AMA Delegates Divided on 'Pay for Performance' Tactics

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CHICAGO — The American Medical Association's new policy on pay for performance will limit its ability to negotiate with Congress, several medical specialty society groups claim.

Tensions surfaced at the annual meeting of the AMA's House of Delegates, when delegates voted to oppose any private or federal initiative that did not meet AMA's new principles and guidelines on pay for performance. These and other provisions were contained in a report that established the AMA's principles as official policy.

"Let's face it, pay for performance is here," said AMA Secretary John Armstrong, M.D., who headed the organization's task force on the issue. These new policies will help the organization establish a leadership position on pay for performance, "so when programs are being developed, we have a voice to say: This is the way to do it, that they should not just be used as a tool to cut reimbursement."

However, not everyone agrees with such a hard-line approach. "To say that 'you better meet every single one of these principles and guidelines,' that's digging in your heels—and tying your hands," Mary Frank, M.D., president of the American Academy of Family Physicians, told this newspaper.

"There needs to be flexibility in dealing with Congress, and the AMA is not being flexible," said Ralph Hale, M.D., delegate from the American College of Obstetricians and Gynecologists.

"You don't want to tie the hands of the AMA" on pay-for-performance programs, Stuart Cohen, M.D., delegate from the American Academy of Pediatrics, said in an interview.

Bob Doherty, the senior vice president for governmental affairs and public policy for the American College of Physicians, observed that the AMA's actions might specifically limit its ability to support a pay-for-performance bill linked to fixing the Medicare physician fee schedule, "if the bill in question doesn't meet all of the conditions set by the House of Delegates."

The AMA in its proceedings had expressly decided not to link pay for performance with Medicare pay. "We think they're separate issues," John Nelson, M.D., the AMA's immediate past president, told this newspaper.

But whenever physician groups have brought up the payment fix—either with Centers for Medicare and Medicaid Services Administrator Mark McClellan, M.D., or with members of Congress—the suggestion has always been that "there's no way we were going to get a [sustainable growth rate] fix without there being some kind of a quid pro quo, that they were going to look at this issue in light of other things, such as pay for performance," Dr. Frank said.

The two issues were highlighted extensively in a letter sent by ACP, AAFP, AAP, and ACOG to Senate Majority Leader Bill Frist (R-Tenn.), outlining their own wish list for physician payment reforms.

Given the limitations of the actions taken by the AMA, "the ACP and the other groups felt we needed to go forward on our own and try to develop the best possible bill based on our own policies," Mr. Doherty said.

In the letter to Sen. Frist, the groups specified that they would support legislation that would provide positive updates to Medicare's physician fee schedule, and reverse cuts that would otherwise occur under the sustainable growth rate (SGR).

In other recommendations, the letter stated that:

- Physicians should receive additional payments for participating in performance measurements and reporting programs.
- Pay should increase proportionately, based on the types of care being measured, by the time and costs associated with documenting performance, and the level of health information technology acquired by the practice to support quality improvement.
- Physicians should not be penalized under the SGR for volume increases that may occur due to compliance with performance measures.

Dr. Frank clarified that the letter "was not a preemptive strike" against the AMA, that the groups had gotten word that the Senate Finance Committee was planning a hearing on pay for performance, and they wanted to weigh in on the issue.

"Although we had issues with the board report, we would have written to the Senate regardless of the AMA's actions," she said.

The hope is the AMA will end up supporting these measures in the Frist letter, "but that is a judgment it will have to make" in the context of its own policy, Mr. Doherty added.

Representatives from the primary care groups stressed that they were not breaking ranks from the AMA, but that they wanted to continue negotiations with the organization on pay for performance. The bottom line is "the AMA does not speak for us as individual policy groups," said Donna Sweet, M.D., delegate from the ACP.

Considering that performance measures for pediatricians currently don't exist—with the exception of immunizations, "the pediatricians want to be involved as [lawmakers] go forward in developing quality measures," AAP's Dr. Cohen said.

In an interview, Dr. Armstrong said the AMA would continue to work with the delegation's specialty groups, to make sure that all physicians were on the same page with pay for performance. ■

TALK BACK

What is your view of the AMA policy of not linking pay for performance with Medicare pay?

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POLICY & PRACTICE

The Fate of COX-2s

The first of several lawsuits against Merck, the manufacturer of the cyclooxygenase-2 inhibitor rofecoxib (Vioxx), got underway in Texas last month. More suits are expected to follow, including one brought by the Physicians Committee for Responsible Medicine which charges that Merck relied on animal tests showing that Vioxx was safe while ignoring mounting clinical evidence that the drug increased cardiac risks in people. Meanwhile, across the border in Canada, an expert panel convened by national health officials recommended last month that Vioxx be allowed back on the market. The panel also voted that celecoxib (Celebrex) should continue to be marketed in Canada and that valdecoxib (Bextra) should not be allowed back on the market. Celebrex is currently the only COX-2 inhibitor available in Canada. Merck voluntarily withdrew Vioxx from the market in 2004 in response to evidence that the drug increases the risk of cardiovascular events. Pfizer suspended sales of Bextra last year due to concerns about a serious skin disorder and short-term cardiovascular risk.

Rheumatologist Takes Helm

A rheumatologist is now heading the U.S. Bone & Joint Decade, a 10-year effort to raise awareness and improve treatment of musculoskeletal diseases. Nancy Lane, M.D., was elected to a 2-year term as president at the group's annual board meeting in June. Dr. Lane currently serves as the director of the Center for Healthy Aging and is a professor of medicine and rheumatology at the University of California, Davis. She is also the coeditor for the journal Arthritis & Rheumatism. Dr. Lane succeeds Regis O'Keefe, M.D., who served as president of the initiative since 2003. Dr. O'Keefe is a professor of orthopedics at the University of Rochester (N.Y.).

The Cost of Smoking Deaths

Smoking deaths cost the nation $92 billion in lost productivity on an annual basis, from 1997 to 2001, the Centers for Disease Control and Prevention reported. This reflects an increase of about $10 billion from the annual mortality losses for the years 1995 through 1999. During the same period, an estimated 438,000 premature deaths occurred each year as a result of smoking and exposure to secondhand smoke. To reduce the toll, "we must provide the 32 million smokers who say they want to quit with the tools and support to do it successfully," CDC Director Julie Gerberding, M.D., said in a statement. In an independent action, the American Medical Association's House of Delegates took measures to discourage tobacco use at its annual meeting, voting to support increases in federal, state, and local excise taxes on tobacco. Such increases in the excise taxes should be used to fund the treatment of those afflicted by tobacco-related illness, and to support counter-advertising efforts, the resolution stated.

Health Insurance Statistics

The ranks of the uninsured appear to be leveling off, according to a survey conducted by the CDC's National Center for Health Statistics. In 2004, 42 million Americans of all ages were without health insurance, about the same level as in 1997, the first year this survey began tracking these statistics. In addition, one in five adults aged 18-64 years were without health insurance last year, a number that had been steadily rising in recent years, but also leveled off in 2004. The survey showed continued improvements in coverage for children: Seven million children aged under 18 years were without health insurance in 2004, compared with 10 million children in 1997.

Uneasy Retirement

Baby boomers are concerned about their financial and health security—and would favor setting aside a portion of their earnings in a special account to save for future medical expenses, a report from the Commonwealth Fund stated. In a nationally representative sample of 2,000 adults aged 50-70, very few thought they would have enough income and savings for retirement and three of five adults in this age group worry that they will not be able to afford medical care in the future. More than 50% of those working or with a working spouse said they would not have job-based retiree health benefits when they retire. These fears are somewhat warranted: 12 million older adults are currently uninsured or have had histories of unstable coverage. The survey reflected a strong interest among older adults in a Medicare health account that would allow people to add to savings as well as receive the traditional Medicare benefit.

NIH Extends Disclosure Deadline

Officials at the Department of Health and Human Services are giving employees at the National Institutes of Health more time to report prohibited financial interests and to divest stock. In its announcement of the extension, HHS wrote that the department is considering issuing revisions to its current ethics regulations. In February, the agency issued regulations prohibiting NIH employees from engaging in consulting relationships with organizations that are substantially affected by NIH decisions. And NIH employees who are required to file financial disclosure statements are prohibited from acquiring or holding financial interests, such as stocks, in these affected organizations. NIH employees now have until Oct. 3, 2005, to file financial disclosure reports and until Jan. 2, 2006, to divest of prohibited financial interests. This is the second extension offered to NIH employees. "There's no doubt in my mind that at the end of the day the advice that NIH gives has to be completely untainted, completely unimpeachable, and completely trusted," NIH Director Elias Zerhouni, M.D., said during a teleconference sponsored by the Kaiser Family Foundation.

—Mary Ellen Schneider