

Health Reform

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PL 111-148), an historic act expected to cover 32 million uninsured Americans at a cost of \$940 billion while reducing the deficit by \$143 billion over that same time frame. One week later, on March 30, 2010, the President signed into law a package of negotiated changes to the new health reform law – the Health Care and Education Reconciliation Act of 2010 (PL 111-152). In addition to addressing health care, the reconciliation act overhauls federal financial aid programs, making the federal government the sole originator of federal loans to college students. The following is a summary of these acts' health reform provisions that are of interest to osteopathic medical education.

Incentive Payment for Primary Care Services

The act provides a 10 percent bonus payment for primary care services provided by a primary care practitioner between January 1, 2011, and January 1, 2016. A primary care practitioner is defined as a physician with a specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine or is a nurse practitioner, clinical nurse specialist, or physician assistant. In addition, the primary care services, as designated by specified Healthcare Common Procedure Coding System codes, must account for at least 60 percent of the practitioner's allowed charges. This provision is a first step towards addressing payment inequities facing primary care providers.

Medicaid Parity

A provision in the reconciliation measure, which will only be in effect in 2013 and 2014, further bolsters primary care by creating parity with Medicare for primary care Medicaid providers, defined as those with specialties in family medicine, general internal medicine, and pediatric medicine, for the provision of primary care services.

Creation of the Independent Medicare Advisory Board

The Independent Medicare Advisory Board was created to control costs in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) is required to determine whether the projected per capita growth rate for the program is set to exceed the target growth rate for a given year. When it is, the board is charged with developing a proposal with recommendations to reduce the growth in Medicare that must be implemented by the Secretary of Health and Human Services (HHS) unless Congress enacts legislation that would alter the proposal. The recommendations of the board cannot ration health care, raise revenues, increase beneficiary premiums or cost sharing, or restrict the eligibility criteria. The board may make recommendations to improve the health care delivery system, health outcomes, and beneficiary access to necessary and evidence-based items and services. Fifteen board members will be appointed by the President, with the advice and consent of the Senate, and the Secretary of HHS, the Administrator of CMS, and the Administrator of Health Resources and Services Administration (HRSA) will serve as ex officio, nonvoting members. It is estimated that this board will save \$28 billion over 10 years.

Graduate Medical Education

The act makes a series of changes in the Graduate Medical Education (GME) Program, some of which promote primary care. It does not, however, lift the cap on residency slots.

- **Distribution of additional residency positions:** This provision encourages training in primary care and general surgery. CMS will calculate the number of unused residency slots, defined as the difference between total available resident slots and a hospital's actual full-time equivalent (FTE) of residents, over the last three years. Sixty-five percent of these unused slots will be included in a pool for redistribution. Rural teaching hospitals with less than 250 beds will be exempt. Certain other hospitals will also be exempt if they demonstrate they have a specific plan to fill the unused slots within two years of enactment. The Secretary of HHS is required to increase the resident limit for each qualifying hospital submitting a timely application. Hospitals receiving an increase are required to ensure that the number of FTE residents in primary care residency is not less than the average during the three most recent cost reporting periods and that not less than 75 percent of the positions attributable to such an increase are in a primary care or general surgery residency. In determining the redistribution, the Secretary will consider the likelihood that the positions will be filled in the first three cost reporting periods and whether the hospital has an accredited rural training track. Priority will be given to hospitals in States with a resident-to-population ratio in the lowest quartile, whether the hospital is located in a rural area and whether the hospital is located in a State, DC, or a territory that is among the top 10 in terms of the ratio of the total population living in an area designated as Health Professional Shortage Area (HPSA) to the total population.
- **Counting Resident Time in Nonprovider Settings:** All the time spent by a resident will count toward the direct and indirect GME payment without regard to the setting where the activities are performed, if the hospital continues, or in the case of a jointly operated residency program, the involved entities continue to incur the costs of the stipends and the fringe benefits of the resident during the time the resident spends in the setting.
- **Rules for Counting Resident Time for Didactic and Scholarly Activities:** When calculating GME payments, Medicare will count the time that residents in approved training programs spend in certain non-patient care activities in a nonhospital setting that is primarily engaged in furnishing patient care; this will include time spent in didactic conferences and seminars, but will not include research that is not associated with the treatment or diagnosis of a particular patient. Medicare will count all vacation, sick leave, and other approved leave spent by the resident in an approved training program.
- **Preservation of Resident Cap Positions from Closed Hospitals:** The Secretary will promulgate regulations to establish a process where residency allotments in a hospital with an approved medical residency program that closes could be used to increase the residency limit for other hospitals.

Teaching Health Centers

- **Grant Program:** The act creates a grant program in which teaching health centers (THCs) will receive three-year grants for up to \$500,000 to establish new accredited or expand primary care residency programs. The funds may be used to cover costs for curriculum development; recruitment, training and the retention of residents and faculty; accreditation; and faculty salaries during the development phase. \$25 million is

authorized for fiscal year (FY) 2010, and \$50 million for fiscal years 2011 and 2012 and such sums as are necessary for each subsequent fiscal year.

- **Payments to THCs that Operate GME Programs:** THCs listed as sponsoring institutions of graduate medical residency training programs will receive payments for direct and indirect expenses under a formula outlined in the act.

Prevention and Wellness

The act includes provisions to strengthen how the health care system approaches prevention and wellness programs.

- **Establishment of the National Prevention, Health Promotion and Public Health Council:** This council is charged with the coordination of federal prevention, wellness, and public health activities, including the development of a national strategy to improve health.
- **Creation of a Prevention and Public Health Fund:** This fund will expand and sustain funding for prevention and public health programs. It authorizes an initial appropriation of \$500 million in FY 2010, which is raised to \$2 billion in FY 2015. These funds may be used for programs authorized by the Public Health Service Act for prevention; wellness; and public health activities, including prevention research and health screenings, such as the Community Transformation Grant Program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs.
- **Coverage of Preventive Services:** Cost sharing for preventive services will be eliminated in Medicare and Medicaid effective January 1, 2011. Medicare beneficiaries will also have access to a comprehensive health risk assessment and the creation of a personalized prevention plan.

Workforce Provisions

- **National Health Care Workforce Commission:** The act establishes a 15-member national commission, appointed by the Government Accountability Office's Comptroller General, to report recommendations to Congress and the Administration on workforce goals, priorities, and policies. The commission is responsible for reviewing health care workforce and projected workforce need; coordinating among Federal agencies, as well as identifying barriers to improved coordination at all levels; commissioning evaluations of education and training activities; and encouraging innovation. The commission must submit an annual report to Congress and the Administration beginning in 2011. Congress will use this information when determining appropriations to discretionary programs or in restructuring other federal funding sources.
- **State Health Care Workforce Development Grants:** Competitive grants are created under HRSA for the purpose of fostering state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels. Grants will support innovative approaches to increase the number of skilled health care workers such as health care career pathways for young people and adults. The partnership must include a state workforce investment board, with representatives from other organizations, including a postsecondary institution. One-year planning grants of up to \$150,000, with a 15% match, and two-year implementation grants, with a 25% match and an additional third year for high-performing grantees, are authorized. \$8 million is authorized for FY

2010 and such sums as are necessary in subsequent years for the planning grants, whereas \$150 million is authorized for FY 2010 and such sums as are necessary in subsequent years for the implementation grants.

- **Health Care Workforce Assessment:** The act codifies the existing National Center for Health Care Workforce Analysis and establishes several regional centers for health workforce analysis to collect, analyze, and report data related to Title VII primary care workforce programs. The regional centers will coordinate with state and local agencies collecting labor and workforce statistical information and coordinate and provide analyses and reports on Title VII to the National Health Care Workforce Commission. It calls for the national center to maintain and publicize an Internet registry of grants awarded and a data base of information from longitudinal evaluations on performance measures. In addition, the act authorizes \$7.5 million for each of FY 2010 – FY 2014. It also authorizes grants to support state and regional centers for health workforce analysis at \$4.5 million for FY 2010 – FY 2014 and grants for longitudinal evaluations at such sums as are necessary for FY2010 – FY2014. The Advisory Committee on Training in Primary Care Medicine and Dentistry is extended to include: development and implementation of performance measures; publication of guidelines for longitudinal evaluations; and recommended appropriation levels. Similar changes are made to the Advisory Committee on Interdisciplinary, Community-Based Linkages and the Advisory Council on Graduate Medical Education.
- **Federally Supported Student Loan Funds:** To increase the appeal of the Primary Care Loan Program, the act eases current criteria for schools and students to qualify for loans as well as shortens the length of the primary care practice requirement. It also lowers the additional interest rate that students failing to comply with their loan agreements must pay from 18 percent to two percent.
- **Health Care Workforce Loan Repayment Programs:** The act establishes a loan repayment program for pediatric subspecialists and providers of mental and behavioral health services, including substance abuse prevention and treatment services, to children and adolescents who are working or will be working in a HPSA, Medically Underserved Area, or with a Medically Underserved Population. The program is authorized at \$30 million for FY 2010 – FY 2014 for pediatric medical and surgical specialists and \$20 million for FY 2010 – FY 2013 for child mental and behavioral health specialists.
- **Public Health Workforce Recruitment and Retention Program.** This provision offers loan repayment to public health students and workers in exchange for working at least 3 years at a federal, state, local, or tribal public health agency. This program is authorized at \$195 million for FY 2010 and such sums as are necessary in subsequent years for FY 2011 – FY 2015.
- **Title VII Reauthorization**
 - **Primary Care Training Programs:** The act reauthorizes Title VII programs, including training in family medicine, general internal medicine, general pediatrics, and physician assistantship. Funds are awarded to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve primary care academic units or programs that improve clinical teaching and research. Priority is given to programs that educate students in team-based approaches to care and innovative teaching models, such

as the patient-centered medical home. Provides five-year grants to a public or nonprofit private hospital, school of medicine or osteopathic medicine, an affiliated physician assistant program, or other public or private nonprofit entity. Funds could be used to operate a demonstration program that includes training, tools and curricula, and continuing education relevant to patient-centered medical homes. This section also authorizes joint degree programs to provide interdisciplinary and inter-professional graduate training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies, and injury control. This section is authorized at \$125 million for FY 2010 and such sums as necessary for FY 2011 – FY 2014. Fifteen percent of the appropriation is to be allocated to physician assistant training programs. However, the ratable reduction provision, which reduced the disciplines' statutory funding levels proportionately when the total appropriation was less than the sum of those statutory levels, is repealed by the act.

- **Centers of Excellence:** The Centers of Excellence program, which develops a minority applicant pool to enhance recruitment, training, academic performance and other supports for minorities interested in careers in health, is reauthorized at \$50 million for FY 2010 – FY2015 and such sums as are necessary in subsequent years.
- **Health Care Professionals Training for Diversity:** The act reauthorizes the *Faculty Loan Repayment Program* at \$5 million for FY 2010-2014, in which individuals from disadvantaged backgrounds, who agree to a specified term of service as members of the faculties of health professions schools -- including osteopathic medicine -- will have \$30,000 of the principal and interest of their educational loans forgiven. The *Scholarships for Disadvantaged Students Program* is reauthorized at \$51 million for FY 2010 and such sums as are necessary in subsequent years for FY 2011-2014. The *Educational Assistance in the Health Professions Regarding Individuals from a Disadvantaged Background Program* is reauthorized for \$60 million in FY 2010 and such sums as are necessary in subsequent years for FY 2011-2014.
- **Primary Care Extension Program:** The act creates a Primary Care Extension Program to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health. The Agency for Healthcare Research and Quality will award planning and program grants to state hubs including, at a minimum, the state health department, state-level entities administering Medicare and Medicaid, and at least one health professions school. These state hubs may also include Quality Improvement Organizations, Area Health Education Centers, and other quality and training organizations.
- **National Health Service Corps:** The act authorizes the following funding levels for the National Health Service Corps (NHSC) scholarship and loan repayment programs: FY 2010 -- \$320 million; FY 2011 – \$414 million; FY 2012 -- \$535 million; FY 2013 -- \$691 million; FY 2014 -- \$893 million; FY 2015 -- \$1.15 billion. Funding for FY 2016 and beyond is indexed.

Rural Health

- **Rural Practice Provisions:** Included in the reconciliation act are additional Medicare reimbursements in FY 2010 to physicians with practice costs that are lower than average and a \$400 million fund will be created for extra Medicare payments in FY 2011 and FY 2012 to hospitals in counties ranked in the lowest quartile of per capita Medicare spending
- **Geographic Variation:** The act creates a new “value-based payment modifier,” which will be separate from the geographic adjustment factors, and, starting in 2015, differential payments based on the quality and cost of care will be made.
- **Medicare Payment Advisory Commission Study on Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas:** The act requires the Medicare Payment Advisory Commission (MedPAC) to review payment adequacy for rural health care providers and provide a report to Congress by January 1, 2011. MedPAC shall analyze the rural payment adjustments outlined in this section, beneficiaries’ access to care in rural communities, adequacy of Medicare payments to rural providers, and quality of care.
- **Community Health Centers and National Health Service Corps Fund:** The fund is created to provide for sustained national investment in these programs for FY 2011 – FY 2015 and will be used to increase appropriations for these programs above the FY 2008 level.

Comparative Effectiveness Research

The act establishes a non-profit Patient-Centered Outcomes Research Institute, overseen by a Board of Governors, to identify research priorities and conduct research comparing the clinical effectiveness of medical treatments. Findings from the research conducted will not be construed as mandates, guidelines, or recommendations for payment, coverage or treatment, or used to deny coverage.