Healthcare Reform: An Overview of the Patient Protection and Affordable Care Act

After fourteen months of summits, roundtables, committee hearings, white papers, calls to action, floor debate, raucous town hall meetings and closed-door negotiations, on March 23, 2010, President Obama signed into law the most sweeping healthcare legislation since Medicare's creation in 1965 -- the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148). The bill passed both Houses of Congress without a single republican vote, and with 34 House democrats voting against the measure. Shortly thereafter, on March 30, the president signed the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) into law. This bill contained a number of modifications to the PPACA. Together, the combined new health law addresses a number of key areas of reform:

- Quality, affordable health care for all Americans
- Expanding the role of public programs
- Improving the quality and efficiency of health care
- Prevention of chronic disease and improving public health
- Health care workforce
- Transparency and program integrity
- Improving access to innovative medical therapies
- Community living assistance services and supports
- Revenue provisions

Quality, affordable health care for all Americans

The new health law expands health insurance coverage to an additional 32 million individuals (now covering roughly 95% of non-elderly, legal residents of the United States) through a shared responsibility approach. Systemic insurance market reform will eliminate discriminatory practices by health insurers such as pre-existing condition exclusions. Tax credits for individuals, families, and small businesses are provided to help ensure that insurance is affordable. Key provisions:

Health Insurance Market Reforms

- Bans coverage exclusions of pre-existing health condition
- Eliminates lifetime limits on benefits and places restrictions on annual limits on benefits
- Requires insurers that offer dependent coverage to allow children to be covered on their parents' insurance policy up to age 26
- Provides standards for medical loss ratios to ensure premiums pay for benefits
- Requires guaranteed issue and guaranteed renewability of coverage
- Requires health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health.
- Health insurance claims process will be standardized and streamlined.

Insurance Exchanges and CO-OPs

- Creates by 2014 state-based and state-administered health insurance exchanges (marketplaces) through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Prohibits health plans from discriminating against any health care provider acting within their state scope of practice law that wants to participate in the plan, but plans are not required to contract with any willing provider
- Requires health plans to implement a process for appealing coverage determinations and claims
- Requires health plans to publicly disclose information on claims payment policies, enrollment, denials, rating practices, out-of-network cost-sharing and enrollee rights
- Creates the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all states
- Authorizes the Office of Personnel Management to contract with private health insurers to offer at least two multi-state qualified health plans (at least one non-profit) to provide individual or small group coverage through state-based exchanges
- Create four benefit categories of plans (bronze, silver, gold, and platinum) plus a separate catastrophic plan (for individuals up to age 30) to be offered through the Exchange, and in the individual and small group markets.

Individual and Employer Mandates

- Requires most individuals to have minimum acceptable coverage or pay a tax penalty beginning in 2014; exemptions allowed for those who cannot afford coverage, religious objectors or if the individual has income below the tax filing threshold
- Requires employers with more than 50 full-time employees to provide health care coverage or pay a penalty
- Provides refundable, advanceable, and sliding-scale premium credits for individuals and families with modified gross incomes up to 400 percent of the federal poverty level
- Provides tax credits to small employers with 25 or fewer full-time employees and average annual wages of no more than $50,000 that purchase health insurance for their employees

Expanding the role of public programs

The new health law expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion. These bills provide enhanced federal support for the Childrens Health Insurance Program, simplify Medicaid and CHIP enrollment, improve Medicaid services, provide new options for long-term services and supports, improve coordination for dual-eligibles, and improve Medicaid quality for patients and providers. Key provisions:

- Expands Medicaid to all individuals under age 65 with incomes up to 133 percent of the federal poverty level
- Provides 100 percent federal funding to states for costs of newly eligible individuals for 2014-2016
- Increases payments for primary care services provided by primary care physicians (family medicine, general internal medicine or pediatric medicine) to 100 percent of the Medicare payment rates for 2013 and 2014; states will receive 100 percent federal funding for increased payment rates

- Maintains current structure of the Children's Health Insurance Program (CHIP), with a 23 percent increase in the match rate in 2015 through 2019
- Implements a number of quality improvement initiatives including the development of quality measures for Medicaid eligible adults, prohibits Medicaid payment for serves related to health care acquired condition, and establishes several Medicaid demonstration projects to study the use of bundled payments for hospital and physician services, global payments and pediatric accountable care organizations

Improving the quality and efficiency of health care

The new health law aims to improve the quality and efficiency of U.S. medical care services for everyone, and especially for those enrolled in Medicare and Medicaid. Payment for services will be linked to better quality outcomes and substantial investments are made improve the quality and delivery of care and support research to inform consumers about patient outcomes resulting from different approaches to treatment and care delivery. New patient care models will be tested and created. An Independent Payment Advisory Board (IPAB) will develop recommendations to reduce Medicare payments if costs continue to rise. Key provisions:

Linking Payment to Quality Outcomes in Medicare

- A value-based purchasing program for hospitals will launch in 2013 to link Medicare payments to quality performance on common, high-cost conditions, including cardiac and surgical care.
- The Physician Quality Reporting Initiative (PQRI) is extended through 2014, with incentives for physicians to report Medicare quality data. Participating physicians will receive a 1% bonus in 2011 and .5% bonus payments from 2012-14. Beginning in 2015 physician payments will be reduced if they do not successfully participate in the PQRI program. The penalty is 1.5% in 2015 and 2% in subsequent years. Physicians who participate in a qualified Maintenance of Certification Program may fulfill the PQRI requirements.
- Medicare's physician resource use feedback program is expanded to provide for development of individualized reports by 2012. Reports will compare the per capita utilization of physicians (or groups of physicians) to other physicians who see similar patients. Reports will be risk-adjusted and standardized to take into account local health care costs.
- Establishes a value-based payment modifier under the physician fee schedule, which will be implemented in a budget-neutral manner and will adjust Medicare physician payments based on the quality (measures that reflect health outcomes) and cost of the care they deliver. Quality and cost measures will be risk-adjusted and geographically standardized. The new payment system will be phased-in over a two-year period beginning in 2015.
- Starting in 2015, hospitals in the top 25th percentile of rates of hospital acquired conditions for certain high-cost and common conditions would be subject to a 1% payment cut under Medicare. The Secretary of HHS is required to submit a report to Congress by January 1, 2012 on the appropriateness of establishing a healthcare acquired condition policy related to other providers participating in Medicare, including, outpatient hospital departments, ambulatory surgical centers, and health clinics.

National Strategy to Improve Health Care Quality

- Requires the Secretary to establish and update annually a national strategy to improve the delivery of health care services, patient health outcomes, and population health. Establishes, not later than January 1, 2011, a Federal health care quality internet website.

- The President will convene an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.
- Authorizes $75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). New measures will assess, among other things, health outcomes and functional status of patients. HHS will publicly report on patient outcomes measures.
- Provides $20 million to support the endorsement and use of endorsed quality and efficiency measures by the HHS Secretary for use in Medicare, reporting performance information to the public, and in health care programs.
- Requires HHS to collect and aggregate data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance information. As amended by Section 10305, requires the Secretary of HHS to develop a plan for the collection and public reporting of quality measures.

Encouraging Development of New Patient Care Models

- Establishes within the CMS a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally. Examples of new models include:
  - global payments to groups of providers
  - accountable care organizations,
  - varying payments to physicians who order advanced diagnostic imaging services according to the physician's adherence to appropriateness criteria
  - establishing comprehensive payments to Healthcare Innovation Zones
- Establishes a Medicare shared savings program for accountable care organizations. ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others). ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.
- Establishes a national, voluntary pilot program on payment bundling to encourage hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models. The HHS Secretary is required to establish this program by January 1, 2013 for a period of five years. Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending. Finally, the Secretary of HHS has the authority to expand the payment bundling pilot if it is found to improve quality and reduce costs.
- Establishes a hospital readmissions reduction program whereby payments for hospitals would be reduced by 1% in 2013, 2% in 2014 and 3% in 2015 and beyond if hospitals do not meet readmission criteria.
- Extends through Sept. 2011 the gainsharing demonstration program to evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care. An additional $1.6 million is authorized for this program.
- It is estimated that Medicare will save $13 billion over 10 years from the implementation of new payment models.

Medicare Payment Changes

- The national average "floor" on Medicare's geographic payment adjustment (commonly known as the GPCI) for physician work expired at the end of 2009. The law re-establishes that floor in 2010. In 2010 and 2011, Medicare will also reduce the GPCI adjustment for physician practice expenses in rural and low-cost areas. And, beginning in 2011, the practice expense GPCI adjustment will be brought up to the national average for "frontier" states (Montana, North Dakota, South Dakota, Utah and Wyoming). These provisions will result in increased Medicare payments for physicians in 56 localities in 42 states, Puerto Rico and the Virgin Islands.
- The Secretary of HHS is directed to regularly review fee schedule rates to identify misvalued codes under the physician fee schedule. This review will focus on codes for which there has been the fastest growth; codes that have experienced substantial changes in practice expenses; codes for new technologies or services; multiple codes that are frequently billed in conjunction with furnishing a single treatment and codes which have not been subject to review since the implementation of the RBRVS including services that have experienced high growth rates. The Secretary would have enhanced authority to adjust fees schedule rates that are found to be misvalued or inaccurate.
- The equipment utilization factor for advanced imaging services will be increased from 50 to 75% in 2011. Excludes low-tech imaging such as ultrasound, x-rays and EKGs from this adjustment. Also adjusts the technical component discount on single session imaging studies on contiguous body parts from 25 percent to 50 percent. This provision is estimated to save $2.3 billion over 10 years.

Independent Payment Advisory Board

- Creates a 15-member Independent Payment Advisory Board (IPAB) tasked with presenting Congress with comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. All members of the Board are appointed by the President, with advice and consent of the Senate,
- Beginning in 2014, in years when Medicare costs are projected to be unsustainable, the Board's proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. Congress would be allowed to consider an alternative provision on a fast-track basis. The Board is required to make non-binding Medicare recommendations to Congress in years in which Medicare growth is below the targeted growth rate.
- Hospitals are exempt from cuts through 2019.
- The Board is required to make annual recommendations to the President, Congress, and private entities on actions they can take to improve quality and constrain the rate of cost growth in the private sector.

Health Care Quality Improvements

- Builds on the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (AHRQ) to support research, technical assistance and process implementation grants. Grants funded under this section will identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services.
- Provides funding to the Assistant Secretary for Preparedness and Response to support at least 4 multiyear contracts or competitive grants to support pilot projects that design, implement, and

evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma systems. Requires the HHS Secretary to support emergency medicine research, including pediatric emergency medical research.
- Reauthorizes and improves the trauma care program, providing grants administered by the HHS Secretary to States and trauma centers to strengthen the nation's trauma system. Grants are targeted to assist trauma care centers in underserved areas susceptible to funding and workforce shortages.

Prevention of chronic disease and improving public health

An extensive set of initiatives dedicated to health promotion and disease prevention are included in the new law. The new law would, among other things, authorizes a grant program for the operation and development of School-Based Health Clinics; provide coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services; and waive beneficiary coinsurance requirements for most preventive services, requiring Medicare to cover 100%percent of the costs. Additional funds for research in the area of public health services and systems are authorized.

Advancing Research and Treatment for Pain Care Management

- Authorizes an Institute of Medicine Conference on Pain Care to evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations.
- Authorizes the Pain Consortium at the National Institutes of Health to enhance and coordinate clinical research on pain causes and treatments.
- Establishes a grant program to improve health professionals' understanding and ability to assess and appropriately treat pain.

Health care workforce

To ensure a diverse and competent workforce, the new law will encourage innovations in health care workforce training, recruitment, and retention, and will establish a new workforce commission. Provisions will help to increase the supply of health care workers. These workers will be supported by a new workforce training and education infrastructure. Key provisions:

National Health Care Workforce Commission

- Establishes a 15 member National Health Care Workforce Commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources.
- The majority of the commission must be non-providers, and is required to include at least one representative of consumers and one of labor unions. Initial appointments must be made no later than September 30, 2010.
- Specific topics to be reviewed include:
  - current health care workforce supply and distribution

  - health care workforce education and training capacity, including the number of students who have completed education and training, the number of qualified faculty, the education and training infrastructure and the education and training demands
  - education loan and grant programs
  - implications of new and existing federal policies which affect the health care workforce including Medicare and Medicaid GME policies
- The Commission shall submit recommendations to the Congress, the Department of Labor and the Department of Health and Human Services about improving safety, health and worker protections in the workplace for the health care workforce.

Investment in Pediatric Health Care Workforce

- Establishes a pediatric specialty loan repayment program under which eligible individuals agree to be employed full-time for at least 2 years in providing pediatric specialty (including pediatric surgery) services.
- The federal government will make payments on the principal and interest of undergraduate, graduate or graduate medical education loans of not more than $35,000 a year for each year of service for no more than 3 years.
- Eligible individuals include pediatric surgical specialists who is entering or receiving training in an accredited pediatric surgical specialty residency or fellowship.

Expanding Access to Primary Care Services and General Surgery Services

Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years. This bonus is no longer budget-neutral (initially the provision would have offset half of the cost of the primary care and general surgery bonuses with reductions in all other physician services).

Medicare GME Changes

- Beginning July 1, 2011, directs the Secretary of HHS to redistribute residency positions that have been unfilled for the prior three cost reports and directs those slots for training of primary care physicians.
- Modifies IME and DGME rules counting resident time in outpatient settings and allows flexibility for jointly operated residency training programs so time spent by the resident in a non-hospital setting is counted toward DGME and IME if the hospital incurs the costs of the stipends and fringe benefits.
- Modifies rules for counting resident time for didactic and scholarly activities allowing hospitals to count this time toward IME and DGME costs.

Wakefield Emergency Medical Services for Children Program

- Reauthorizes the program to award grants to States and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment.

Transparency and program integrity

To ensure the integrity of federally health programs, this section of the law creates new requirements to provide information to the public on the health system and promotes a new set of requirements to combat fraud and abuse in public and private programs. Key provisions:

Prohibition on physician-owned hospitals

- Prohibits physician-owned hospitals that do not have a provider agreement prior to December 31, 2010, to participate in Medicare.
- Existing physician-owned hospitals may continue to participate in Medicare under certain requirements addressing conflict of interest, bona fide investments, and patient safety issues, and expansion limitations.
- Provides a limited exception to the growth restrictions for grandfathered physician owned hospitals that treat the highest percentage of Medicaid patients in their county (and are not the sole hospital in a county).
- This provision is estimated to save Medicare $500 million over 10 years.

Transparency reports and reporting of physician ownership or investment interests

- Requires drug, device, biological and medical supply manufacturers to report transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital. (Note: this provision does not apply to industry support of professional associations)
- Includes payments for consulting arrangements, honoraria, give, entertainment, food, travel, education, research, royalty or license, grants, etc.
- Duplicative State or local laws would be preempted by Federal law; however, Federal preemption would not occur for State or local laws that are beyond the scope of this section.

Disclosure requirements for in-office imaging services

Referring physicians who provide in-office ancillary imaging services must inform the patient in writing that the individual may obtain the specified service from a person other than the referring physician, a physician who is a member of the same group practice as the referring physician, or an individual who is directly supervised by the physician or by another physician in the group practice.

Comparative Effectiveness Research

- Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board (which includes 4 physicians, at least one of which must be a surgeon) appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research.
- Requires the Institute to ensure that subpopulations are appropriately accounted for in research designs.
- Prohibits any findings to be construed as mandates on practice guidelines or coverage decisions and contains patient safeguards to protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.
- Findings published by the Institute do not include practice guidelines, coverage, payment, or policy recommendations.
- Provides funding for the Institute (through the establishment of a new trust fund that is funded in part by the federal government and in part by fees imposed on health insurance plans) and authorizes and provides funding for the Agency for Health Research and Quality to disseminate research findings of the Institute, as well as other government-funded research, to train researchers in comparative research methods and to build data capacity for comparative effectiveness research.

Medicare, Medicaid, and CHIP Program Integrity Provisions

- Reduces waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs.
- Establishes a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities.
- Expands the recovery audit contractor (RAC) program to Medicaid, Medicare Advantage and Medicare's prescription drug benefit program.

Medical Liability Demonstration Program

Authorizes HHS to Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations. Preference will be given to states that have developed alternatives in consultation with relevant stakeholders and that have proposals that are likely to enhance patient safety by reducing medical errors and adverse events and are likely to improve access to liability insurance. Plaintiffs may opt out of the demonstration program at any time. Funding is authorized for five years beginning in fiscal year 2011.

Improving access to innovative medical therapies

The new law establishes a process under which FDA will license a biological product that is shown to be biosimilar or interchangeable with a licensed biological product, commonly referred to as a reference product. No approval of an application as either biosimilar or interchangeable is allowed until 12 years from the date on which the reference product is first approved. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS cannot make a determination that a second or subsequent biological product is interchangeable to that same reference product until one year after the first commercial marketing of the first interchangeable product.

Community living assistance services and supports (CLASS)

The law establishes a new, voluntary, self-funded long-term care insurance program, the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations. Under the law, HHS will develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides a cash benefit that is not less than an average of $50 per day. No taxpayer funds will be used to pay benefits under this provision.

Revenue provisions

A number of tax-related provisions are included:

- Excise tax on high cost employer-sponsored health coverage. Levies an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is above the threshold of $10,200 for single coverage and $27,500 for family coverage.

- Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.
- Increases the additional tax for HSA withdrawals prior to age 65 that are used for purposes other than qualified medical expenses from 10 percent to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses increases from 15 percent to 20 percent.
- Limits the amount of contributions to health flexible spending accounts to $2,500 per year beginning in 2013. The cap is indexed at CPI-U in subsequent years.
- Imposes an annual fee on the pharmaceutical manufacturing sector. The amount of the fee is $2.5 billion in 2011, $2.8 billion in years 2012-2013, $3.0 billion in 2014-2016, $4.0 billion in 2017, $4.1 billion in 2018 and $2.8 billion in 2019 and years thereafter. This non-deductible fee is allocated across the industry according to market share with a reduction in share for companies with annual sales of branded pharmaceuticals of less than $400 million.
- A new excise tax is imposed on the sale of medical devices by the manufacturer or importer equal to 2.3 percent of the sales price. The tax is deductible for federal income tax purposes. The excise tax does not apply to any sale of eyeglasses, contact lenses, hearing aids, or any medical device of a type generally purchased by the public at retail. In addition, sales for export and sales of devices for use in further manufacturing are exempt from the excise tax.
- Imposes an annual fee on the health insurance sector. The amount of the fee is $8.0 billion in 2014, $11.3 billion in years 2015-2016, $13.9 billion in 2017, and $14.3 billion in 2018. For years after 2018, the amount of the annual fee is the amount for the preceding year increased by the rate of premium growth for the preceding calendar year. This non-deductible fee is allocated across the industry according to market share and does not apply to companies whose net premiums written are $25 million or less. The fee also does not apply to any employer or governmental entity.
- Increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent.
- Limits the deductibility of executive compensation for insurance providers.
- Increases the Medicare payroll tax rate by 0.9 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married couples filing jointly). The revenues from this tax will be credited to the HI trust fund. This provision also expands the hospital insurance tax to include a 3.8 percent tax on income from interest, dividends, annuities, royalties and rents which are not derived in the ordinary course of trade or business, excluding active S corporation or partnership income, on taxpayers with income above $200,000 for singles ($250,000 for married filing jointly).
- Imposes a 10% tax on amounts paid for indoor tanning services.
- Creates a two year temporary tax credit subject to an overall cap of $1 billion to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.
- Excludes from gross income payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas.

Issues not Adequately Addressed in the Health Reform Law

Medicare Physician Payment Reform

The new health law failed to repeal Medicare's flawed sustainable growth rate (SGR) formula. While Congress continues to pass temporary measures to prevent payment cuts (22% in 2010 and

cumulative cuts of over 40% over the next several years), lawmakers have not yet taken action to permanently fix the payment system.

Medical Liability Reform

Despite findings by the Congressional Budget Office (CBO) that comprehensive medical liability reforms that include an effective cap on non-economic damages would save the federal government $54 billion over 10 years, Congress did not include proven medical liability reforms, based on California or Texas models, in the new health law.

Private Contracting

The new health law does not guarantee patients and physicians the right to privately contact without penalty. Under current Medicare law, physicians must opt-out of Medicare for 2 years in order to engage in private negotiations with Medicare patients for services provided.

Graduate Medical Education

The new health law does not remove or modify the current caps on federally funded residency slots.