IMPLEMENTING HEALTH REFORM

Redistributing Residencies to Primary Care

The Affordable Care Act includes several provisions aimed at highlighting the importance of primary care. One provision aims to increase the number of primary care physicians by shifting more residency positions into primary care and general surgery. Under 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, primarily in rural and physician-shortage areas. Certain hospitals (such as rural teaching hospitals with fewer than 250 beds) are exempted. The shift is slated to take place in July.

Dr. Wendy Biggs of the American Academy of Family Physicians explains how residency programs – and the supply of primary care physicians – will be affected.

RHEUMATOLOGY 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.

First and foremost, we need payment reform.

DR. BIGGS

RN: 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 are 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 their 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).

RN: 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.

RN: 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 – including 39,000 family physicians – are required to raise the proportion of primary care physicians to 40% of all physicians. 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.

RN: 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. ■

DR. BIGGS is the assistant director of the division of medical education at the AAFP.

Senate Passes Amendment To Repeal ACA's Tax Reporting Requirement

BY MARY ELLEN SCHNEIDER

The Senate signaled its intention to repeal from the health reform law a tax-reporting requirement that has been labeled as overly burdensome by the medical and business communities.

The Affordable Care Act currently includes a provision requiring businesses – including physician practices – to file a 1099 tax form with the Internal Revenue Service for all vendor payments of more than $600 per year. The requirement is set to take effect in 2012.

Sen. Debbie Stabenow (D-Mich.) proposed repealing the 1099 requirement as an amendment to the FAA Air Transportation Modernization and Safety Improvement Act (S. 223).

Last month, the amendment was passed by a vote of 81-17.

The American Medical Association has been lobbying against the 1099 requirement, noting that compliance would be expensive and would negatively impact physicians' practices.

"It is estimated that paperwork already takes up as much as a third of a physician's workday – time that could be better spent with patients – and this provision would only increase that burden," AMA President Cecil B. Wilson said in a statement.The reporting requirement is one of the few potential changes to the Affordable Care Act on which Democrats and Republicans can agree. In his State of the Union address, President Obama singled out the repeal of the 1099 requirement as a change he would support. The mention drew a standing ovation from members of Congress. ■

White House Overhauls Conscience Rule for Health Workers

BY ALICIA AULT

The White House has issued a rule that would mostly overturn a regulation that was widely interpreted to allow health care providers to opt out of providing services such as contraception or abortion, or bar federal funding to those entities that did not accommodate providers' wishes to deny services.

The so-called conscience rule was issued in 2008 at the end of the George W. Bush administration. The new regulation mostly rescinds that rule.

In issuing the new regulation, the Health and Human Services department said that it "supports clear and strong conscience protections for health care providers who are opposed to performing abortions," and that protections that have existed for decades will continue to offer the same coverage.

But, the Bush administration rule was overbroad and confusing, HHS said in the final rule published in the Federal Register. The new rule will retain an enforcement mechanism set up under the 2008 regulation, but will mostly jettison the rest of it.

"Strong conscience laws make it clear that health care providers cannot be compelled to perform or assist in an abortion," said HHS in a statement.

"Many of these strong conscience laws have been in existence for more than 30 years. The rule being issued today builds on these laws by providing a clear enforcement process."

The agency proposed rescinding the Bush rule in March 2009 and received more than 300,000 comments on the proposed rule, the majority of which were form letters generated by various organizations, HHS said. More than 97,000 supported a rescinding of the 2008 rule, about 187,000 opposed any revision, and the rest were of various opinions.

NARAL Pro-Choice America, which claimed to have generated more than 25,000 of the comments, applauded the change. "The language published today reaffirms the principles of protecting the doctor-patient relationship by repealing the most onerous and intrusive parts of Bush's last-minute refusal rule," said President Nancy Keenan in a statement.

The rule goes into effect on March 18. ■