IMPLEMENTING HEALTH REFORM

Redistributing Residencies to Primary Care

The Affordable Care Act includes several provisions to highlight the importance of primary care. Under one provision, section 5503 of the ACA, hospitals must give up a portion of their unused residency slots to go into a pool to be redistributed to primary care and general surgery residency programs, mostly in rural and physician-shortage areas. Certain hospitals (such as rural teaching hospitals with fewer than 250 beds) are exempted. The shift is slated for July.

Dr. Wendy Biggs, assistant director of the American Academy of Family Physicians' division of medical education, explains how residency programs – and the supply of primary care physicians – will be affected.

CARDIOLOGY NEWS: How many slots are likely to be available to primary care and general surgery through this provision?

Dr. Biggs: It's difficult to quantify the exact number. The Balanced Budget Act of 1996 froze or capped the number of residency positions for hospitals. Most institutions have their resident count close to or over their cap. According to the Council on Graduate Medical Education (COGME) Twentieth Report, the number of residency slots in the United States grew 6.3% between 2003 and 2006. Hospitals do not receive federal graduate medical education money for positions over their cap. Because hospitals self-fund these resident positions, they tend to be in high income–generating subspecialty areas. The government is redistributing 65% of unused, federally subsidized residency slots. Therefore, the number of slots will likely be in the hundreds, whereas we need tens of thousands of primary care physicians to take care of the health needs of our population.

CN: Where will these residency slots likely go?

Dr. Biggs: The law allows hospitals to apply for more residency positions. Slots will be granted based on the hospital's likelihood of filling the positions within 2 years and whether it has an accredited rural-training track. Overall, 75% of the redistributed positions must go to primary care or general surgery, but the percentage of primary care vs. general surgery positions is not specified. Moreover, the law has no provision to ensure that any resident who begins a primary care program will in fact practice in primary care rather than subspecialize after the first year of training.

Geographically, the states with the lowest resident physician-to-population ratio will get 70% of the redistributed positions. States with a large number of residency programs, such as New York and California, are more likely to get the redistributed residency positions, since they also have the largest populations (making a lower ratio).

CN: Given lagging interest in primary care in recent years, will programs be able to fill additional positions?

Dr. Biggs: The government is functioning under the "if you build it, they will come" scenario. However, more primary care residency positions do not mean more U.S. graduate applicants for those positions. Recent years have seen the creation of new medical schools and increasing class sizes in existing medical schools. However, until we resolve factors discussed in the COGME report – including improved reimbursement, debt management, and decreased administrative burden – U.S. medical students may continue to choose specialties other than primary care.

The COGME report recommends that 40% of physicians should practice primary care. Currently, we are at 32%.

DR. BIGGS

CN: How much of a difference will this make in increasing the size of the primary care workforce?

Dr. Biggs: The impact likely will be minimal. The government is not making new resident slots; it is simply redistributing them. The COGME report recommends that 40% of physicians should practice primary care. Currently, we are at 32%. An additional 63,000 primary care physicians are required to raise the proportion of primary care physicians to 40%. The number of residency slots to be redistributed probably numbers in the hundreds. Although the intent of the legislation is good, the actual increase will be insufficient.

CN: What other changes are needed to get more physicians into primary care?

Dr. Biggs: First and foremost, we need payment reform. Primary care physicians must be recognized for their value to the health care system. The COGME report suggests that the average incomes of these physicians must achieve at least 70% of median incomes of all other physicians. We have the data from the Canadians who several years ago experienced a substantial drop in physicians entering primary care. They improved the reimbursement to family physicians and saw a surge in medical student interest and entry into family medicine.

We need to move away from systems that pay for episodic care and toward payment mechanisms that recognize the value of care coordination. We need to value the hallmarks of the Patient-Centered Medical Home: first-contact access, patient-focused care over time, comprehensive and coordinated care, family orientation, community orientation, and cultural competency. ■

ACP Urges Congress Not to Repeal Health Reform

BY ALICIA AULT

FROM AN AMERICAN COLLEGE OF PHYSICIANS TELECONFERENCE

WASHINGTON – The American College of Physicians came out strongly against any repeal of the Affordable Care Act, and instead is calling on the White House and Congress to come to an agreement on how to tinker with the bill so that it still meets its objectives of covering more Americans, improving access, and reducing the cost of care.

At its annual State of the Nation's Health Care briefing, ACP President J. Fred Ralston Jr. said that "a highly partisan and polarized debate over health care reform legislation regrettably has taken the country's 'eye off the ball' " of achieving the Affordable Care Act's (ACA's) multiple goals, including "ensuring a sufficient supply of primary care physicians and other specialties facing shortages."

Dr. Ralston said that the stage is being set for a self-defeating debate that will only lead to a worsening of the nation's health care problems.

"Instead of turning away from the ACA's promise of ensuring access to affordable health insurance to nearly all Americans, the ACP believes that Congress should seek bipartisan common ground on making improvements to it, including giving states more freedom earlier to implement the coverage expansions in a way that best meets their own needs," he said.

Bob Doherty, the ACP's senior vice president for governmental affairs and public policy, was more blunt about the unfolding political landscape, with Republicans bent on repeal and Democrats intent on preserving every bit of the law intact. Neither side will win, said Mr. Doherty.

"The law won't go away, as most Republicans hope, but restrictions on funding and enforcement could undermine its effectiveness, as many Democrats fear."

He said it was ironic that Republicans might seek to strip funding from such programs as incentives for establishing electronic medical records, comparative effectiveness, and higher Medicare and Medicaid payments for physicians. Most of these very programs have been championed by Republicans in the past, said Mr. Doherty.

In its report, the ACP urged the White House and Congress to give states more options to cover their residents, and to do it sooner than called for under the ACA. The physicians' group is supporting the bipartisan Empowering States to Innovate Act, a bill cosponsored by Sen. Ron Wyden (D-Ore.) and Sen. Scott Brown (R-Mass.).

The White House and Congress should also find a mutually acceptable replacement for Medicare's Sustainable Growth Rate (SGR), said Mr. Doherty. Instead of eliminating comparative effectiveness programs, Congress should embrace them as a means of reducing health care costs.

Medical liability reform is another area that is ripe for bipartisan solutions, said Mr. Doherty. President Obama supported reform in his State of the Union address and seems open to suggestions, he said. The ACP is backing a bill that would cap noneconomic damages, even though it has little chance of making its way through Congress, Mr. Doherty said. And the group would like to see pilots of so-called health courts, which would create a no-fault system with specially trained judges.

A key element of the ACP's wish list for the White House and Congress: a national conversation on "how to conserve and share health care resources effectively, efficiently, judiciously, and fairly, based on the evidence of their clinical effectiveness and value, and in accord with distinctive American values, including individualism," said Mr. Doherty.

That position is more thoroughly fleshed out in a white paper released by the ACP at the briefing, "How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?"

Dr. Ralston said that the ACP believes that "this is the first time a major physician membership society has called for a national consensus on conserving and allocating health care resources and proposed a framework on how to make such decisions." But, he added, "to be clear, the ACP is not proposing that care be rationed."

The idea is that physicians should have access to the best possible evidence on diagnostics and treatments, and that they should be able to share that with patients and make informed decisions about how to proceed.

The United States already limits access to services just by virtue of the fact that people do not have insurance or because insurance companies limit benefits or require cost sharing, said Dr. Ralston. Socioeconomic, racial, and ethnic factors also affect access, he added.

He said that Americans have to address the reality that spending is increasing at an unaffordable pace, and decide how best to allocate limited resources. "We know it won't be easy," Dr. Ralston concluded. ■