03/16/11 - Primary Care Physician Workforce

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Background

Strengthening and modernizing the health care workforce was a major goal of the Patient Protection and Affordable Care Act (ACA). The ACA contains dozens of provisions related to health care workforce issues, including strengthening primary care, national workforce policy development, increasing the supply of health care workers, and more. This Implementation Brief focuses on those provisions of the ACA that specifically target the strengthening of the primary care physician workforce.

There are over 800,000 practicing physicians and residents currently in the United States, but only 32% designate themselves principally as primary care practitioners (PCPs), namely, practitioners of family medicine, general internal medicine, and general pediatrics.[1] While the absolute number of primary care residents has risen in recent years, the increase is occurring at a slower rate than for specialty residents. Between 1995 and 2006, the number of medical residents going into primary care increased 6%, whereas the number of residents focusing on specialty care increased 8%.[2] Furthermore, certain specialties, such as family medicine, have seen a decline in the absolute numbers of residents.[3] Without any changes the Association of American Medical Colleges estimates that there will be a shortage of approximately 21,000 PCPs by 2015.[4] As PCPs are instrumental in providing health care coordination, health education, and preventive care services, and also in identifying at-risk populations and detecting the early stages of disease,[5] a shortage of this magnitude could place an enormous strain on the health care system. Furthermore, implementation of the ACA can be expected to result in even more demand for primary care physicians.[6]

Changes Made by the Health Reform Law (P.L. 111- 148, §§ 5201, 5207, 5301, 5405, 5501, 5503, and 5508)

The ACA made a number of changes with respect to improving and strengthening the primary care physician workforce.[7] They can be classified into four major areas:

Financial incentives to practice primary care

- The ACA increases Medicare Part B payments for primary care services by 10 percent between January 1, 2011 and December 31, 2015.[8] In addition to receiving regular Medicare payments for services provided over this period, PCPs can also recover an additional 10 percent of the cost of providing certain primary care services, as defined in the statute. Those who can take advantage of the latter incentive include physicians specializing in family, internal, geriatric, or pediatric medicine for whom primary care services accounted for at least 60 percent of their allowed charges under Part B for a prior period as determined by the Secretary of Health and Human Services (HHS).
- The ACA also increases Medicaid reimbursement levels for primary care services to 100% of Medicare levels for the fiscal year 2013-2014.
- The ACA also amends provisions of the Public Health Services Act (PHSA) relating to educational loans for health care professionals. The new law modifies the current federal student loan program for medical students electing to specialize in primary care in several ways:[9]

- the time a physician must practice in primary care is reduced from "the date on which the loan is repaid in full"[10] to "10 years (including residency training in primary health care) or through the date on which the loan is repaid in full, whichever occurs first;"[11]
- the penalty for noncompliance with loan requirements is significantly reduced; an
- the Secretary of HHS is prohibited from considering a loan recipient's parental financial information when determining financial need.

- Lastly, the ACA authorizes funds to carry out the National Health Service Corps Scholarship and Loan Repayment Program.[12] The scholarship program covers tuition, fees, and costs for students enrolled in a medical degree program.[13] After graduation, recipients of the scholarship are expected to work for up to four years as a primary care physician in an area of need. The Loan Repayment Program is eligible to primary care physicians in exchange for two years of service in a community-based area of high need.[14]

Revisions to Graduate Medical Education

The ACA also includes changes to graduate medical education (GME) aimed at increasing the number of primary care residency positions.[15] There are two key ways in which the ACA revises graduate medical education:

- First, the law calls for a redistribution of unused residency positions. The ACA requires the Centers for Medicare and Medicaid Services (CMS) to take 65 percent of a hospital's unused Medicare-funded GME positions and redistribute them to other hospitals according to factors prescribed by Congress (unless a hospital exhibits one of several characteristics set out in the law).

- In order to get priority in receiving an increase in residency positions, a hospital must establish that it will fill the residency positions within 3 years of the increase and that 75 percent of the new residency slots will go to primary care or general surgery residency programs. Furthermore, the Secretary of HHS will distribute residency positions on a priority basis according to whether a hospital: has a resident-to-population ratio in the lowest quartile; is located in an area that is among the top 10 States, territories or districts in terms of the ratio of people living in a health profession shortage area (HPSA) to the total population; or is located in a rural area.

- The ACA also creates a GME payment program under which the Secretary can make payments for direct and indirect expenses to qualified teaching health centers for expansion and establishment of new approved primary care residency training programs.[16]

Primary Care Extension Program

Another provision of the ACA authorizes the Secretary, through the Director of the Agency for Healthcare Research and Quality (AHRQ), to establish the Primary Care Extension Program, which will provide support and assistance to PCPs and help educate PCPs about preventative medicine, evidence-based medicine, health promotion, chronic disease management, and mental health.[17] The Secretary can award grants to states to create Primary Care Extension Program State Hubs, which are comprised of the state health department, the administrating agency of the state

Medicaid program, the state-level administrating agency of the Medicare program, and the departments that train PCPs in one or more health professions schools in the state. States can receive one of two types of grants: program grants lasting for six years awarded to states that have submitted fully developed implementation plans for the Hub, or planning grants lasting for two years awarded to states with the goal of developing a plan for the Hub.

Grant Programs

Finally, the ACA increases funding for a competitive grant program aimed at supporting primary care education and training.[18] Under this discretionary program, the Secretary may make grants/contracts to public or nonprofit educational institutions in order to plan, develop or implement a professional training program for primary health care residencies (including family medicine, general internal medicine, or general pediatrics). Such grants/contracts can also be used to provide financial assistance to the programs, develop a program for the training of physicians who will teach one of the primary health specialties, to operate joint degree and interdisciplinary programs, and to provide training in new competencies, like patient centered medical homes.

Implementation

Agency

CMS has authority over the Medicare payments and GME provisions. The HHS Health Resources and Services Administration (HRSA) is the fiscal and administrative agent for the grant and loan programs.

Key Dates

None.

Process

The health reform law does not provide specific direction to HHS regarding the administrative process used to implement the law. The agency therefore has the discretion to use a range of tools to implement the statute, such as publishing regulations in the Federal Register with a public notice and comment period, or using other types of approaches such as posted policy instructions, funding availability announcements (where applicable), official letters to affected entities (such as letters to state Medicaid agencies), and posted rulings and notices. Agency

websites can be checked regularly for updates.

Key Issues

Supply: Generally, will the new ACA provisions reduce the barriers that currently discourage medical students from pursuing primary care careers? For example, will a four-year, 10% boost in Medicare payments drive physicians into primary care when they would otherwise choose a different field of medicine? Indeed, there appears to be anecdotal concern that the new provisions won't even be enough to keep current PCPs in the workforce, much less increase the primary care workforce.

GME Revisions: There is anecdotal concern that any new "primary care" positions resulting from redistribution will be co-opted by specialty positions; how will CMS enforce the rule that 75 percent of the new residency slots will go to primary care or general surgery residency programs? Also, will the redistributed slots allow more primary care students to do their clinical training in community-based settings?

Primary Care Extension Program: Could the extension program alleviate concerns about students and young physicians being intimidated by the breadth of knowledge required for primary care?[19] Similarly, might the program alleviate problems that medical schools have finding high-quality ambulatory care teaching sites for students interested in primary care?[20]

Grant Program Funding: The increased funding has been authorized but not appropriated. Given the current budgetary and political climate, will the increase be funded and, if so, can it be sustained long enough to increase participation in primary care fields?

Agency Action

On June 30, 2010, CMS released proposed regulations regarding Medicare support for GME, including the process for redistributing unused residency positions.[21] Comments were received until August 31, 2010 and the final rule is expected to be released in November 2010.

On July 13, 2010, CMS published in the Federal Register a Notice of Proposed Rule for

"Medicare Program; Payment Policies Under the Physician Fee Schedule and

Other Revisions to Part B for CY 2011."[22] Included in this proposed rule is the

Medicare incentive for primary care physicians as established by ACA §5501. Comments were accepted until August 24, 2010.

On September 27, 2010, the Secretary of HHS announced that $253 million is available to improve and expand the primary care workforce under the Prevention and Public Health Fund of the ACA. The grants are awarded under six health professions programs administered by HRSA and are designed to build the primary care workforce and provide community-based prevention services. For a complete listing of how the money will be spent, read the press release.

On November 24, 2010, CMS published final rules pertaining to the GME provisions.[23]

On November 29, 2010 CMS published final rules pertaining to the physician incentive provisions.[24]

Authorized Funding Levels

For the Medicare incentive payments, the changes address individual entitlements and thus do not specify an aggregate amount of spending.

For the provisions regarding GME, the changes are regulatory in nature and therefore do not directly include the award of federal funds.

For the education loan programs, the changes are regulatory in nature and therefore do not directly include the award of federal funds.

For the Primary Care Training Grants: Congress authorized to be appropriated $125 million for fiscal year 2010, and such sums as necessary for the years 2011 through 2014. For each fiscal year, 15 percent of the grant funds must go to physician assistant training for practice in primary care.

For the National Health Service Corps, the following amounts were authorized to be appropriated: $320,461,632 for fiscal year 2010, $414,095,394 for fiscal year 2011, $535,087,442 for fiscal year 2012, $691,431,432 for fiscal year 2013, $893,456,433 for fiscal year 2014, $1,154,510,336 for fiscal year 2015.

For the Primary Care Extension Program: Congress authorized to be appropriated $120 million for each of fiscal years 2011 and 2012, and such sums as necessary for fiscal years 2013 and 2014.

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[1] GAO Report ? Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services. Published 2008: http://www.gao.gov/new.items/d08472t.pdf.
[2] A. Bruce Steinwald, "Primary Care Professionals Recent Supply Trends, Projections, and Valuation of Services," Testimony before the Senate Committee on Health, Education, Labor, and Pensions, Feb. 12, 2008: http://www.gao.gov/new.items/d08472t.pdf.
[3] Barbara Bein, "Match Results: 2010 Fill Rate for Family Medicine Highest Ever," American Academy of Family Physicians, Mar. 18, 2010: http://www.aafp.org/online/en/home/publications/news/news-now/resident-student-focus/20100318matchresults.html.
[4] U.S. Department of Health and Human Services News Release, "Sebelius Announces New $250 Million Investment to Strengthen Primary Health Care Workforce," June 16, 2010: http://www.hhs.gov/news/press/2010pres/06/20100616a.html.
[5] Institute of Medicine (1996). Primary Care: America's Health in a New Era. National Academies Press. p. 3.
[6] Stephen R. Smith, "A Recipe for Medical Schools to Produce Primary Care Physicians," 364 N Engl J Med 496-97 (February 10, 2011), available at http://www.nejm.org/doi/full/10.1056/NEJMp1012495.
[7] The ACA also contains many provisions that target increasing the supply of non-primary care specialty physicians. For example, the ACA authorizes the Secretary of Health and Human Services to make educational loan repayments on behalf of physicians who practice pediatric medical or surgical subspecialties in underserved areas. See ACA § 5203.
[8] ACA § 5501(a).
[9] ACA § 5201.
[10] 42 U.S.C. § 292s(a)(1)(B) (2000) as enacted November 13, 1998, amended by P.L. 111-148, March 22, 2010.
[11] ACA § 5201(a)(1)(A).
[12] ACA § 5207.
[13] 42 U.S.C. § 254l
[14] 42 U.S.C. § 254l-1.
[15] ACA § 5503(a).
[16] ACA § 5508(c).
[17] ACA § 5405(a).
[18] ACA § 5301.
[19] See Smith, "A Recipe for Medical Schools to Produce Primary Care Physicians," at http://www.nejm.org/doi/full/10.1056/NEJMp1012495.
[20] *Id.*

[21] To read the Proposed Rule and Comments, go to: www.regulations.gov and enter ID number CMS-2010-0209-0001.
[22] 75 Fed. Reg. 40040.
[23] 75 Fed. Reg. 71800.
[24] 75 Fed. Reg. 73170.

GAO Report - Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services. Published 2008: http://www.gao.gov/new.items/d08472t.pdf .A. Bruce Steinwald, "Primary Care Professionals Recent Supply Trends, Projections, and Valuation of Services," Testimony before the Senate Committee on Health, Education, Labor, and Pensions, Feb. 12, 2008: http://www.gao.gov/new.items/d08472t.pdf.Barbara Bein, "Match Results: 2010 Fill Rate for Family Medicine Highest Ever," American Academy of Family Physicians, Mar. 18, 2010: http://www.aafp.org/online/en/home/publications/news/news-now/resident-student-focus/20100318matchresults.html.U.S. Department of Health and Human Services News Release, "Sebelius Announces New $250 Million Investment to Strengthen Primary Health Care Workforce," June 16, 2010: http://www.hhs.gov/news/press/2010pres/06/20100616a.html.Institute of Medicine (1996). Primary Care: America's Health in a New Era. National Academies Press. p. 3.Stephen R. Smith, "A Recipe for Medical Schools to Produce Primary Care Physicians," 364 N Engl J Med 496-97 (February 10, 2011), available at http://www.nejm.org/doi/full/10.1056/NEJMp1012495.The ACA also contains many provisions that target increasing the supply of non-primary care specialty physicians. For example, the ACA authorizes the Secretary of Health and Human Services to make educational loan repayments on behalf of physicians who practice pediatric medical or surgical subspecialties in underserved areas. See ACA § 5203.ACA § 5501(a).ACA § 5201.42 U.S.C. § 292s(a)(1)(B) (2000) as enacted November 13, 1998, amended by P.L. 111-148, March 22, 2010.ACA § 5201(a)(1)(A).ACA § 5207.42 U.S.C. § 254l42 U.S.C. § 254l-1.ACA § 5503(a).ACA § 5508(c).ACA § 5405(a).ACA § 5301.See Smith, "A Recipe for Medical Schools to Produce Primary Care Physicians," at http://www.nejm.org/doi/full/10.1056/NEJMp1012495.*Id.*To read the Proposed Rule and Comments, go to: www.regulations.gov and enter ID number CMS-2010-0209-0001.75 Fed. Reg. 40040.75 Fed. Reg. 71800.75 Fed. Reg. 73170.