AOA Shelves Student Plan for Combined Match

Association gives controversial combined match proposal a stay for 1 more year.

BY BRUCE DIXON
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CHICAGO — The American Osteopathic Association's House of Delegates at its annual meeting agreed to keep a controversial combined osteopathic/allopathic resident match proposal on life support for 1 more year, following lengthy testimony on the concept of combining the organization's Intern/Resident Registration Program with the National Resident Matching Program.

The original resolution on a combined match, presented by the Bureau of Osteopathic Education and the AOA Council on Postdoctoral Training, called for keeping the status quo—that is, two separate matches.

The resolution was amended in deference to the position of the two largest osteopathic student organizations, the Council of Osteopathic Student Government Presidents and the Student Osteopathic Medical Association (SOMA), which back further exploration of the issue.

As passed, the resolution resolves "that the AOA, in cooperation with the American Association of Colleges of Osteopathic Medicine, conduct a thorough analysis and evaluation of the benefits, detriments, and outcomes for the profession with respect to continuing a separate match vs. adoption of a single joint match and report the findings back to the AOA House of Delegates in 2006."

Half of graduating osteopathic medical students participate in the Intern/Resident Registration Program, which announces its results 1 month before the allopathic National Resident Matching Program (NRMP). Most of the remaining students apply through the NRMP to programs accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Many students apparently favor a joint match, believing the opportunity to rank osteopathic and allopathic programs simultaneously would give them additional program options without the need to choose one match or the other.

In reference committee, Karen J. Nichols, D.O., AOA board member and trustee, and dean of the Chicago College of Osteopathic Medicine, said a combined match would undermine the profession's "equal but separate" status, a view generally held by the AOA leadership. The existing match system provides students adequate opportunity to attain advanced placement into programs and training positions accredited by both AOA and ACGME, as well as to link from traditional internships into accredited residencies, she said.

A combined match would undermine the osteopathic profession's 'equal but separate' status.

DR. NICHOLS

"If there are 10,000 MD graduates every year and 2,000 DO graduates every year, and you put them together, who do you think is going to be running the program? The bigger group," Dr. Nichols said.

She presented results of two surveys conducted this year: an AOA survey of 2,800 graduating doctors of osteopathy and her own survey of 300 students at her institution and the Arizona College of Osteopathic Medicine, conducted 1 month after completion of both match programs. In the larger survey, 70% said they favored a combined match. Furthermore, 75% responded that they had matched into their first-choice program, and 90% reported matching into their first- or second-choice program.

Results of the AOA survey suggested that students who listed allopathic residencies as their first choice were most likely to add AOA positions if a combined match was offered. "If the student's first choice was an osteopathic residency, that was no problem," said Dr. Nichols. "The group we were trying to tease out were those who listed allopathic first and osteopathic second. We chose this group because we had such a high percentage of students successfully matching in their first or second choice, and this is really the only group that would have been able to add more students to osteopathic programs," said Dr. Nichols.

Student leaders were unconvinced that a combined match would be a good idea. SOMA President Marty Knott said his organization believes "we don't know enough about the potential impact of a combined match."

SOMA trustee and AOA alternate delegate Sean N. Martin, with the Virginia College of Osteopathic Medicine, told this newspaper that the major determinants of students' residency choices are location and quality.

If students "want to remain near their families or want to live in a particular area, they should be able to do that. If we can just take all the energy that we're using on the pros and cons of a joint match and rechannel that to come up with creative ways to increase the number of residency programs or dually accredited residency programs, I think that would be . . . in the best interests of the profession," he said. ■

Congress Floats Plan to Fix Medicare Physician Fee Schedule

BY JENNIFER SILVERMAN
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Any legislative approach to fixing Medicare's sustainable growth rate system "would be prohibitively expensive," according to House Ways and Means Chair Bill Thomas (R-Calif.).

Attaining a permanent fix is possible, however, provided that Congress and the Bush administration work on efforts to combine administrative and legislative actions, Rep. Thomas and Nancy L. Johnson (R-Conn.), health subcommittee chair, wrote in a letter to Mark McClellan, M.D., administrator of the Centers for Medicare and Medicaid Services.

The plan is one of several in Congress that seek to fix the Medicare physician fee schedule, as physicians face a looming 4.3% cut to their reimbursement in 2006. CMS actuaries project negative payment updates of minus 5% annually for 7 years, beginning in 2006, if the flawed sustainable growth rate (SGR) is not corrected.

CMS could do its part by removing prescription drug expenditures from the baseline of the SGR, something it should have the authority to do, the letter suggested. Because drugs aren't reimbursed under the fee schedule, it's illogical to include them in the expenditure total when calculating the schedule's update.

The agency should also account for the costs of new and expanded Medicare benefits, which are included in the SGR calculation, the letter stated.

On a legislative fix, Rep. Thomas wrote that "the time is ripe" to tie physician payments to quality performance. CMS demonstration projects on performance-based payments in Medicare "will provide us with the experience we need to design appropriate rewards for delivering quality care," he wrote.

At press time, Rep. Johnson was prepping to introduce a pay-for-performance bill that would repeal the SGR and base future updates for physician payments on the Medicare Economic Index (MEI).

At a recent hearing, Dr. McClellan told Rep. Johnson such a measure could come at a high cost: that is, MEI-based increases would be $183 billion over 10 years.

CMS, meanwhile, is working to remove Part B drugs from the formula, although the procedure "presents difficult legal issues that we haven't yet been able to solve." It also would not solve the entire problem, as positive updates would not take place for several years, regardless of whether CMS removed drugs prospectively or retrospectively, his testimony indicated.

In addition, he cautioned Rep. Johnson's subcommittee that removal of drugs would increase beneficiary premiums.

Physicians groups offered support for this legislative approach at the hearing. "We're committed to improving quality of care, but to make further quality improvements physicians must be adequately reimbursed for treating Medicare patients," John H. Armstrong, trustee to the American Medical Association, testified.

Leaders on the Senate Finance Committee have since introduced a pay-for-performance bill, although it may not get the same kind of support from physician groups as the forthcoming Johnson bill.

Applying the notion that Medicare should attain better "value" for its money, the bill from Sen. Chuck Grassley (R-Iowa) and Sen. Max Baucus (D-Mont.) proposes to link a small portion of physician Medicare payments to reporting of quality data and demonstrated progress against quality and efficiency measures. The measures would focus on health care processes, structures, outcomes, patient experience of care, efficiency, and use of health information technology.

Participation would be voluntary, but those choosing not to report quality data would receive a reduced payment update.

Unlike the Johnson proposal, the Senate bill fails to include a fix to the SGR, Mary Frank, M.D., president of the American Academy of Family Physicians, said in a statement. Instead, the legislation "attempts to improve the payment system to physicians without attempting to stem the declining Medicare reimbursement rate."

Physicians could face lower Medicare payments and additional costs under such requirements, Dr. Frank said. While it might increase doctors' costs in order to meet and report specific care standards, the bill "doesn't help them obtain the technology to do so," she said. Without the technology to participate in the bill's proposed reporting system, physicians' reimbursement will be cut even further, hindering their ability to afford the technology.

The outcome is family physicians may be forced to drop Medicare beneficiaries, Dr. Frank said. In addition, "tons of implementation questions" aren't broached in this bill, said Michele Johnson, senior governmental relations representative of the Medical Group Management Association.

"Right now, there are no evidence-based, valid scientific measures of efficiency, unless you're talking about clinical measures," Ms. Johnson said. It's unclear how such measures would be developed under the legislation, and how people would physically report these quality measures.

In a summary of the bill, the authors said they didn't address the sustainable growth rate because they wanted to limit provisions to quality improvement, value-based purchasing, and health information technology. However, "sense of the Senate" language (nonbinding language that accompanied the bill) did acknowledge that the negative physician update needed to be addressed, based on the "unsustainable" nature of the SGR.

Primary care groups had lobbied Senate Majority Leader Bill Frist (R-Tenn.) for a pay-for-performance bill that would provide positive updates to Medicare's physician fee schedule, as well as reverse cuts that would otherwise occur under the SGR.

If any language from Grassley-Baucus is approved, "it will probably be inserted into end of the year must-pass legislation," Ms. Johnson said. Standing alone, the bill is too risky on the Senate floor because it would give Democrats an opportunity to reopen the Medicare Modernization Act. "The Republicans don't want that." ■