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Stand for Quality report

Stand for Quality, a coalition of more than 165 organizations from across the health care spectrum, released a framework to the Administration and Congress on improving quality and affordability of health care. The framework makes six recommendations:

1. Set national priorities and provide coordination for quality improvement
2. Endorse and maintain nationally standardized measures
3. Develop measures to fill gaps in priority areas
4. Ensure that providers and other stakeholders have a role in developing policies on use of measures
5. Collect, analyze, and make performance information available and actionable
6. Support a sustainable infrastructure for quality improvement

The complete report and list of supporting organizations can be found at http://standforquality.org.

Ways and Means holds hearing on MedPAC report

On March 17, 2009, the House Ways and Means Health Subcommittee held a hearing on "MedPAC's Annual March Report to the Congress on Medicare Payment Policy," featuring Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC).

Hackbarth summarized MedPAC's recommendations and stressed the need to boost the primary care workforce by adjusting the relative value unit (RVU) calculations for primary care procedures and redistributing payments across physician specialties more equitably. In addition, Hackbarth addressed workforce shortages by recommending the elimination of fee-for-service payments and a move toward bundling and bonus payments for coordinated care through the medical home.

Chairman Pete Stark (D-CA) expressed support for the development of a public health insurance program similar to Medicare that would increase options and coverage for the public while competing with private plans. He argued that no mechanisms allow government to push the private sector into adopting more cost-effective, high-quality systems. Ranking member Wally Herger (R-CA) disagreed, noting dysfunctions within the Medicare and Medicaid systems and focused instead on cost control—mentioning overpayments for hospice care, home health services, skilled nursing facilities, indirect medical education, and advanced imaging. Herger maintained that Medicare has consistently underpaid providers and hospitals, forcing private payers to compensate for lost revenues.

House continues health care reform hearings

On March 24, 2009, the House Energy and Commerce Health Subcommittee held a hearing on "Improving Access to Care." The hearing was the third in a series of health care hearings entitled, "Making Health Care Work for American Families." Members of the subcommittee took this chance to examine racial, ethnic, and geographic disparities in access to health care, and the role the health care workforce plays in addressing these disparities. Particular emphasis was placed on the primary care and nursing workforce shortages. Members also discussed the role of Medicare and Medicaid in addressing those shortages.

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In opening remarks, Chairman Frank Pallone (D-NJ) stated that in addition to providing universal coverage for all Americans, Congress must work to eliminate disparities in the health care system, ensure the future of the health care workforce, and make prevention a national priority. In addition, Pallone stated that existing programs, including Medicare, Medicaid, Title VII, and the National Health Service Corps, should be strengthened and new avenues to reduce disparities and expand the workforce be explored. Seconding the statement, Rep. Henry Waxman (D-CA), Chairman of the full House Energy and Commerce committee added that legislation must ". . . address the barriers to access that insurance coverage by itself can't fix."

House Small Business Committee hearing on FY2010 budget

On March 18, 2009, the House Small Business Committee held a hearing examining President Obama's proposed FY2010 budget. Specifically, Chairwoman Nydia Velazquez (D-NY) asked witnesses to address the issue of how small physician practices would be impacted by cuts to the Medicare payment system. The proposed budget resets the baseline for the physician payment system, effectively eliminating the scheduled 21% cut scheduled to go into effect on January 1, 2010.

Witnesses included several representatives of provider organizations, including the American Medical Association, American College of Physicians, and American College of Surgeons, who expressed support for this provision of the Obama budget. Members also posed questions related to the shortage of primary care physicians and the challenges of implementing health information technology systems.

Chairwoman Velazquez, Ranking Member Sam Graves (R-MO), and numerous other members of the Committee articulated their own concerns about the payment system and the need to address the physician workforce shortage, at least in part, through the budget process.

Rep. Joe Barton (R-TX), Ranking Member of the full House Energy and Commerce Committee, noted that expanding physician-owned hospitals is a way to increase access to care for patients, given their consistency in demonstrating high-quality care and high patient satisfaction. Rep. Nathan Deal (R-GA), Subcommittee Ranking Member, stressed that any large-scale health care reform package should include "significant medical liability reform provisions," a belief echoed by other Republicans on the Subcommittee.

MedPAC discussion of GME and health care delivery reform

During its March 12-13, 2009 meeting, MedPAC began examining whether the nation's graduate medical education (GME) system will support health care delivery reform. After a background presentation on current GME structure, functions, and policies, discussion focused on whether present curricula provide residents with the skills necessary to practice 21st century medicine and whether current regulations and Centers for Medicare & Medicaid Servcies (CMS) policies create disincentives for training residents in ambulatory (nonhospital) settings.

Background data

In 2007–2008, the most recent year in which data were available:

- More than 150 medical schools and colleges of osteopathic medicine were training almost 86,000 medical students, including approximately 21,600 first-year students. Additional schools are in the pipeline and existing schools are increasing class sizes.
- More than 1,100 hospitals received Medicare payment for training medical residents and fellows. These hospitals received approximately $2.9 billion in direct graduate medical education payments and approximately $6.0 billion in indirect medical education (IME) payments. MedPAC staff continue to maintain that the current 5.5% IME adjustment results in payments that are twice the empirical costs of teaching hospitals compared with nonteaching institutions.
- More than 9,000 American Osteopathic Association and/or Accreditation Council for Graduate Medical Education residency programs trained more than 110,000 residents and fellows.

GME and delivery system reform

To focus care on the beneficiary, improve quality, and control Medicare spending, MedPAC has recommended or examined a variety of delivery system reforms. These reforms include a medical home pilot, creating disincentives for hospital readmissions, bundled payments, linking payment to quality, comparative effectiveness research, and measuring physicians' resource use. Changes in medical education curricula may be needed to support these reforms and better equip students and residents with the skills they need to deliver care in a reformed delivery system.

According to a recent Rand study in selected internal medicine programs, curricular improvements may be needed particularly in the following areas: quality measurement and practice improvement; care coordination and multidisciplinary teamwork, particularly in outpatient settings; cost awareness; patient safety; interpersonal communication, both with other health professionals and with patients; electronic medical records and other health IT functions, including computer physician order entry; and the time resident physicians spend in patient care in nonhospital settings and with patients in managed care. Although the study found that most programs provide at least some training in these areas, overall, the cur-

ricula were found to fall far short of recommendations by the Institute of Medicine and other experts.

Nonhospital training

During the presentation, MedPAC staff identified a number of barriers to ambulatory training, including patient care duties and on-call coverage in acute care settings; loss of GME payment for resident time spent in educational activities; complicated CMS rules for calculating "all or substantially all" of the costs of training in nonhospital settings; rigid nonhospital agreement requirements; and the paperwork burdens of scheduling and tracking residents training in multiple ambulatory settings. Several Commissioners expressed interest in further examination of ways to eliminate these and other disincentives to training residents in nonhospital venues.

MedPAC discussions on accountable care organizations

In April, MedPAC held a meeting to discuss accountable care organizations (ACOs), an idea originally proposed by Elliott Fisher of Dartmouth Medical School as a mechanism to control health care costs and improve quality.

An ACO is a group of providers that would be held responsible for the quality and cost of health care for a population of Medicare beneficiaries. According to MedPAC, ACOs would have a financial incentive to reduce the growth rate in Medicare spending. ACOs could help control volume growth by tying bonuses and penalties to overall Medicare spending.

MedPAC commissioners debated the complexities of whether ACOs should be voluntary or mandatory, what entities would be designated as ACOs, how to keep beneficiaries in ACOs, whether ACOs would work in rural areas, how to share the bonuses, and the size of the incentives to make ACOs effective.

According to MedPAC, ACOs need to be large enough so that changes in quality and resource use could be measured with some confidence (at least 5,000 patients). The problem is ACO incentives for individuals to restrain volume may be too small to overcome fee-for-service incentives. ACOs could be a vehicle to push providers to take bundled payments.

MedPAC commissioners acknowledged the difficulties involved in changing the structure of health care delivery and how it is paid. Such changes will take a long time.

Department of Health and Human Services announces appointment

The U.S. Department of Health and Human Services has announced appointments for Health Information Technology National Coordinator and for the Federal Coordinating Council for Comparative Effectiveness Research.

David Blumenthal, M.D., M.P.P. is the Obama Administration's choice for National Coordinator for Health Information Technology. As the National Coordinator, Dr. Blumenthal will lead the implementation of a nationwide health information technology infrastructure as called for in the American Recovery and Reinvestment Act.

Dr. Blumenthal most recently served as a physician and director of the Institute for Health Policy at The Massachusetts General Hospital/Partners HealthCare System in Boston, Massachusetts. He was Samuel O. Thier Professor of Medicine and Professor of Health Care Policy at Harvard Medical School. He also served as director of the Harvard University Interfaculty Program for Health Systems Improvement. Before that appointment, he was Senior Vice President at Boston's Brigham and Women's Hospital and served as Executive Director of the Center for Health Policy and Management.