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 some rural teaching hospitals) are exempted. The shift is slated to take place in July.

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

Clinical Endocrinology 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.

CEN: 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.

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

DR. BIGGS

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.

CEN: 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.

CEN: 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.

CEN: 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 also need to value the hallmarks of the Patient-Centered Medical Home: first-contact access, patient-focused care provided over time, comprehensive and coordinated care, family orientation, community orientation, and cultural competency. ■

Health IT Group Warns Congress to Uphold Incentives

BY NASEEM S. MILLER

Bipartisan support of health information technology is urgently needed so that incentives aimed at encouraging physicians and hospitals to adopt electronic health record systems remain in place, according to a report by the Healthcare Information & Management Systems Society.

"Our member-created Call-for-Action report offers policy makers concrete solutions that will help promote the adoption and use of health IT to contribute to higher-quality, more cost-effective patient care," David Roberts, HIMSS vice president for government relations, said in a statement.

It is yet to be seen whether the federal stimulus funds for health IT will be affected during the current budget battles at the Congress.

Nevertheless, the report, 2011-2012 Public Policy Principles, encourages continued progress toward implementation of the "meaningful use" criteria, which enable physicians to receive incentives that are tied to Medicare reimbursements if their adoption of electronic health record systems meets the criteria. The provision is part of the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

"We agree with Dr. David Blumenthal," the national coordinator for Health IT, that "these are historic times. The HITECH Act is bringing the power of electronic health records to our health care system. However, these new initiatives should not create a new form of 'digital divide' and our goal is to make sure that all constituencies benefit from these efforts," the organization wrote in its annual report.

The report urges policy makers to make the following their top priority:

- ► Supporting the National Quality Forum's National Priorities Partnership, which aims to create a consensus on standard for measuring performance.
- ► Ensuring a consolidated communications tool and comprehensive road map for meaningful use.
- ► Defining each new meaningful use stage at least 18 months before the beginning of the next stage.
- ► Establishing grievance processes for providers seeking to fulfill meaningful use criteria.
- ► Developing an open and transparent EHR certification criteria process.
- ► Supporting the establishment of an informed patient identity solution.
- ► Expanding and making permanent current Stark exemptions and anti-kickback safe harbors for EHR users.
- ► Eliminating the HIPAA Business Associate Agreement requirement.
- ► Providing grants and other incentives to establish so-called Health IT Action Zones that demonstrate effective health IT adoption practices by providers who care for patients in medically underserved populations.
- ► Aligning federal policy to facilitate electronic business processes.

The report also calls for a "structural payment reform," suggesting the repeal of Sustainable Growth Rate (SGR) physician payment program and bringing up Medicaid reimbursement up to that of Medicare's. Without such changes, the report warns, "all health IT initiatives are at risk as providers may choose instead to withdraw from these federal programs."

In his proposed budget, President Obama has laid out a plan to pay for the first 2 years of the SGR so that the physician reimbursement rates will not be cut. His plan is to fix SGR in 10 years. ■

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