

MedPAC Recommends Changes in Doctor Training

In its latest annual report to Congress, the Medicare Payment Advisory Commission (MedPAC) included recommendations to change the way Medicare pays for doctors' graduate medical education (GME). If Congress accepts the recommendations – as it did MedPAC's earlier recommendations that ultimately had a large impact on the health care reform law, i.e., cut Medicare spending and help pay for coverage of the uninsured – the system for training doctors could undergo a significant change.

At a June 15 briefing marking the release of the report, MedPAC Executive Director Mark Miller said, "The current graduate medical education system produces superb physicians." He added, however, that commissioners are concerned about the system's structure, i.e., whether current methods of training are able to produce a mix of medical professionals that will lead change in health care delivery from a focus on fee-for-service medicine to focusing on quality of care, better coordinated care, and restraining costs. "We found that curriculums we looked at in residency programs didn't focus on things like working in multi-disciplinary teams, didn't use quality metrics . . . didn't focus on the use of IT – those types of skill sets," Miller explained. He added that the training systems "tended to be highly focused on inpatient care and less on out-of-hospital types of care."

Noting that Medicare spends \$9 billion annually on financing GME, Miller said, "Our recommendation is to take \$3.5 billion of that . . . and make it performance-based funding." The money would go to programs that emphasize team-based care, compliance with quality-based performance measures, better coordinated care, and treatment outside of hospitals in primary care clinics and in nursing homes, for example. MedPAC's recommendations also call for research on: workforce needs in a better organized and more efficient system; how medical education should foster diversity in terms of seeking students from different races, income levels, and geographic areas; and specific approaches that work best to bring health care professionals to medically underserved communities. In addition, to achieve a greater understanding (Cont'd page 3)

Medicare Physician Payment Cuts Delayed

In an unexpected turn of events, the House on June 24 cleared a six-month extension in increased Medicare payment rates for physicians, less than a week after the Democratic leadership declared the Senate-passed measure dead on arrival in the House.

The 417-1 vote to pass the measure came after House Speaker Nancy Pelosi told reporters earlier that day that her frustration with Senate inaction on a broader package extending expired middle class tax cuts and jobless benefits had prompted her to try to move the six-month extension that the Senate passed June 18, even though she considered that measure "totally inadequate" and "poorly written."

President Obama signed the bill into law on June 25.

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HHS Awards Grants to Test Medical Malpractice System Alternatives

On June 11, the Department of Health and Human Services (HHS) announced that it had awarded more than \$23 million for demonstration projects and planning grants to develop alternatives to the current medical malpractice legal system. In response to calls for caps on malpractice awards and concerns that the current system leaves doctors too vulnerable to costly litigation, President Obama first proposed the *Patient Safety and Medical Liability Initiative* in a speech to a joint session of Congress in September 2009.

The initiative is being run by HHS's Agency for Healthcare Research and Quality (AHRQ). Carolyn Clancy, AHRQ Director, described the initiative as "... a path-making moment where we're going to get information we need to try and change a system that is broken for both patients and doctors." She added that AHRQ would conduct "a very robust evaluation" of the projects, which will include a focus on getting new medical malpractice systems enacted into law at the state level.

To date, \$19.7 million in three-year demonstration project grants has been distributed for seven proposals to reduce preventable harm to patients, to inform injured patients promptly of medical mistakes, for efforts to provide prompt compensation, and for settling malpractice disputes via a court-directed alternative dispute model. Another \$3.5 million will be awarded for 13 one-year planning grants that meet several goals of the initiative, including preventing medical injuries. They include supporting safe harbor for physicians who can prove they followed state-endorsed evidence-based care guidelines in patient treatment, and promoting transparency and enhanced communication between providers and patients when avoidable injuries occur.

The grants were awarded based on the recommendations of a 20-member advisory committee that included a former American Medical Association (AMA) board member, trial lawyer representatives, and citizen advocacy groups. In a June 11 statement, AMA said it supports the initiative and would work with state medical societies to implement the proposals.

For details on the demonstration projects, go to <http://www.ahrq.gov/qual/liability/demogrants.htm>.

For information on the planning grants, go to <http://www.ahrq.gov/qual/liability/planninggrants.htm>.

AHRQ Reports on Readmission and ED Use Rates

According to the latest *News and Numbers* report from the Agency for Healthcare Research and Quality (AHRQ), about four in 10 patients who sought acute care between 2006 and 2007 made multiple visits to the hospital either for an inpatient stay or for an ED visit. "Most admission studies only report information on patients who have multiple hospital inpatient stays," the report says. "They exclude patients who sought care in the ED." By including ED use, the researchers discovered that the rate of multiple visits was increased by more than one-third, from an average of 1.5 to 2.1 acute care hospital visits per patient.

AHRQ analyzed data on 15 million patients in 12 states – Arizona, California, Florida, Hawaii, Massachusetts,

Missouri, Nebraska, New Hampshire, New York, South Carolina, Tennessee, and Utah – and found that more than a third (35.1%) of those with coronary atherosclerosis were readmitted at least once to the hospital. Multiple readmissions were also found for 30.3% of patients with uncomplicated diabetes, 28.2% with high blood pressure, and 20.8% with asthma.

Looking at the same patients, 21.5% of those with coronary atherosclerosis, 23.4% of those with hypertension, 23.6% of those with asthma, and 27.9% of those with simple diabetes had multiple visits to the ED, with an average number of trips ranging between 1.4 and 1.6. (Cont'd page 4)

CDC Reports Alarming Increase in Abuse of Prescription Drugs

A study by the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMSHA) published in CDC's latest weekly report on death and disease reveals a steep increase in ED visits by people abusing prescription pain drugs such as OxyContin, Vicodin, and Dilaudid. Between 2004 and 2008 the abuse of such opioid medications increased more than 111% overall, and 29% during 2007-2008 alone. The increase in ED visits occurred among both men and women and was seen across the age spectrum, including teens and young adults, the researchers found.

According to the report, the estimated number of ED visits for the non-medical use of opioid painkillers rose from more than 144,600 in 2004 to almost 306,000 in 2008. ED visits due to misuse of oxycodone rose 152% between 2004 and 2008. For products containing hydrocodone, ED visits rose 123% to more than 89,000; and for the heroin-substitute methadone, ED visits rose 73% to close to 64,000. For one drug, hydromorphone, ED room visits for misuse soared by 259% over the four years of the study.

"This is a significant public health concern," said Peter Delaney, Director of the Office of Applied Studies at SAMSHA. He added, "We have a lot of data now that people are misusing prescription drugs and the rate is growing." Much of the problem is the result of the increased availability of these medications, he explained. As for how to stem the abuse of these drugs, Delaney believes doctors must discuss the proper use of these painkillers with their patients. Pharmacists are also key educators and can tell patients how to dispose of the unused portion of a prescription, he said.

David Katz, director of the Prevention Research Center at Yale University School of Medicine, said that "more attention should be directed to the hazards of prescription and over-the-counter drugs, so that their hazards are as well and widely known, and as respected by parents and children alike, as those of illicit drugs." He added, "However, we should be careful that in our efforts to keep prescription drugs out of the wrong hands, we don't withhold them from those in true need. Both narcotic abuse and inadequate treatment of chronic pain are important problems, and we should not fix one by compounding the other."

The problem of drug misuse also takes its toll on children. Earlier this month a CDC report found that one in five high school students in the United States has taken a prescription medication that was not prescribed for them. Also, last August the CDC reported that the leading cause of accidental poisonings among American children can be found in the family medicine cabinet. And, according to this latest report, each year in the United States, more than 71,000 children aged 18 and younger are seen in EDs for unintentional overdoses of prescription and over-the-counter drugs.

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of how individual institutions spend their GME dollars and determine how much funding is needed to support high quality education, MedPAC urges HHS to "annually publish a report that shows Medicare medical education payments received by each hospital and each hospital's associated costs."

Finally, with the goal of making Medicare a more innovative purchaser of health care, MedPAC is exploring the idea of "reference pricing," a payment system in which a new item or service is paid at the same rate as an existing item that has comparable clinical benefit. In such a system, Medicare would not pay any higher rates for a more expensive product that had the same clinical benefit as a less costly product.

AHRQ Reports on Readmission and ED Use Rates (Cont'd from page 2)

The database also sorted patients by payer source. Medicare beneficiaries had the highest rate of readmissions as inpatients, but Medicaid beneficiaries had the highest number of ED visits. Among Medicare patients, 42% experienced multiple hospital admissions and 38% multiple ED visits. For Medicaid patients, 23% experienced multiple hospital admissions and 50% went to the ED more than once. As for uninsured patients, 22% had multiple hospital readmissions and 38% had multiple ED visits but were not admitted. Privately insured patients were the least likely to require multiple hospital readmissions (19%) or make multiple visits to the ED (29%). The data revealed that patients living in the poorest communities had similar readmission rates compared to those living in the wealthiest communities, about 1.5 stays per patient.

The AHRQ report is one of numerous studies underway to determine the extent to which patients are treated and discharged, but then are readmitted for care for the same illness. This situation not only strains healthcare resources, but in many cases may be avoided with closer care and monitoring after the patient goes home. “Devising effective strategies to reduce the rate of multiple acute care hospital visits by the same person requires a thorough understanding of the factors that contribute to repeat visits,” the report says.

Analysis of Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed comprehensive health reform – the *Patient Protection and Affordable Care Act* (P.L. 111-148) – into law. An analysis of the law focusing on those provisions of interest to AAEM and its members can be found at http://www.aaem.org/UserFiles/file/analysis_ppaca%281%29.pdf.

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