Minority Medical School Enrollment Up in 2010

Total Hispanic enrollment rose by 9%, and the number of blacks/African Americans was up 2.9%.

BY JANE ANDERSON

FROM A REPORT BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

More minority students enrolled as first-year medical students in 2010, with Hispanic male medical students especially increasing their numbers, according to new data released by the Association of American Medical Colleges.

The number of black/African American and American Indian first-year medical students also grew this year, and every U.S. region saw increases in medical school enrollment diversity, said AAMC President and CEO Dr. Darrell Kirch.

"The bottom line is, we see more minority students pursuing a career in medicine," Dr. Kirch said in a telephone press briefing to announce the findings.

Improved diversity will help communities meet their health needs, especially with the increased need for physicians triggered by the Affordable Care Act, he said. "You don't improve the health of a community without having a workforce that reflects the diversity of that community," Dr. Kirch said, adding that it's not enough for health care reform to provide insurance if there aren't enough physicians. "An insurance card can't take care of you – you need to have a physician to do that."

Hispanic men increased their enrollment in medical school by 17.1%, while enrollment by Hispanic women grew by 1.6% over 2009, according to the AAMC report. Total Hispanic enrollment rose by 9%. First-year Hispanic enrollees in U.S. medical schools totaled 1,539 in 2010, compared with 1,412 in 2009, according to AAMC.

Black/African American enrollment, meanwhile, grew by 2.9% over 2009. A total of 1,350 black/African American students enrolled in medical school as first-year students in 2010, compared with 1,312 students in 2009.

Asian students also saw gains, with enrollment increasing 2.4% in 2010 to 4,214 from 4,114 in 2009, according to the AAMC report.

Overall, the level of applicants to U.S. medical schools has remained steady for at least the past 4 years, although the total number of first-time applications increased by 2.5% in 2010, said Dr. Kirch.

"Medical school remains a very compelling career choice," he said. About 42,000 potential students, including 31,063 first-time applicants, competed for about 18,000 openings, he said.

One new medical school – the Virginia Tech Carilion Medical School – accepted its first class this year, and two more are in line to accept their first classes next year, Dr. Kirch said. Another seven medical schools are in the accreditation process, he said.

"This effort to expand medical school enrollment will enable us to add 7,000 more annual graduates," he said, adding, "we're not focused solely on new schools. We're also focused on [increasing enrollment at] existing schools." ■

Comparative Effectiveness Data Could Help Medicare

BY ALICIA AULT

FROM HEALTH AFFAIRS

The use of comparative effectiveness research would give Medicare a sophisticated tool for making coverage decisions on the basis of quality, but the federal health program's ability to use such data is hamstrung by political interests and the health reform law, according to two researchers.

"We believe that the time is ripe for Medicare to use comparative effectiveness research to reach a new paradigm of paying equally for services that provide equivalent results," the authors wrote.

Dr. Steven D. Pearson, president of the Institute for Clinical and Economic Review in Boston, and Dr. Peter B. Bach, an attending physician at Memorial Sloan-Kettering Cancer Center in New York, say that Medicare can take advantage of the burgeoning comparative effectiveness movement to change its ways (Health Affairs 2010;29:1796-804).

The Obama administration is helping create a larger comparative effectiveness enterprise through some $1.1 billion that was set aside as part of the American Recovery and Reinvestment Act of 2009. In March 2009, the Department of Health and Human Services announced that 15 experts would guide investments and coordinate research through the Federal Coordinating Council for Comparative Effectiveness Research.

However, the council's role is limited in that it will not set clinical guidelines, or establish payment rates or tell Medicare what to cover. The Affordable Care Act further spelled out restrictions on how comparative effectiveness findings could be used by the federal government.

Currently, Medicare covers a drug, device, product, or service if evidence supports its effectiveness. No comparisons are made to other products. Payment is set separately, based on arcane formulas that cover cost and maybe a small profit.

Dr. Pearson and Dr. Bach propose that Medicare instead link coverage and payment decisions at the outset. The program could still use the "reasonable and necessary" threshold in deciding when to cover a product or service. But regulators could adopt a three-tiered effectiveness scale that would let them assign differing reimbursement to each level.

For instance, a superior rating would garner the highest payment. Such a product would have the fewest side effects or offer the most effective treatment when compared with similar treatments.

Next down would be the "comparable" product or service. Payment would be slightly less than that for the superior product, as in the difference between what is paid for a brand name and a generic pharmaceutical, for example.

The lowest rating, "insufficient evidence," would be covered and reimbursed at the conventional cost plus a small profit, but the payment level would be reevaluated every 3 years.

The authors said a 3-year time frame can act as both a carrot and a stick. Having coverage – at current Medicare rates – is better than not having coverage, so innovation will not be stifled. Limiting that rate to only 3 years gives manufacturers and clinicians greater incentives to conduct comparative effectiveness studies.

Dr. Pearson reported no conflicts. He is a member of the National Institutes of Health's Comparative Effectiveness Research Steering Committee and was a previous vice chair of the Medicare Evidence Development and Coverage Advisory Committee. Dr. Bach made no disclosures. He serves on the Committee on Performance Management of the National Committee for Quality Assurance and the Institute of Medicine's National Cancer Policy Forum. ■

Reform Brings Tighter Rules on Utilization Rates, Self-Referrals

BY RICHARD M. KIRKNER

FROM THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF NUCLEAR CARDIOLOGY

PHILADELPHIA – Health care reform, in the guise of the Patient Protection and Affordable Care Act signed into law by President Obama last spring, will require physicians to deal with new regulations on utilization of imaging equipment and self-referrals.

Despite rumblings of overturning the law, Dr. Kim Williams said at the meeting that health care reform is here to stay. "It would be very difficult, though not impossible – but very difficult to flip a house of Congress and to repeal this." Regulations will be phased in over the next 4 years, he said.

'One will have to inform patients in writing at the time of the referral that they can obtain services from someone other than the referring physician.'

The equipment utilization rate that Medicare uses to establish reimbursements is due in 2011 for an adjustment for three types of imaging – MRI, CT, and PET – but excludes single-photon emission computed tomography (SPECT). Dr. Williams of Wayne State University in Detroit, described the equipment utilization rate as "a mechanism to actually decrease reimbursement." Medicare actually rolled back the rate for MRI, CT, and PET from 90% to 50% in 2010, but will bump it back up to 75% in 2011, he said.

Meanwhile, the Affordable Care Act tightens requirements on self-referrals. Dr. Williams raised a hypothetical situation. "Running an EKG – is that self-referral? Yes," he said, "but it hasn't come onto anyone's radar screen because it isn't a lot of money." He cited other "elements of the house of medicine" with accusing cardiology and other specialties of inappropriate self-referral.

Like the equipment utilization rate, the disclosure provisions on self-referral cover MRI, CT, and PET but not SPECT, at least not yet, Dr. Williams said. "Most of us look at that [from the viewpoint that] a patient expects a self-respecting practice to own its equipment, so it isn't that onerous," he said. "But the devil is in the details."

Among those details he outlined: "One will have to inform patients in writing at the time of the referral that they can obtain services from someone other than the referring physician or someone in the referring physician's practice." That takes the form of a list of at least 10 other providers within a 25-mile radius, including phone numbers and distance. The final regulation should go into effect on January 1.

The Affordable Care Act also empowers the Medicare Payment Advisory Commission (MedPAC) to make nonbinding recommendations to Congress on payment revisions. One problematic area MedPAC is looking at is developing payment tools that take into account providers' utilization rates, Dr. Williams said. "If your utilization is high, you get less reimbursement," he said. "The problem with that is that nobody mentioned risk adjustment."

Dr. Williams said that he had no relevant disclosures. ■