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AMA Interim Meeting coverage

Delegates approve principles to guide physician employment

As the number of doctors in independent practice declines, the Association's policy aims to ensure that patient welfare stays ahead of employer imperatives.

KEVIN B. O'REILLY
AMNEWS STAFF

Honolulu The autonomy of the rising number of employed physicians ought to be respected, and patient care should come before the financial interests of employers, according to principles on physician employment adopted in November at the American Medical Association Interim Meeting.

The principles, contained in an AMA Board of Trustees report the House of Delegates adopted, cover potential flash points in physician-employer relationships such as conflicts of interest, contracting, payment agreements, peer reviews, performance evaluations and medical staff-hospital relations.

"The principles for physician employment provide a broad framework to help guide physicians and their employers as they collaborate to provide safe, high-quality and cost-effective



PHOTO BY LUCI PEMONI / AP IMAGES FOR AMERICAN MEDICAL NEWS

patient care," said AMA board member Joseph P. Annis, MD, an anesthesiologist from Austin, Texas. "The guidelines reinforce that patients' welfare must take priority in any situation where the interests of physicians and employers conflict."

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Melissa J. Garretson, MD, a delegate for the American Academy of Pediatrics and a pediatrician in a Texas emergency department, talked about the pressure she faces to meet her employer's performance goals. "Over the past few years, it's gotten uglier and uglier," she said.

Insurance exchanges emerge as red vs. blue

Despite newly relaxed federal deadlines, some largely GOP-led states have decided to reject the option of operating the coverage marketplaces themselves.

JENNIFER LUBELL
AMNEWS STAFF

Washington The federal government gave states more time to decide if they want to pursue their own health insurance exchanges under the Affordable Care Act, but the leaders of some states said they already knew which way they were heading.

On Nov. 16, when states originally were to inform the Dept. of Health and Human Services of their plans,

Bruce Greenstein, secretary of the Louisiana Dept. of Health and Hospitals, made it clear in a letter to HHS that his state did not want to take on the risks of developing its own exchange. The ACA authorized exchanges as marketplaces through which consumers could shop for coverage, and it encouraged states to form their own. A federal exchange will operate in any state that does not launch one.

"With incomplete regulations and unrealistic deadlines, states and the federal government will struggle to have a health insurance exchange ready for open enrollment on Oct. 1, 2013, that is not beset with major complications for the insurance market and the respective residents of the states," Greenstein wrote to

HHS Secretary Kathleen Sebelius.

HHS extended the deadline for interested states to submit declarations and blueprints on state-based exchanges to Dec. 14, responding to
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AMA meeting special section

Physicians at the Interim Meeting gather at a microphone to speak at the House of Delegates. Full coverage starts on page 15.

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Here's what buyers want to know and how you can prepare your answers.
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When judgments risk poor ratings

Refusing patients' demands for inappropriate care could result in financial penalties.
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GPCIs: Medicare's disputed borders

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Records requests clash with privacy protections

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Delegates approve principles to guide physician employment

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For example, if an employer requires or pressures physicians to send referrals within the health care organization, that practice ought to be disclosed to patients, the AMA policy states. Another principle at stake is physicians' freedom to advocate for their patients or act on matters of professional judgment, which the house said employers should not restrict.

Also, employers should make clear to doctors the factors on which their compensations are based and how their performances will be evaluated. Employed physicians should have the same rights to participate in medical staff self-governance as doctors in independent practices, the policy states.

The house's move comes as the proportion of physicians with an ownership stake is falling. In 2000, 57% of the nation's 682,470 practicing physicians owned at least a part of their medical practices. In 2013, that figure is expected to be 36%, according to an analysis of data from the AMA and MGMA-ACMPE done by the consulting firm Accenture. The report, published Oct. 31, said physicians cite business expenses, health plan hassles, electronic health record requirements and high patient volumes as reasons why they are thinking about leaving independent practice.

Young physicians eye employment

In November 2011, the house adopted policy stating that the AMA "will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems and other entities."

As a member benefit, the AMA offers information and advice to doctors on matters pertaining to their relationships with hospitals, health systems and other entities on issues such as breaches of contract, medical staff bylaws, sham peer reviews, economic credentialing and the denial of due process. The Association has

5 PRINCIPLES TO ADDRESS CONFLICTS OF INTEREST

The AMA adopted a set principles for physician employment, five of which address conflicts of interest. The policy seeks to help doctors manage the "divided loyalty" they may face as employed physicians.

- A doctor's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or undertreat patients, which employed physicians should strive to recognize and address.
- Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any matter regarding patient care interests, the profession, health care in the community and the independent exercise of medical judgment. Employed doctors should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
- Doctors should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must ensure that agreements or understandings (explicit or implicit) restricting, discouraging or encouraging particular treatment or referral options are disclosed to patients.
- Assuming a position such as medical director that may remove a doctor from direct patient-physician relationships does not override professional ethical obligations. ... Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

SOURCE: AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT ADOPTED BY THE HOUSE OF DELEGATES, NOVEMBER

model contracts available for physicians negotiating employment terms with hospitals or group practices. The recently formed Integrated Physicians Practice Section, which will represent physicians employed at integrated health systems, will join the house at the June 2013 Annual Meeting in Chicago.

The principles were proposed by the Organized Medical Staff Section and referred to the board for study at the Annual Meeting in June. The newly adopted principles coming out of the board report set out general guid-

ance on physician employment, said Lee Perrin, MD, a Boston anesthesiologist and OMSS alternate delegate.

The principles are especially important to younger physicians, who are opting for employment in greater numbers, said Jesse M. Ehrenfeld, MD, an alternate delegate for the American Society of Anesthesiologists.

"Young physicians like me are more likely to be employed by hospitals or large, integrated health practices compared to older physicians, and therefore the principles delin-

eated in this report are of great importance to our demographic," said Dr. Ehrenfeld, who spoke on behalf of the Young Physicians Section. "This report is timely in subject and scope. As more young physicians become salaried employees, they will benefit from this important guidance."

Thirty-two percent of final-year residents say hospital employment is their first choice of practice settings, according to an Oct. 5, 2011, survey conducted by physician recruiting firm Merritt Hawkins. In 2001, only 3% of final-year residents listed hospital employment as the most appealing practice option.

The policy was adopted on a voice vote. The house directed the AMA to disseminate the principles among graduating residents and fellows and advocate for adoption of the guidelines by trade groups representing hospitals and medical groups.

More to come on physician employment

Meanwhile, the AMA Council on Ethical and Judicial Affairs appears likely to study some of the ethical dilemmas facing employed physicians. At an open forum, the council invited delegates to discuss their personal experiences with physician employment.

Several delegates reported feeling pressure from their employers to meet financial goals and improve on measures of patient satisfaction. Among them was Melissa J. Garretson, MD, a delegate for the American Academy of Pediatrics from Stephenville, Texas, who is employed as a pediatrician in an emergency department.

"Over the past few years, it's gotten uglier and uglier, and harder to do what's right for patients in the ER when all that anyone cares about is patient complaints," Dr. Garretson said. When she went to a committee meeting regarding renewal of her credentials, administrators asked why she had double the complaint rate of her colleagues. Their patient complaint rate was 0.01%, while Dr. Garretson's was 0.02%, she said. Refusing patient requests for inappropriate care can result in complaints that have no merit, she explained.

The AMA ethics council typically studies topics addressed at open forums and presents related reports for the house's consideration within 12 to 18 months. ♦

Insurance exchanges emerge as red vs. blue

Continued from preceding page

a request from the Republican Governors Assn. RGA spokesman Mike Schrimpf said his organization was pleased the Obama administration had "acknowledged that governors have not been provided enough information" and had signaled a willingness to work with GOP governors on key issues. But the leaders of more than a dozen states, mostly Republicans, indicated they would not pursue a state-based exchange anyway.

In a letter to HHS, Wisconsin Gov.

Scott Walker said 90% of residents in his state already have insurance coverage without the help of an exchange. Choosing a state option would subject residents to "a federal mandate lacking long-term guaranteed funding," he wrote.

The funding issue appeared to be a primary factor supporting the decisions to reject state-run marketplaces. Georgia Gov. Nathan Deal demonstrated "fiscal responsibility" by blocking implementation of a state-based exchange, Rep. Phil Gingrey, MD, (R, Ga.), said in a statement.

Ohio Gov. John Kasich said his state will not launch an exchange but was not prepared to be completely hands-off, either. In a letter to HHS, Kasich said the state will default to a federally facilitated exchange, but that Ohio will seek to retain regulatory control over local health insurance plans operating in the exchange as well as the authority to determine Medicaid eligibility. His office also cited a cost rationale for rejecting the state-run option.

The ACA, however, provides substantial grant money to cover state

exchange startup costs, and neither states nor the federal government is expected to bear the maintenance costs of exchanges, said Caroline Pearson, a director for consultant Avalere Health LLC. "Once exchanges are up and running, both states and the federal government will be self-sustaining — in most cases relying on premium assessments on participating plans to support ongoing operating costs."

These states also are overlooking the advantages state-based exchanges would provide, said Dan Mendelson, Avalere's founder and CEO. Forgoing a state-based or even a partnership ex-

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Insurance exchanges emerge as red vs. blue

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change with the federal government means a state will default entirely to federal control. In rejecting a state-based option, some officials said they would be too limited in what they could do, but a federal exchange actually may offer less flexibility, he said.

Running its own program would make it easier for a state to coordinate with Medicaid, Mendelson said. Many low-income people are “going to go back and forth between Medicaid and the exchange. And when a state is engaged in its exchange, it will be able to ensure continuity with

that population.”

Tim Maglione, senior director of government relations for the Ohio State Medical Assn., pointed out another possible issue with Kasich’s stance. Any state-federal disputes on insurance oversight eventually might require a court intervention, he said.

State exchanges seeking a strategy

Sixteen states and the District of Columbia, largely led by Democrats, have expressed their intent to pursue their own exchanges, according to Avalere data at this article’s deadline. For those states, next steps aren’t just

about creating administrative structures for the marketplaces, said Alan Weil, executive director of the National Academy for State Health Policy.

States must be efficient in how they regulate the health insurance market, he said. Developing an exchange involves simplifying and integrating eligibility systems and expanding the capacity of physicians and other health care professionals. “We’re pushing a lot more people into coverage. We expect demand to go up,” he said.

States pursuing their own exchanges include Washington, which

submitted its blueprint a month before the original November deadline, and Maryland, one of the first recipients of federal money to develop an exchange. In expanding insurance access to a projected 730,000 residents using federal subsidies, Maryland has a goal of lowering uncompensated care costs in the state while expanding access to primary care physicians and preventive services, said Tequila Terry. She’s director for plan and partner management with the Maryland Health Benefit Exchange.

But some Maryland physicians are wary about proposals that may dissuade physicians from participating in exchange plans or even practicing in the state. There have been discussions, for example, that health plans may want to pay physicians at Medicaid rates, said Gary Pushkin, MD. He’s an orthopedic surgeon in Balti-

STATE EXCHANGE DECISIONS SO FAR

Some states and the District of Columbia already have decided whether to run their own health insurance exchanges, launch partnership exchanges with the federal government or defer to a federally facilitated exchange. Others are leaning toward a certain strategy.

- 16 states (plus D.C.) have decided to run state exchanges.
- 2 states are likely to choose state exchanges.
- 4 states have decided to pursue partnership exchanges.
- 8 states are likely to select partnership exchanges.
- 17 states have decided to defer to a federal exchange.
- 3 states are likely to choose a federal exchange.

SOURCE: AVALERE HEALTH’S STATE REFORM INSIGHTS, UPDATED NOV. 19

more who sits on the board of trustees of MedChi, The Maryland State Medical Society. He also participated in the exchange’s plan management committee. Another discussion involves imposing a tax on physicians and others to help fund the exchange, he said.

Maryland already has problems attracting doctors because it’s an expensive place to live and pay rates are low, and these types of proposals could further scare them away, Dr. Pushkin said. The fact that the doctor tax is being considered “gives me one more reason to ask why I should continue practicing,” he said.

Still, the hope is that physicians will be able to work out these issues with other stakeholders, said Gene Ransom III, MedChi’s CEO. “The process has been very collaborative, bringing brokers, insurers and physicians to the table,” he said.

By 2014, “every state is going to have an exchange,” Mendelson said. “Right now, what you’re hearing is a lot of grinding of the wheels in preparation for a significant policy change.” ♦

Progress is reported on 5-year strategic plan [PAGE 16]

AMA House of Delegates

■ COVERAGE FROM THE 66TH INTERIM MEETING, NOVEMBER 10-13 IN HONOLULU ■

Guidance on health care teams approved

Adopted policy seeks to help physicians leading patient-centered medical homes, while addressing a new environment of work force shortages and increased demand for health services.

CHARLES FIEGL AND KEVIN B. O'REILLY
AMNEWS STAFF

Honolulu Physicians leading health care teams have new policy to guide their practices in a way that is designed to meet the challenges of treating a more robust patient population amid the work force shortages projected for future years.

The American Medical Association House of Delegates adopted a report and recommendations on physician-led interprofessional health care teams on Nov. 13. The new policy addresses how teams can optimize patient-centered, coordinated and high-quality care for patients, said Carl A. Sirio, MD, a critical care specialist from Pittsburgh and a member of the AMA Board of Trustees.

"The future of health care delivery is patient-centered and will require a team approach, and physicians and health care professionals need to be prepared to efficiently work together to provide quality patient care," Dr. Sirio told delegates to the Interim Meeting.

To help manage the health industry's work force shortage, the AMA Council on Medical Service wrote a report



PHOTO BY TED GRUDZINSKI / AMA

Patients "want to know that there is a doctor in charge of their care," said Donna Sweet, MD, an internist in Wichita, Kan., and chair of the AMA Council on Medical Service.

with the AMA Council on Education to address interprofessional health care teams that can work together to provide high-quality and efficient services.

"We are also entering into the era of the patient-centered medical home where hopefully we can leverage all of our skills to the best advantage of the patient," said Wichita, Kan., internist Donna Sweet, MD, chair of the AMA

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Standards sought as clinical use of gene sequencing accelerates

Diagnostic mysteries are being solved using genomic-based technologies. Overcoming barriers to clinical implementation is the next step, AMA delegates say.

KEVIN B. O'REILLY
AMNEWS STAFF

Honolulu Appropriate professional standards and regulation will help ensure that recent advances made in the use of genomic-based technologies benefit more patients, according to policies adopted at the American Medical Association Interim Meeting.

In its action, the AMA House of Delegates recognized the utility of these genomic technologies and encouraged the development of standards to guide clinical use as well as best practices for the laboratories performing such tests. The AMA also will support regulatory and payment policies to enable doctors to use these diagnostic tools when clinically appropriate, while protecting patient rights such as confidentiality and freedom from genetic discrimination.

It took more than 10 years and cost \$2.7 billion for the Human Genome Project to sequence the entire human genome. Next-generation sequencing of the human genome, or NGS, has sped the process dramatically, said the AMA Council on Science and Public Health report that the house adopted.

An entire individual genome can be sequenced in two to three days for less than \$5,000, with the cost expected to fall to less than \$1,000 soon. The amount of data in that sequencing would occupy more than 400,000 pages when printed, with as many as 50,000 clinically important gene variants requiring examination using specialized clinical software. Incidental findings could require hours of genetic counseling for patients and families, the AMA report said.

Improved health outcomes seen

"NGS-based technologies have the potential to drive significant improvements in patient care," said Sandra A. Fryhofer, MD, chair of the science council. "Already, these technologies have shown remarkable ability to end the diagnostic

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PHOTO BY LUCI PEMONI / AP IMAGES FOR AMERICAN MEDICAL NEWS

A full slate of resolutions

Dermatologists Cyndi Yag-Howard, MD, (at left) and Jessica Krant, MD, were among the delegates voting on reports and resolutions at the American Medical Association's Interim Meeting in Honolulu. Among the issues delegates discussed were health care teams, gene sequencing, the physician shortage and principles for physician employment. For more information about what went on, go the the AMA's meeting site at www.ama-assn.org/go/interim2012.



PHOTO BY TED GRUDZINSKI / AMA

Sandra A. Fryhofer, MD, chair of the AMA science council, sees much potential in NGS-based technology.

Clinical use of gene sequencing

Continued from preceding page

odyssey for patients with disorders that are resistant to standard diagnostic procedures and targeted genetic testing.

“Cancer patients also stand to gain from improved molecular analysis that enables accurate tumor classification, and improved diagnosis and management options,” she said. “But challenges such as managing extremely large data sets, return of results, and regulation and reimbursement must be addressed in order to fully realize the incredible potential of NGS-based technologies to improve health outcomes.”

Genomic-based technologies such as whole-genome sequencing and whole-exome sequencing can identify disease-causing gene mutations and will be used increasingly in diagnosis and treatment, the science council’s report said.

For example, doctors using whole-exome sequencing were able to arrive at a definitive diagnosis for a boy with a life-threatening form of inflammatory bowel disease. After the mutation was identified, a cell transplant was performed that relieved the boy’s symptoms and let him eat and drink again. Studies have provided evidence that these genomic-based technologies should be considered in cases when a genetic condition is suspected but targeted genetic testing has proven negative.

“Advances in DNA sequencing technology offer patients and physicians a new diagnostic tool to help improve health outcomes, but clinical challenges must be addressed to realize the full potential benefits of this technology,” said Robert M. Wah, MD, a McLean, Va., reproductive endocrinologist and immediate past chair of the AMA Board of Trustees.

“While cost and time barriers to genetic sequencing have been reduced, important privacy, practice, payment and regulatory issues — including how to compensate physicians and other health care professionals for the considerable work-related demands required — must still be addressed.” ♦

Call for flu-shot mandate in long-term-care setting

Nearly half of health care professionals in this area skip getting an influenza vaccination. The requirement will protect a vulnerable group of patients, delegates say.

KEVIN B. O'REILLY
AMNEWS STAFF

Honolulu Physicians and other workers who have direct contact with patients in long-term-care settings should be required to get the influenza immunization annually, said the American Medical Association House of Delegates. Workers who have medical contraindications or religious objections should be exempt from the vaccine requirement, said the policy adopted at the Association’s Interim Meeting.

“Many health care organizations now have mandatory immunization,” said internist Eric Tangalos, MD, a delegate from Rochester, Minn., who spoke on behalf of the American Medical Directors Assn., which proposed the policy. “It saves lives, saves money and keeps people on the job. And with regard to [this resolution], we’re talking about protecting the most frail, most vulnerable population of patients.”

About two-thirds of all health care

workers got the influenza vaccination during the 2011-12 flu season, and 86% of physicians were immunized, said the Sept. 28 *Morbidity and Mortality Weekly Report* published by the Centers for Disease Control and Prevention. The immunization rate for health workers in long-term-care facilities was 52%, compared with 68% in physician offices and 77% in hospitals. Health care organizations that require their employees to get flu shots achieve an average immunization rate of 98%, the CDC said.

Requiring immunization of those working in long-term-care settings will benefit all patients, said Jonathan Weisbuch, MD, PhD, a Phoenix preventive medicine specialist and alternate delegate for the American Assn. of Public Health Physicians.

“This is a strong public health issue,” Dr. Weisbuch said. “Not only do we immunize those who work in these facilities and protect patients there, but it’s a way of increasing herd immunity across the population, so the virus is diminished.”

Support for vaccine requirement grows

In October, Rhode Island became the first state to mandate that all health care workers with direct patient contact get a flu shot. Since 2010, several

About two-thirds of all health care workers got flu shots in the 2011-12 flu season, including 86% of physicians.

organizations have announced their support for mandatory flu shots, including the National Business Group on Health, the American Academy of Pediatrics and the Society for Healthcare Epidemiology of America.

Previously, the AMA stopped short of supporting vaccine mandates for doctors. In November 2010, the house adopted ethics policy saying physicians have an obligation to accept immunization for vaccine-preventable diseases unless they have a medical, religious or philosophical reason to avoid doing so.

The AMA supports universal immunization, which means asking workers with patient contact to get vaccinated and making it as easy as possible for them to do so, but not making it a condition of employment. The AMA has policy opposing religious or philosophical exemptions from school vaccine mandates. ♦

Progress is reported on 5-year strategic plan

The AMA’s CEO provides updates to delegates on the three areas of focus.

DAMON ADAMS AND CHARLES FIEGL
AMNEWS STAFF

Honolulu The American Medical Association is setting up research partnerships with 30 physician organizations in six states to begin enhancing professional satisfaction by shaping delivery and payment models. The effort will determine which practice design elements best support high-quality care, long-term doctor satisfaction and practice sustainability.

AMA Executive Vice President and CEO James L. Madara, MD, told the Association’s House of Delegates about those steps as part of a progress report on the AMA’s five-year strategic plan. He gave the update on Nov. 10 at the opening session of the Interim Meeting.

Enhancing professional satisfaction and practice sustainability by helping doctors navigate delivery and payment models is one of three areas of focus of the plan. The other two are improving patients’ health outcomes and accelerating change in medical education. Dr. Madara first presented the plan to the house in June at the Annual Meeting in Chicago.

At the Interim Meeting, Dr. Madara referred to the goals that drive the strategy as “moon shots”

— ambitious targets that are reachable with focus and commitment. He said former President John F. Kennedy set in motion the original moon shot in 1961 by announcing the goal of landing a man on the moon. Kennedy’s vision sparked innovation and ideas, he added.

“Like Kennedy’s challenge, our long-range strategy is aimed at mobilizing the AMA, this house, the thousands of physicians you represent and the larger medical community in support of something greater,” Dr. Madara said.

“The achievements that are possible through the fulfillment of this strategy will not only shape a better future for patients and physicians, but for the country as a whole.”

AMA staff have been meeting with experts in health outcomes to assess the work being done in that area and determine where the AMA can contribute toward improving outcomes, he said. The Association will identify a set of conditions and select long-term and intermediate outcomes to focus on those conditions.

To accelerate change in medical education, the AMA’s actions will include developing new methods for measuring and assessing competencies for physicians at all training levels and promoting methods to achieve patient safety,

performance improvement and patient-centered care, Dr. Madara said. At the annual meeting of the Assn. of American Medical Colleges in early November, he announced a process to select schools that want to revise their curricula around the AMA’s targeted objectives. In spring 2013, five to 10 proposals will be picked, with selected schools implementing them in summer 2014.

“Physicians want and need help in navigating a rapidly evolving health care environment, and through this initiative, the AMA will work to provide such,” Dr. Madara said.

Delegates attended educational sessions related to the strategic plan. In a session on improving health outcomes, officials with the

health system Hawaii Pacific Health told attendees about their experiences with measuring and achieving better patient outcomes. Physicians cannot know how well they are doing unless they have good data to measure quality, said Melinda Ashton, MD, vice president of quality for the health system.

“We don’t achieve 100% every time, but we absolutely shoot for it, because we believe that our patients deserve the right care,” she said. ♦



PHOTO BY TED GRUDZINSKI / AMA

Executive Vice President and CEO James L. Madara, MD, cited goals as “moon shots.”

Policies target doctor shortages, GME cuts

Delegates call for the expansion of J-1 visa waivers and protection of existing residency slots.

KEVIN B. O'REILLY
AMNEWS STAFF

Honolulu With a massive physician shortage looming, the American Medical Association took several steps at its Interim Meeting aimed at expanding access to physician care in underserved areas and protecting the training pipeline from funding cuts.

The Assn. of American Medical Colleges estimates there will be a shortage of 130,600 doctors by 2025, with half of the shortfall coming in primary care specialties. Already, doctors are in short supply in many rural and inner-city areas.

One attempt to address the latter shortages is the J-1 visa waiver program, which the House of Delegates said should be expanded.

The program allots 30 positions in each state for international medical graduates who complete their graduate medical education and pledge to work two years in a Dept. of Health and Human Services-designated shortage area in exchange for waivers from the return-home visa requirement.

The house said the number of slots should be increased from 30 per state to 50, and directed the AMA to publish J-1 visa waiver statistics on its website. The AMA also will post a frequently-asked-questions document about the program, which state administrators say is underused because of onerous employer requirements and bureaucratic complexity.

In addition, delegates directed the AMA to oppose cuts in federal funding for graduate medical education that would lead to the closure of residency programs or the dismissal of residents from current positions. Of particular concern to delegates was pediatric GME funding. Unlike adult residency slots that are funded through Medicare, pediatric residency funding must be approved annually by Congress.

Children's hospitals train 40% of general pediatricians and 43% of pediatric specialists. The Children's



PHOTO BY LUCI PEMONI / AP IMAGES FOR AMERICAN MEDICAL NEWS
Rochester, N.Y., pediatrician Thomas K. McNerny, MD, says cuts in residency slots might mean fewer pediatric specialists, who are in short supply.

Hospitals Graduate Medical Education Payment Program was threatened with \$48.5 million in funding cuts under President Obama's proposed 2011 fiscal-year budget. The cuts were avoided, but the AMA ought to take a stand to protect existing residency slots, delegates said.

"If we were to lose these residency positions, or even a small portion of them, then how do we train these folks to become physicians?" asked Thomas K. McNerny, MD, a delegate for the American Academy of Pediatrics from Rochester, N.Y. "In pediatrics, in particular, our specialists are in short supply, so we're worried that the last thing we need is fewer specialists for our children."

The AMA already has policy opposing a 1997 cap on Medicare-funded residency positions, and favors expanding GME funding to meet physician work force needs. The house reaffirmed these policies in response to Interim Meeting resolutions regarding the shortages of practicing pediatricians and pediatric residency positions. ♦

Health care teams

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Council on Medical Service.

The councils' report cites recent studies that project a physician shortage reaching 130,600 by 2025. A shortage of nurses is expected to hit 260,000 that year. The estimated 30 million patients obtaining health coverage in 2014 under the health system reform law is a factor leading demand for more health care services.

Delegates defined team-based health care as "the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care."

The AMA will advocate that the physician leader of an interprofessional health care team be empowered to perform a full range of medical interventions.

"We think that's the way patients would like to see it," Dr. Sweet said. "They want to know that there is a doctor in charge of their care. Once they know that, then you can entrust parts of their care to other practitioners or professionals."

Other members of the team, such as nurse practitioners and health educators, also should be enabled to work up to the level of their individual licenses and training, delegates said.

The house adopted 11 principles to help guide physician leaders of teams. The principles call for focusing on patient- and family-centered care, making clear the team's mission and values, collaborating with team members on patient care, and being accountable for clinical care, quality improvement, efficiency of care and continuing education.

Another policy states that the AMA would "encourage independent physician practices and small group practices to consider opportunities to form health care teams, such as through independent practice associations, virtual networks or other networks of independent providers."

Also, the AMA will urge medical education accrediting bodies to help medical schools and residency programs incorporate doctor-led interprofessional education. Delegates directed the AMA to encourage the development of the skills that doctors, nurses and other health professionals need to work in teams.

About a third of medical schools do not require interprofessional education experiences of their students, according to the AMA Council on Medical Education report the house adopted.

It is not only physician training programs that can impede interprofessional education, said former AMA President J. James Rohack, MD, a cardiovascular disease specialist from Bryan, Texas. "Barriers also exist in the accreditation of nursing, public health, pharmacy and other professions," Dr. Rohack said in virtual reference committee testimony. "For the other professions to educate with us, those [barriers] need to be addressed collaboratively." ♦

Meeting Notes

Medical Education

ISSUE: Medical schools that have been given preliminary or provisional accreditation status by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation may not be able to land clerkship slots for their students, because unaccredited, for-profit foreign medical schools offer top dollar for these positions.

❑ **PROPOSED ACTION:** Advocate for regulations that would ensure clinical clerkship slots go first to students at accredited U.S. medical schools or those who have preliminary or provisional accreditation status. [Adopted]

ISSUE: Physicians have an obligation to participate in continuing medical education to fulfill a professional commitment to lifelong learning.

❑ **PROPOSED ACTION:** Urge physicians to participate in high-quality,



PHOTO BY TED GRUDZINSKI / AMA
Medical students James Sweet, left, and Elise Diamond help fourth- and fifth-graders put together a model human skeleton during the Doctors Back to School event at Honolulu's Kaewai Elementary School on Nov. 9. The AMA Medical Student Section and Minority Affairs Section sponsored the visit to the school, part of the activities of the AMA Interim Meeting.

certified CME activities that meet their educational needs and adhere to ethical and professional standards. Advise doctors to claim only the CME credit commensurate with

their participation, and to decline any subsidy or compensation for participation that is offered by a commercial entity other than their employers. [Adopted]

Congress is urged to stop automatic cuts to health programs

Delegates direct the AMA to lobby Congress to prevent budget reductions in Medicare, public health and other federal initiatives.

CHARLES FIEGL
AMNEWS STAFF

Honolulu The American Medical Association will push Congress to develop a plan that rescinds cuts to federal health care programs in future years.

The House of Delegates directed the AMA to advocate that lawmakers develop a fiscally responsible alternative to the automatic budget sequestration cuts endangering medical research, work force programs, food and drug safety, and health care for uniformed service members. Legislation should address sequestration of Medicare payments to graduate medical education programs, hospitals and physicians that will endanger access to care and training of physicians, the directive stated.

Testimony during a Nov. 11 reference committee session at the Interim Meeting unanimously supported the resolution by the American College of Physicians, American Assn. of Neurological Surgeons, American Academy of Family Physicians and several other groups.

Under law, federal budget deficits must be cut by \$1.2 trillion beginning in 2013 and throughout the next eight years. Congress and President Obama had agreed to reduce spending across the board during 2011 negotiations to raise the debt ceiling.

The automatic, across-the-board reductions are divided between defense and nondefense spending. Medicaid and Social Security are protected from the cuts, but Medicare payments are not. Pay for physician services would be lowered by 2%.

The sequestration of federal health programs is not limited to Medicare, said Rhode Island internist Yul D. Ejnes, MD, a delegate for the

American College of Physicians. The budget mechanism will affect federal drug safety programs, physician work force growth initiatives and care to dependents of military personnel.

"Given the broad scope of sequestration and its impact on our patients and the work we do, we thought it was important to submit this resolution to get the message out in a timely manner to the Congress," Dr. Ejnes said during reference committee testimony.

Public health programs, which already have marginal support in Washington, are another area that will be damaged by the budget sequester, said AAFP President-elect Reid B. Blackwelder, MD, a family physician from Kingsport, Tenn. Cuts will only exacerbate unmet health care needs, he said. "We do need fiscal responsibility, but our representatives' responses must be proactive and informed," Dr. Blackwelder said. ♦



Dr. Ejnes

Principles offered if Medicare financing shifts

Delegates also set policy calling for compensating physicians for time spent on Medicare recovery audit contractor requests.

CHARLES FIEGL
AMNEWS STAFF

Honolulu Delegates outlined a set of principles for a Medicare defined-contribution system if federal lawmakers seek to move the entitlement program away from its current defined-benefits structure.

The American Medical Association House of Delegates did not endorse the defined-contribution model but rather established principles for such a system. The adopted policy supports retaining traditional Medicare coverage as an option for a senior to purchase with a fixed federal subsidy, along with health plan options run by private insurers. A defined-contribution system also should support increased subsidies for low-income Americans and continued funding for graduate medical education, the AMA said.

"With robust patient protections in place to help the most vulnerable beneficiaries, a defined-contribution program can help ensure the sustainability of Medicare for current and future generations," said AMA President-elect Ardis Dee Hoven, MD. "This policy provides the framework to create the needed balance of access, affordability and financing, and allows seniors the choice of coverage options that include both traditional Medicare and private insurance plans. We will continue to explore the effects of transitioning Medicare to a defined-contribution program on cost and access to care."

Protections for beneficiaries

The policy would require competing private health insurance plans to meet guaranteed-issue and renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraud, follow uniform marketing standards, meet plan solvency requirements, and cover at



PHOTO BY LUCI PEMONI / AP IMAGES FOR AMERICAN MEDICAL NEWS

California internist Marcy Zwelling, MD, was among those recommending compensation for physicians for time spent challenging Medicare audits.

least the actuarial equivalent of the benefit package provided by traditional Medicare. Defined-contribution amounts would be adjusted for beneficiary age, income and health status.

Defined-contribution amounts should be adjusted annually to ensure that insurance coverage is affordable for all seniors, the policy states, and the amounts should reflect changes in health care costs.

Compensation for time lost

Delegates also agreed to push for legislation that would repay physicians for time and other costs associated with appealing recovery audit contractor determinations.

The audit process is an administrative nightmare for hospitals and physicians, said Los Alamitos, Calif., internist Marcy Zwelling, MD, an alternate delegate from the California Medical Assn. She told delegates about a physician in Orange County whose audit involved a lengthy

medical records request seeking large overpayments.

"After days and weeks of complete terror, she was told she owed Medicare \$16," Dr. Zwelling said. "She, of course, was not reimbursed for her time. We think if they're actually going to do these audits that they prove there is a problem."

The Association also will oppose RAC audits of evaluation and management services, such as patient office visits, the adopted policy states. The Association will explain to Congress and the Centers for Medicare & Medicaid Services "why these audits are deleterious to the provision of care to patients with complex health needs."

Another new policy supports every physician's ability to choose not to enroll in Medicare. The policy states the AMA will "seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians." ♦

Meeting Notes

Legislative action

ISSUE: A transition to ICD-10 represents a significant hardship and will increase the bureaucratic and financial burden on physicians.

PROPOSED ACTION: The AMA will reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business. The communication will be sent to all in Congress and displayed on the AMA website. *[Adopted]*

ISSUE: The Supreme Court's decision on the 2010 health system reform law gave states the option, instead of a federal mandate, to expand Medicaid eligibility.

PROPOSED ACTION: The AMA, at the invitation of state medical societies, will work with state and specialty societies on advocating that state governments expand Medicaid eligibility. *[Adopted]*

ISSUE: Pay-for-delay practices involve drug manufacturers paying other drugmakers not to release generic versions of medications.

PROPOSED ACTION: The AMA will support federal legislation to ban pay-for-delay practices in the drug industry. *[Adopted]*

ISSUE: Medicare quality and resource use reports employ cost measurements based on spending for patients related to care provided by other physicians.

PROPOSED ACTION: The AMA will continue to work with CMS to improve the reports so they reflect the quality and cost associated with these other physicians when calculating value-based payment modifiers. *[Adopted]*