are choosing primary care specialties. Congress, as part of health care reform, should modernize GME funding under Medicare and Medicaid to align financial and educational incentives to produce more primary care physicians capable of practicing in patient-centered medical homes in order to serve the growing need of Americans. This would help to satisfy a growing need for first-line and coordinated health and would begin to remedy the changes of the last 10 years where nearly all GME expansion in teaching hospitals has been in subspecialty medicine, often to the detriment of primary care.

Medical students are turning away from primary care for three reasons: poor income relative to other specialties; few primary care role models during their exposure to clinical medicine; and the high, unfunded administrative burden required to care for complex patients. Realignment of training priorities is now urgently needed to achieve true universal access to comprehensive, longitudinal healthcare for all Americans. To accomplish this goal, The Council on Graduate Medical Education recommends the following statutory changes:

Provide incentives and remove statutory barriers to the establishment and expansion of training venues in non-hospital primary care settings, including rural and underserved settings. Our current training infrastructure and funding will not produce enough physicians to meet the future needs in these venues. 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).

Mandate accountability for GME funding in order to reshape the incentives for teaching hospitals and academic medical centers to improve the health of the nation. The nearly $10 billion spent annually on GME (Medicare and Medicaid) is neither monitored nor regulated by the Federal government. Instead, the GME program portfolio is largely driven by the workforce needs of teaching hospitals. Current GME trends are not consistent with developing a more cost effective primary care-based health care system.

Permanently correct the income disparity between primary care and subspecialty physicians. The growing income gap between most subspecialties and primary care is a potent driver of student career choice, for hospital training priorities, and for poor delivery of preventive and coordinated care. GME reforms are necessary, but will be much more effective if combined with reduction of income disparities. Recent data presented at COGME notes that if primary care incomes were to reach a minimum of 60% of the incomes for specialists, current trends away from primary care could be reversed.

Make Graduate Medical Education sites laboratories for innovations in primary care delivery and responsible for producing the next generation of physicians who will work in them. Clinical teaching programs should yield practice innovations that lead to more cost-effective care. They should also prepare new physicians to develop, manage and operate "medical homes" ideally functioning in interprofessional teams with an assortment of providers. In this way, Medicare's investment in primary care training leads to an improved model of care and the workforce necessary to deliver it.

Provide financial support for primary care physicians to establish the infrastructure to coordinate patient care and reduce their administrative burden. Focusing on prevention and early intervention especially for chronic disease has been proven to reduce costs and improve outcomes. However, the current payment system does not reimburse primary care physicians for such care, which has been termed "the medical home".

We appreciate this opportunity to provide advice to the Secretary and key Congressional committees involved in health care reform. We have attached a document of background information and support for these recommendations. In addition, we would like the opportunity to meet with Senators Kennedy and Enzi, and Representatives Waxman, Barton, and Deal, regarding our recommendations. We will follow up with their schedulers to set up appointments.

Sincerely,

/s/

Russell G. Robertson MD
Chair
Council on Graduate Medical Education

Robert Phillips MD MPH
Vice Chair
Council on Graduate Medical Education

This attachment is an update from COGME regarding recommendations made in its 16th and 19th reports and an analysis of recent evidence of how medical education expansion is occurring.

Comments from Key Leaders:

"[W]e have a shortage of primary care providers within our existing workforce. Disturbing reports continue to show the dwindling percentage of medical students who plan to become primary care physicians… The increased cost of education and a lack of sufficient financial incentives for primary care are a significant factor in this decline. These workforce challenges don't just affect the availability of health care. They also have a significant impact on how the health care delivery system performs…So we need to change incentives to promote emphasis on primary care. We should consider reforming Medicare and Medicaid Graduate Medical Education to more effectively foster broader workforce goals."

Opening Statement of Sen. Chuck Grassley
Hearing: Workforce Issues in Health Care Reform: Assessing the Present and Preparing for the Future March 12, 2009

"Overhaul of the health care system must not only provide for universal coverage but also for more primary care doctors and nurses to ensure that an insurance card actually gives the holder access to treatment."

Statement by Rep. Henry Waxman
Hearing: Making Health Care Work for American Families: Improving Access to Care March 24, 2009

"We…find that payments are provided to hospitals without accountability for how they are used or without targeting policy objectives consistent with what Medicare's goals are."[1] "Policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them."[2]
"[MedPAC] found that among the small share of beneficiaries looking for a new primary care physician, 30 percent reported some difficulties finding one. Specifically, 12 percent reported "small" problems and 17 percent reported "big" problems."[3]

Medicare Payment Advisory Commission 2008

<u>The Charter of Council on Graduate Medical Education (COGME)</u>
As a reminder, COGME was authorized by Congress in 1986 to provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs. The legislation calls for COGME to advise and make recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS), the Senate Committee on Health, Education, Labor and Pensions, and the House of Representatives Committee on Energy & Commerce.

The Imperative of Primary Care

COGME is concerned by recent studies showing that the physician training pipeline is contributing to escalating costs that threaten the economic stability of our country. In its 16th report in 2005, COGME recommended a 15% increase in medical school graduates and that "Physicians should be encouraged to select specific specialties with shortages," but refused to be prescriptive about specialty needs. Two recent studies suggest that since the 16th Report, student interest and selection rates for primary care are now 21-24% of graduating students, far below the current 35% share of the physician workforce.[4,5] Surveys of internal medicine residency graduates also suggest that potential primary care physicians are increasingly turning to subspecialty training, hospitalist practice, or other alternative careers.[6] This is further underscored by the results of the 2009 match with regard to family medicine where after a slight uptick in 2008, interest in family medicine among U.S. medical students has returned to its 10-year decline with only 1,083 graduating U.S. medical students -- 89 fewer than last year -- choosing family medicine as their career path. Unfortunately, COGME failed to anticipate how market and medical school influences would further erode interest in specialties shown to be critical to public, personal and economic health.

Likewise, current GME trends are not consistent with a more cost effective primary care-based health care system. Between 2002 and 2006, despite a Medicare GME payment cap, teaching hospitals increased subspecialty training positions by nearly 25% but reduced family medicine training by almost 3%.[3] Since the GME cap was put in place in 1996, primary care internal medicine positions in the annual student Match have fallen by 57%, primary care pediatric positions by 34%, and family medicine by 18%.[7] It is unclear how many of these are being filled outside of the Match and how many have disappeared. While some teaching hospitals maintain a commitment to primary care, to Medicare's goals and to the health of the public, the overall picture suggests that financial concerns have affected the majority of teaching hospitals' decisions about selection of training positions.

Review of Previous COGME Recommendations

The 16th COGME report called for an expansion of undergraduate training positions by15%. Surveys by the Association of American Medical Colleges indicate that allopathic and osteopathic schools are on track to nearly double this mark by 2012.[8] In the 19th COGME report (2007), the Council suggested a need for GME expansion by the same percentage. We recognize now that this failed to account for the fact that GME positions already exceeded allopathic medical school graduates by 30% (In 2007-8, the US graduated about 17,500 allopathic students but had more than 25,000 first year residency positions).[9,10] Despite the already existing excess and Medicare payment cap, first year residency positions grew by nearly 8% between 2002 and 2007.[8] This expansion will accommodate the growth of medical school production; however, because nearly all of this expansion was in subspecialty training, it will reduce primary care production.

The country needs more strategic GME expansion with new incentives for choosing primary care. This is critical to fulfilling Congressman Waxman's and MedPAC's goal of assuring access to primary care. This objective would also support Senator Grassley's goal of reorienting the health care system for improved health outcomes and efficiency.

Current COGME Recommendations

Recommendation 1 of the 19th COGME report calls for aligning GME with future healthcare needs. This is entirely in keeping with MedPAC's recommendation and the current interests of the Senate Finance and HELP committees. The future of healthcare is moving more care, particularly complex care, into the community and even patients' homes. Our current training infrastructure and funding will not prepare physicians for this future. There is a concerted effort to transform primary care practice

into more robust, more complex Medical Homes. We must train the next generation of physicians in this model and GME funding could facilitate this. Medicare's investment in graduate medical education training should be accountable for the health of the public, particularly Medicare beneficiaries, and should move training into new places and models.

Recommendation 2 of the 19th COGME report calls for a broadening of the definition of "training venue". There is currently an imbalance in the locus of training that is not adequately preparing a physician workforce for outpatient care, where most of health care takes place, nor in exposing young physicians to rural and underserved settings. Medicare and Medicaid beneficiaries would benefit from physician training moving out of the hospital into rural and community health centers and physician offices, both directly, in terms of service, but later as physicians exposed to working in these settings decide it is a career option. Training in community, rural and underserved settings has been shown to increase physician choice of working in such settings.[11] The Government Accountability Office has emphasized the intractable problem of physician distribution twice in the last decade.[12] [13] GME funding has become a barrier rather than a facilitator of improving physician distribution and access to care.

Recommendation 3 of the 19th COGME report is to remove regulatory and statutory barriers limiting flexible GME training programs and training venues. Recent regulatory efforts to pay for community-based GME by private practice physicians had the unintended consequence of retrenching training back in hospitals. CMS had the good goal with the "Community Preceptor" regulation of paying for community physician education of trainees. Unfortunately the required payment, or reporting required to avoid it, had the reverse effect of pulling those positions back into hospitals. This new regulation and Medicare's 40 year old model of paying for physician training stand in the way of progress. If Medicare GME funding is retooled, the regulatory process must also be directed by statute, not just report language, to create incentives to accommodate these changes.

Recommendation 4 of the 19th COGME report calls for making accountability for the public's health the driving force for graduate medical education. The nearly $10 billion spent annually on GME can no longer afford to be bent to the needs of hospitals. We appreciate the need to help teaching hospitals with the problems of workforce and financial solvency that GME currently serves, but we cannot afford the byproduct of an overly-specialized and expensive physician workforce. With modification the byproduct of GME funding could be a reshaping of the role of teaching hospitals in meeting the needs of the public. Clearly, 25% growth in subspecialty training when there is no societal imperative for this makes this dependence even more explicit and at odds with societal needs.

COGME's Next Report

COGME is now working on a 20th report that will focus more globally on the alignment of policies along the physician production pipeline to best balance the physician workforce and support health system reform. It will work from the preparation and selection of students for medical school all the way through to payment policies. Our discussions and draft report concepts may be useful to MedPAC and Congressional Committees.

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[1] MedPAC. Public meeting transcript, October 2, 2008; p8. http://medpac.gov/transcripts/1002-1003MedPAC.pdf

[2] MedPAC. Report to Congress: Reforming the Delivery System. June, 2008. Chapter 2: Promoting the Use of Primary Care, p26

[3] MedPAC. Report to Congress: Reforming the Delivery System. June, 2008. Chapter 2: Promoting the Use of Primary Care, p31

[4] Salsberg E, Rockey PH, Rivers KL, Brotherton SE, Jackson GR. US Residency Training Before and After the 1997 Balanced Budget Act. JAMA. 2008; 300(10):1174-1180.
[5] Karen E. Hauer; Steven J. Durning; Walter N. Kernan; et al. Choices Regarding Internal Medicine Factors Associated With Medical Students' Career. JAMA. 2008;300(10):1154-1164.
[6] Bodenheimer, T. Primary care—Will it survive? The New England Journal of Medicine. 2006;355:861-864.
[7] National Residency Match Program data, 1997-2008. Available at http://www.aafp.org/online/en/home/residents/match.html
[8] Croasdale M. Medical schools on target to reach enrollment goals. AMNews. June 23/30, 2008. http://www.ama-assn.org/amednews/2008/06/23/prsb0623.htm
[9] Brotherton SE, Etzel SI. Graduate Medical Education, 2007-2008. JAMA. 2008;300(10):1228-1242.
[10] Barzansky B, Etzel SI. Medical Schools in the United States, 2007-2008. JAMA. 2008;300(10):1221-1227.
[11] Phillips RL, Dodoo MS, Petterson S, Xierali I, et al. Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student & Resident Choices? AAFP (Washington, DC). 2009.
[12] United States Government Accountability Office. Primary care professionals – Recent supply trends, projections, and valuation of services. US GAO, testimony before the US Senate. 2-12-2008. Committee on Health, Education, Labor and Pensions, U.S. Senate.
[13] General Accounting Office. Physician workforce: Physician supply increased in metropolitan and nonmetropolitan areas but geographic disparities persisted. GAO-o4-124. 2003. Washington, DC, General Accounting Office