Antitrust Measures Support Quality Patient Care

BY SUSAN BIRK

FROM THE ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

CHICAGO — Contrary to common perception, "the nation's antitrust laws allow—even encourage—doctors to collaborate in ways that lower costs and improve patient care," according to Jon Leibowitz, chairman of the Federal Trade Commission.

If doctors join forces to fix prices, the FTC will stop them, but if they work together to deliver affordable, high-quality care, "not only will we leave you alone, we'll applaud you. And we'll do everything we can to help you put together a plan that avoids antitrust pitfalls," Mr. Leibowitz said in a speech that sought to dispel any stereotype that physicians might have of the commission as being run by "fastidious bureaucrats" and "surreptitious socialists," determined to keep doctors from charging fair prices for their services.

"Too often, I believe, our antitrust enforcement actions are portrayed as a barrier to improved care. If there is any stereotype I would like to disabuse you of today, that's the one," he said.

The relationship between organized medicine and the FTC has become strained recently by physician opposition to the "Red Flags Rule" that requires small businesses, including medical practices, to develop policies to detect and prevent identity theft.

The American Medical Association, American Osteopathic Association, and Medical Society of the District of Columbia filed suit against the FTC in May to block it from enforcing the rule against physicians. The "bureaucratic burden" imposed by the rule "outweighs any benefit to the public," Dr. Cecil B. Wilson, then AMA president-elect, said in a statement.

Mr. Leibowitz said the commission agrees with physicians that the rule is overreaching, and has urged Congress to provide a legislative fix for the issue as soon as possible. "Fastidious bureaucrats aren't pushing Congress to work quickly to fix the Red Flags Rule that has unintentionally swept up countless small businesses. … The FTC is," he said.

Mr. Leibowitz cited several areas for potential cooperation between physicians and the FTC, all stemming from the Affordable Care Act. The use of health information technology to improve work flow and monitor populations and individuals; clinical integration; and accountable care organizations (ACO) are among the areas that hold potential for collaboration to improve quality and lower health care costs, he said.

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Although they are not "a free pass to fix prices," he said that health information technology systems "can be an important tool" to make patient care more effective and affordable. The FTC recently issued three favorable advisory opinions on HIT use by health care providers.

In the area of clinical integration, the FTC provides guidance to providers in the form of advisory opinions regarding joint ventures. The FTC will analyze a proposal and, where feasible, provide an opinion on whether it would recommend an enforcement action if the proposal were implemented, he said.

With regard to ACOs (integrated health systems that will be responsible for providing care to defined populations), "there is already talk of their moving into the private sector," and "we want to work with you moving forward" to avoid competition issues, he said. "As long as the government purchases the services and unilaterally sets payment levels and terms, there won't be an antitrust issue." He said the FTC will hold a public workshop this fall on competition policy, payment reform, and new care models, including ACOs. ■

New Regs Outline Free Preventive Services

BY MARY ELLEN SCHNEIDER

New health plans will soon be required to offer a range of recommended preventive health services to patients free of charge under the Affordable Care Act.

The requirements will affect new private health plans in the individual and group markets starting with plan years that begin on or after Sept. 23.

The Health and Human Services department estimates that in 2011, the rules will impact about 30 million people in group health plans and another 10 million in individual market plans. The rules do not apply to grandfathered plans.

The administration released an interim final regulation detailing the new requirements on July 14.

Under the final rule, health plans may not collect copayments, coinsurance, or deductibles for a number of recommended preventive services. However, they may collect fees for the associated office visit if the preventive service wasn't the primary purpose of the visit. Patients may also incur cost sharing if they go out of network for the recommended screenings.

The covered services include those given an evidence rating of "A" or "B" from the U.S. Preventive Services Task Force. Those services include breast and colon cancer screenings, diabetes screenings, blood pressure and cholesterol testing, and screening for vitamin deficiencies during pregnancy. Tobacco cessation counseling is also given a high evidence rating by the U.S. Preventive Services Task Force and would be covered under the new rule.

Health plans will have some extra time to begin covering newly recommended services. For recommendations that have been in effect for less than a year, plans will have 1 year to comply after the effective date, according to the interim final rule.

Health plans will also be required to cover the list of adult and childhood vaccines recommended by the Advisory Committee on Immunization Practices.

For children, the rule also requires health plans to cover all preventive care recommended under the Bright Futures guidelines. The guidelines include screenings, developmental assessments, immunizations, and regular well-child visits from birth to age 21 years. These guidelines were developed jointly by the Health Resources and Services Administration and the American Academy of Pediatrics.

A list of the recommended preventive services is available online at www.healthcare.gov/center/regulations/prevention/recommendations.html. ■

ACGME Plans to Reduce Resident Duty Hours in First Year

BY ALICIA AULT

FROM THE NEW ENGLAND JOURNAL OF MEDICINE

The Accreditation Council for Graduate Medical Education has revisited its standards for resident duty hours and determined that some modifications should be made, mostly for first-year residents. All other residents should still be subject to an 80-hour work week and up to 24 hours of continuous duty.

The 16-member ACGME task force that wrote the standards will review public comments and make any modifications considered necessary before July 2011, when the new standards will go into effect.

The original ACGME standards, established in 2003, have been the subject of much consternation in the medical community, with opinions differing over whether they have been too restrictive or too loose to properly protect patients and ensure a good quality of life for residents.

According to the latest report, written by Dr. Thomas J. Nasca, Dr. Susan H. Day, and Dr. E. Stephen Amis Jr. on behalf of the ACGME task force, the 2003 standards had the following three "problematic" elements, as identified by the educational community and the public:

► The limits on duty hours may have created a shift mentality among residents, which tends to conflict with the duty to serve patients.

► Many academic programs began focusing on meeting the duty hour restrictions, perhaps at the expense of education.

► The 80-hour work week, with up to 24 hours of continuous duty, was seen by many as compromising patient safety.

In 2008, the Institute of Medicine took a hard look at the ACGME standards and, among other things, recommended that no residents should exceed 16 hours of continuous duty.

The ACGME convened the task force to consider the IOM recommendations. One of the biggest challenges, according to the authors, was to reconcile the IOM's suggestion for an across-the-board restriction on duty hours with the continuing plea from academic programs that duty hours needed to be tailored to each specialty (N. Engl. J. Med. 2010 [doi:10.1056/NEJMsb1005800]).

The ACGME panel also had to weigh whether there was sufficient evidence to show that working more than 16 hours or up to 30 hours continuously led to more medical errors, as has been suggested by many critics.

According to the ACGME panel, the data thus far indicate only that first-year residents are more prone to mistakes as a result of sleep deprivation. Therefore, the task force urged a new paradigm for the first year of residency, whereby residents cannot be on duty for longer than 16 hours continuously and should have 10 hours off and 8 hours free of duty between their scheduled duty periods. First-year residents are not allowed to moonlight, and they must have direct, in-house, attending-level supervision.

All residents are allowed to work up to an additional 4 hours to facilitate patient handoffs—an area of concern for patient safety.

The panel decided not to tailor duty hours to specialties "because studies have not shown that the safety effect of current standards varies with specialty," said the authors.

The IOM had also criticized the ACGME for not properly enforcing the duty hours. The task force said that enforcement is an "inherent" challenge, partly because there are some 9,000 accredited programs.

Wake Up Doctor, a coalition of public interest and patient safety groups that has been pushing the ACGME to further restrict resident hours, said that the new standards don't go far enough. ■