

# COGME Letter to Constituents

- **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.

# Letter Continued

- **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”.