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Summary This article provides an update on recent MedPAC meetings as well as an update on current legislation regarding graduate medical education. Also included are updates on the physician quality reporting initiative and funding for Title VII programs.

MedPAC September 2009 report

In preparation for the March 2010 report to Congress, Medicare Payment Advisory Commission (MedPAC) commissioners were given the latest projections of Medicare's long-term financial situation. Medicare's reserves are expected to be exhausted by 2017 and the government program will not be able to cover benefits.

MedPAC reviewed the factors causing the growth in health care spending such as technology, income, insurance, prices, changes in longevity and demographics, changes in health status, and organization of the health care delivery system. For example, 50% or more of the spending is attributed to technology. New imaging services can improve care or promote inappropriate use. Chronic conditions have increased and there is a higher rate of diagnosis and treatments. Defensive medicine is not considered a major driver in health care spending.

Medicare beneficiaries are facing a growing financial liability. Although 75% of beneficiaries will not pay a higher premium in 2010 because of the hold harmless provision, which limits how much can be taken out of Social Security, 25% of beneficiaries who are not protected will pay a higher premium to compensate for the cost of revenue lost from the hold harmless provision.

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MedPAC commissioners also discussed regional variation in Medicare spending and service use. Regional variation in Medicare spending is often confused with regional variation in service use. Spending can vary for several reasons including differences in regional prices and regional differences in patients' condition. However, MedPAC found that even after adjusting for prices, health status, and other factors, a substantial level of regional variation remains.

In addition, MedPAC conducted six physician focus groups on comparative effectiveness research (CER) during the summer. Comparative effectiveness initiatives are not well understood by practicing physicians. A minority of physicians are opposed to CE efforts. Those who oppose CE believe they receive enough information through sources such as journals and conferences, and they believe research would lead to mandatory guidelines from the government and private payers. They said personal experience was sufficient to make treatment decisions.

Although a majority of physicians supported more CE data, they expressed concerns about study designs, costs, effect on innovation, liability reform, study bias, and researchers' conflict of interest. Credible CER has to be transparent. Physicians from the focus groups suggested that the studies should be concise and easy to read; and results should be disseminated through personal digital assistants or specialty society e-mails. In addition, the focus groups suggested that studies should focus on high-priced, new technologies before they are widely diffused in practice. MedPAC member Ron Castellanos said, "We don't have good strategies in getting good information to the physician

level. With funding there could be better communication, not just to physicians, but to the general public."

MedPAC also conducted a study on the episodes that account for the largest share of Medicare spending and that grew the fastest over time. Of the 20 episodes that accounted for the greatest share of total Medicare spending, only two were acute conditions (closed fracture or dislocation and bacterial lung infections). The rest were chronic conditions. Of the 20 fastest growing clinical episode groups, two were acute conditions (spinal trauma and infection of the lower genitourinary system). The rest were chronic conditions. Half of the 20 episodes that accounted for the most total Medicare spending were also among the 20 fastest growing.

MedPAC reviews physician self-referral law

MedPAC is exploring options for modifying the in-office ancillary exception to the physician self-referral law. The physician self-referral law prohibits physicians from referring Medicare/Medicaid patients for designated health services (DHS) to a provider with which the physician has a financial relationship. However, physicians are allowed to provide most DHS in their offices, which include clinical lab tests, imaging, physical therapy, radiation therapy, and other services.

While the in-office ancillary exception has benefits such as access/convenience for the patients and obtaining faster test results, many concerns exist as well. For example, the exception could lead to higher overall volume; it is unclear whether additional services are appropriate or contribute to improved outcomes, and also the exception could skew clinical decision-making. Imaging services, outpatient therapy, radiation therapy, and tests are rapidly growing in volume.

Options for modifying the exception are to exclude all imaging services, exclude imaging services not generally performed on the same day as an office visit, and exclude practices from performing imaging unless they are paid on a capitated basis. These concepts could be applied to other in-office services. However, limiting the in-office exception could lead to access problems and fragmented care; many practices have invested in equipment, etc., to provide ancillary services and doctors could see the limitation as interfering with the practice of medicine. Other options include strengthening quality standards, improving payment accuracy, measuring and reporting physician resource use, bundling, and encouraging use of clinical guidelines.

Physician Quality Reporting Initiative (PQRI)

In its 2010 Medicare Physician Fee Schedule Proposed Rule, the Centers for Medicare and Medicaid Services (CMS) proposes to continue implementing quality improvement initiatives for physicians through PQRI. Among the proposals, CMS will implement provisions of Medicare Improvements for Patients and Providers Act that would enable group practices to qualify for a 2010 incentive payment based on a determination at the group practice level rather than at the individual level. CMS also is looking to limit the use of claims-based reporting in the future. The agency proposes to begin accepting quality data through electronic health records in 2010.

Graduate medical education

The Physician Workforce Enhancement Act of 2009 (H.R. 914) directs the Secretary of Health and Human Services to establish an interest-free loan program, whereby hospitals committed to starting new osteopathic or allopathic residency training programs in one of eight medical specialties or a combination of these specialties (family medicine, internal medicine, emergency medicine, obstetrics/gynecology, general surgery, pediatrics, preventive medicine, or mental health) could secure start-up funding to offset the initial costs of starting such programs. Hospitals are required to repay the amount in full over a defined period of time, thus reducing the long-term financial impact on the federal government.

The Resident Physician Shortage Reduction Act (H.R. 2251) seeks to increase the nation's physician training capacity by 15% over the next three years. The legislation places an emphasis on the establishment of new residency programs in primary care and general surgery. Finally, the bill promotes training in nonhospital settings by clarifying existing regulations and allowing residency positions to be allocated to hospitals that expand or create training opportunities in nonhospital settings such as Community Health Centers.

The Graduate Medical Education Advancement Act (H.R. 2301) provides reform to the graduate medical education (GME) system to ensure residency training programs have the needed resources to train our nation's next generation of physicians. The bill seeks to create new training opportunities in nonhospital settings as well as clarify existing regulations governing nonhospital training by permitting GME and indirect medical eduction (IME) reimbursement for educational activities that occur in the hospital as well as nonhospital clinical settings. Finally, H.R. 2301 also allows hospitals to count the time residents spend training and providing patient care in outpatient settings. Under existing law, hospitals often continue to incur the costs of the stipends and fringe benefits of the resident during this time, but are unable to recoup these costs through GME payments. Providing training opportunities in "real world" settings such as ambulatory care centers provides residents with exposure to primary care specialties and increases the likelihood that residents will choose to practice in these settings.

The Preserving Access to Primary Care Act (H.R. 2350) would provide a critical boost to the primary care physician workforce through innovative changes to the Medicare payment structure and GME system, among other reforms. This bill emphasizes improving primary care through alternative payment mechanisms, expands the Patient-Centered Medical Home (PCMH), and strengthens the current GME system in the United States by increasing the number of residency training programs in primary care programs and eliminating barriers to training physicians in nonhospital, community-based settings by reforming direct GME and IME reimbursements. In addition, this bill addresses the burden of the educational debt carried by many young physicians by providing scholarships and loan forgiveness for primary care physicians who agree to practice in underserved areas would address geographic disparities in access to care and allow medical school graduates to pursue training opportunities in medical specialties based on their individual career interests and talents rather than their financial obligations.

Title VII funding

The American Recovery and Reinvestment Act of 2009 directs $200 million to Health Resources and Services Administration for all the disciplines trained through the primary care medicine and dentistry programs, the public health and preventive medicine programs, the scholarship and loan repayment programs authorized in Title VII (Health Professions) and Title VIII (Nurse Training) of the PHS Act, and grants to training programs for equipment. Funds may also be used to foster cross-state licensing agreements for health care specialists.

President Obama signed the FY 2009 Omnibus Appropriations bill on March 11, 2009. The bill boosts funding for Title VII to $222 million, a $28 million (14.3%) increase over FY 2008.

On May 7, 2006, President Obama's detailed budget[1] request was released. The budget includes $265 million for Title VII (19.4% increase). This includes $101 million (16.1% increase) for Title VII diversity programs and a 16.5% increase for primary care.

The House Labor-HHS Subcommittee approved their FY 2010 Appropriations bill. The bill includes $266 million for Title VII (a $45 million, 20.1% increase over FY 2010). Similar action has not been taken in the Senate.

To coordinate efforts surrounding Title VII funding, the American College of Osteopathic Family Physicians is actively involved with the Health Professions and Nursing Education Coalition (HPNEC). HPNEC is an informal alliance of more than 70 organizations[2] representing a variety of schools, programs, health professionals, and students dedicated to educating professional health personnel. Together, the members of HPNEC advocate for adequate and continued support for the health professions and nursing education programs authorized under Titles VII and VIII of the Public Health Service Act. The members of the Coalition believe these programs are essential to the development and training of tomorrow's health professionals and are critical to providing continued health services to underserved and minority communities. The FY 2010 HPNEC brochure[3] is available online.

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