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Summary Earlier this year, ACOFP President Jan Zieren, DO, MPH, FACOFP dist., wrote to the US Congress expressing support for three pieces of legislation. The article also offers an update on MedPAC.

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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 to clarify existing regulations governing nonhospital training by permitting GME and indirect medical education (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 graduate medical education 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. This 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.

Update on MedPAC

Accountable care organizations (ACOs), originally proposed by Elliott Fisher of Dartmouth Medical School as a mechanism to control health care costs and improve quality, were among the topics discussed by MedPAC in March 2009.

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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 (in at least 5000 patients). The problem is that ACO incentives for individuals to restrain volume may be too small to overcome the 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. "How do we alter the program so there is reward for organizations that do things right? How do we help them out?" asked Chairman Hackbarth.

Other topics discussed by MedPAC

Physician resource use measurement

MedPAC commissioners discussed policy principles to guide the Medicare Improvements for Patients and Providers Act (MIPPA)–mandated physician resource use measurement program being developed by the Centers for Medicare and Medicaid Services. Among the principles for the measurement program: transparent, actionable (feedback must provide detailed information), uses multiple sources, opportunity for physician input, and outreach and education (Medicare must explain feedback to physicians). Commissioners supported the principles, noting the program should be kept simple. Although the tools are not perfect, they are sufficient to provide information for comparisons. One commissioner said it is important to shape physicians' understanding of their own practices and how they compare with their peers.

They also discussed options for releasing or aggregating Medicare data to support other organizations' physician measurement efforts. Commissioners looked at two options: (1) release Medicare claims data with appropriate beneficiary privacy protection to entities, or (2) create a claims data clearinghouse. Commissioners leaned toward creating a clearinghouse to which entities send their claims and are merged with Medicare claims. The claims are grouped into episodes using Medicare's methodology. Entities receive results or the results plus Medicare claims data.

Improving Medicare's chronic care demonstration programs

MIPPA directs MedPAC to conduct a study on the feasibility and advisability of establishing a Medicare Chronic Care Practice Research Network (MCCPRN). The commission must take into account prior and existing care coordination and disease management demonstrations and pilots. The report to Congress was due by June 15, 2009. CMS pilots and demonstrations have had mixed results, with little evidence of cost neutrality or savings and scattered evidence of success in improving process, satisfaction, and outcomes.

The Medicare Coordinated Care Demonstration has neither reduced net Medicare costs nor had positive effects on patient adherence measures. Final evaluation is expected in 2010 or 2011. Under the Medicare Health Support pilot, the cumulative fees paid far exceeded savings produced and there have been no statistically significant effects on hospital admission/readmission rates or emergency department visits. CMS extended the Care Management for High-Cost Beneficiaries Demonstration and the Physician Group Practice demonstration.

Commissioners expressed frustrations about the lack of effect by the demonstrations and that those participating did not receive timely feedback. Commissioners were not convinced that establishing MCCPRN would be the right step to take.

Follow-on biologics

Follow-on biologics (FOB), or a generic version of biologics, is a new topic for MedPAC. Spending on high-priced biologics totaled more than $40 billion in 2007. According to MedPAC, Medicare pays for biologics under Parts B and D. Under Part B, biologics account for $7 billion (43%) of drug spending in 2007. Follow-on biologics offer a potential savings, but Medicare cannot achieve savings because of the lack of a regulatory pathway for follow-on biologics. MedPAC commissioners acknowledged that they needed more information on FOBs before delving into recommendations. Mark Miller, MedPAC's Executive Director, noted that there are broader payment strategies that could play a role in biologics. Chairman Hackbarth questioned where MedPAC enters into this issue; how Medicare would pay for biologics and more broadly new technology; and whether it is a good case to address new technology?

MedPAC commissioner Michael Chernew, PhD, of Harvard Medical School said payment for new technology is beyond the scope of FOBs. Commissioner Ron Castellanos said "we need the science" before talking about the reimbursement policy. Commissioners also said Congress should consider expanding the authority of the FDA to deal with the new complexity of issues.