



ACP

AMERICAN COLLEGE OF PHYSICIANS
SERVICES, INCORPORATED
INTERNAL MEDICINE | *Doctors for Adults*

Preserving Patient Access to Primary Care Act (H.R. 7192) Background and Summary

Background

General internists are leaving practice sooner than other physician specialties at the same time that fewer medical students are choosing to make the practice of general internal medicine and primary care their central career goal. Approximately 21% of physicians who were board certified in the early 1990s have left internal medicine, compared to a 5% departure rate for internal medicine subspecialists. According to a new survey published on September 10, 2008 by the Journal of the American Medical Association, only two percent of fourth year medical students plan to work in internal medicine, compared to nine percent in 1990.

The number of third-year internal medicine residents choosing to pursue a career in an internal medicine subspecialty or other specialties has risen each year for the past eight years, while the percentage choosing careers in general internal medicine has steadily declined. In 2007, only 23% of third-year internal medicine residents intended to pursue careers in general internal medicine, down from 54% in 1998. Even more disheartening, only 14% of first-year internal medicine residents intend to pursue general internal medicine. For some students, internal medicine has become a less competitive “fall back” option rather than a true career choice.

Over 86% of graduating medical students have educational debt. Medical education debt was 4.5 times as high in 2003 as it was in 1984, far outpacing increases in the consumer price index. The average medical school graduate in 2007 carried a debt burden of approximately \$140,000. About 5% of all medical students will graduate with debt of \$200,000 or more. Students with large debts are much more likely to be influenced by debt in their career choices. Those students with debt in excess of \$150,000 are the least likely to select a primary care residency.

Practicing physicians and medical graduates today are facing challenges the likes of which we have not seen. Unfortunately, the physician payment system today places more value on the volume of services as opposed to prevention and coordination of care that can lead to better outcomes. For example, Medicare will pay \$30,000 on average under Medicare Part A for a limb amputation for a diabetic patient, but pay very little to primary care physicians for helping their diabetic patients avoid the medical complications that lead to amputations. Furthermore, Medicare payments—largely due to annual cuts triggered by the Sustainable Growth Rate (SGR) are consistently inadequate and unpredictable, which forces physicians to make difficult decisions about whether to lay off staff, reduce their Medicare patient population, defer spending investments on capital improvements like electronic medical records or health information technology, or opt for an early retirement. The constant barrage of daily regulations and documentation requirements coming from federal health agencies and private payers forces physicians to spend more time on red-tape which ultimately takes away from patient care and necessitates that primary care physicians work longer hours. Medical graduates have fewer incentives these days to choose primary care as a career because of excessive



American College of Physicians
Background and Summary
H.R. 7192

student debt, a lack of loan repayment and scholarship programs, an unfavorable medical liability system, and the lure of more lucrative medical specialties. When taken together, these numerous barriers wind up impacting the primary care physician workforce in such a way that access to these vital services is impeded.

Summary of H.R. 7192

Findings on the Importance of Primary Care

Findings: Statement by Congress on the importance of primary care in improving outcomes and reducing costs; recognition by Congress that primary care is facing an imminent shortage of physicians trained in general internal medicine, family medicine and pediatrics.

TITLE 1: Medical Education Incentives

Medical education grants to support primary care: Establishes grants to teaching institutions to improve primary care education and training for medical students. Requires grant funds to be used for: (1) the creation of primary care mentorship programs; (2) curriculum development for population based primary care models of care such as the patient centered medical home and (3) increased opportunities for ambulatory, community based training.

The bill also creates several different pathways for physicians who agree to practice in a primary care field to have their medical education expenses paid for or reduced through scholarships and repayment of debt linked to a service obligation and loan deferrals:

- **Scholarship for medical students who meet a service obligation in a *critical shortage health facility*:** A Critical Shortage Health Facility is defined as a public or private nonprofit health facility that does not serve a health professional shortage area, but has a critical shortage of physicians (as determined by the Secretary) in the field of family practice, general internal medicine and pediatrics. A critical shortage health facility could award up to \$30,000 per year in scholarships to medical students if they agree to complete a residency in the field of family practice, internal medicine, or pediatrics, and after completing the residency, to serve as a primary care physician at such facility in such field for a time period equal to the greater of one year for each school year for which the individual was provided a scholarship, for a minimum of two years of service.
- **Loan forgiveness for physicians who meet a primary care service obligation in a *critical shortage area*.** The federal government would agree to pay, for each year of primary care service in a critical shortage area, not more than \$35,000 of the principal and interest of the undergraduate or graduate educational loans of a physician if the physician agrees to serve as a primary care physician in the field of family practice, internal medicine, or pediatrics. A critical shortage area is an area that is not a health professional shortage area (as defined in this Act), but has a critical shortage of physicians in such field. The service requirement can be satisfied through employment in a solo or group practice, a clinic, a public or private nonprofit hospital, or any other appropriate health care entity.
- **Loan deferment:** Amends the Higher Education Act of 1965 to allow medical residents in family medicine, internal medicine, and pediatric training programs to defer education loan repayment throughout the graduate medical training period.



American College of Physicians
Background and Summary
H.R. 7192

International Medical Graduates: Expands and makes permanent the Conrad 30 J-1 Visa waiver program. Exempts from the annual H-1B (specialty occupation) visa cap an alien who has: been awarded a medical specialty certification in internal medicine, pediatrics or family medicine doctoral training and experience in the United States.

Title II: Medicaid-Related Provisions

Medicaid and SCHIP: Provides grants to states to incorporate the Patient Centered Medical Home (PCMH) into Medicaid and SCHIP and to implement all payer demonstration projects. The PCMH ensures that a practice has the infrastructure and capability to provide patient centered, physician-guided coordinated care. It is designed to provide participating patients with direct and on-going access to a primary or principal care physician who accepts responsibility for providing first contact, continuous and comprehensive care to the whole patient, in collaboration with teams of other health professionals as appropriate.

Promoting Children's Access to Covered Health Services: Creates a Medicaid and CHIP Payment and Access Commission (MACPAC) to review access policies and provide annual reports.

Title III: Medicare-Related Provisions

Medicare Payment Reforms: Improves payment systems under Medicare to support, sustain, and enhance the practice of primary care. Improvements include, among others:

- Changing the way that Medicare determines budget neutrality for physician services to consider the impact of primary care in achieving Medicare system-wide savings. For example, Medicare would be directed to consider the impact of care coordination by primary care physicians in achieving measurable reductions in avoidable hospital admissions for patients with chronic diseases
- Directing Medicare to pay for specific care coordination services billed on a fee-for-service basis that have been shown to improve outcomes for patients with chronic illnesses
- Directing Medicare to increase payments for services provided principally by primary care physicians through a separate modifier or bonus payments
- Requiring that Medicare transition to a new payment methodology for qualified PCMHs that will expand upon the current Medicare demonstration project in eight states by allowing qualified PCMH practices nationwide (not limited to those participating in the demonstration project) to receive monthly payment for care coordination to qualified beneficiaries
- Requiring HHS to study and report back to Congress on the process for determining relative values for the fee schedule to assure sufficient expertise and representation of primary care physicians

Assistance to practices in becoming PCMHs: Provides funding for Quality Improvement Organizations to assist small and mid-size practices in acquiring the capabilities needed to become a PCMH.

Preventative Care: The bill includes provisions to support preventative care.

- Eliminates time restriction for initial preventative physical exam
- Eliminates cost-sharing for preventative benefits under Medicare
- Requires HHS to study and subsequently report on facilitating the receipt of preventative health services under Medicare



American College of Physicians
Background and Summary
H.R. 7192

Other Provisions to Support Primary Care:

- HHS study and subsequent report on improving the ability of physicians to assist Medicare beneficiaries in obtaining needed prescriptions under Medicare Part D
- HHS study and subsequent report on improved patient care through increased caregiver and physician interaction
- Improved patient care through expanded support for limited English proficiency services
- Assess the ability of the Medicare program to engage in real-time claims adjudication for services provided

Title IV: Studies

Primary Care Studies: The bill mandates several studies on ways that the federal government can support primary care including:

- Evaluate the higher education-related indebtedness of medical school graduates in the United States at the time of graduation and the impact on specialty choice including the impact on primary care
- Evaluate minority representation in training and in practice in primary care specialties and issue recommendations for achieving a primary care workforce that is more representative of the U.S. population
- Designation of Primary Care as a Shortage Profession: Recent studies have shown that the number of primary care physicians is declining at an alarming rate. For example, only two percent of fourth year medical students plan to work in internal medicine, compared to nine percent in 1990, according to a September 2008 survey of the Journal of the American Medical Association. The Department of Labor shall study the criteria for designation of primary care physicians as shortage professions, including the statutory changes that would be necessary to make such a designation.

ACP anticipates that when the bill is re-introduced in the next Congress, provisions will be included to increase funding for Title VII: Health Professions as well as the National Health Service Corps (NHSC).

For more information on ACP's positions, please visit the Advocacy section on ACP Online, <http://www.acponline.org/advocacy>.