REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-15

Subject: Physician Employment Trends and Principles

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Referred to: Reference Committee J
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At the 2014 Interim Meeting, the House of Delegates adopted Resolution 607, which established Policy D-225.976 directing the American Medical Association (AMA) to examine the potential long-term effects of trends in physician employment on patients and on the medical profession, and report back at the 2015 Interim Meeting. Policy D-225.976 specifies that the study should consider questions such as but not necessarily limited to:

a) What factors have contributed most to increases in the proportion of physicians who are employed?
b) How do employment and concomitant increases in rates of physician "turnover" affect continuity of care and patients' perceptions that the physicians who treat them are dedicated to their long-term well-being?
c) In what other ways might a physician's employment status potentially affect the patient-physician relationship, and how might these effects, if problematic, be mitigated?
d) How do increasing rates of employment affect the physician-hospital/health system relationship?
e) How does employment affect physicians' understanding of and will to engage in advocacy on issues that have historically been of significant importance to physicians, such as medical liability reform and physician reimbursement issues (e.g., SGR)? What effect will employment ultimately have on the collective voice of the medical profession?

The study directed in Policy D-225.976 was subsequently assigned to the Council on Medical Service. The literature often distinguishes between employment and independent practice, although independent practices can have both owner and employed physicians. The Council has focused this report on physicians employed by hospitals and health systems. This report provides background that speculates about physician employment and notes some incentives that drive physician employment opportunities; outlines extensive AMA activity to understand and improve physician employment; explores the questions posed in Policy D-225.976; summarizes relevant AMA policy; and provides policy recommendations.

BACKGROUND

There is widespread interest in physician practice choices, fueled by research that predicts a widespread trend toward physician employment and the purchase of physician practices by hospitals and health systems.[1]

The AMA's 2014 Physician Practice Benchmark Survey[2] (Benchmark Survey), which is a nationally representative sample of non-federal physicians who provide care to patients at least 20

hours per week, involves periodic censuses of physician practice. It confirms a shift toward hospital employment of physicians, but finds that this shift may not be as large as some articles have suggested. The 2014 survey found that 26 percent of physicians worked in practices that were at least partially owned by a hospital and another seven percent were directly employed by a hospital. In contrast, 57 percent of physicians worked in practices that were wholly owned by physicians. The Benchmark Survey has also asked about ownership and employee status and practice type. The percent of physicians who are owners of their practices declined from 76.1 percent in 1983 to 50.8 percent in 2014. Also in 2014, 43 percent of physicians were practice employees and 6.2 percent were practice contractors. The Benchmark Survey finds younger and female physicians more likely to be employed by their practice than older and male physicians.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was signed into law on April 16, 2015. This bipartisan legislation permanently repealed the sustainable growth rate (SGR) formula and provides positive updates for Medicare payments for physician services from July 1, 2015, through the end of 2019, and again in 2026 and beyond. The legislation, like the Affordable Care Act (ACA), includes incentives to work in accountable teams, which in turn may encourage physician employment with hospitals and health systems, including insurers. The goals of accountable care organizations and other forms of team-based care are to provide better value by coordinating care and improving quality. AMA resources for physicians who are navigating these new delivery models are available online. [3]

AMA ACTIVITY

The AMA supports the ability of physicians to choose their mode of practice. The aforementioned AMA Benchmark Survey provides an evidence base for AMA activity. In addition, more recently, the AMA has partnered with RAND Corporation to study physician professional satisfaction. In addition, the AMA has numerous resources to help employed physicians and those considering employment by hospitals or other corporations to preserve independent decision-making, avoid conflicts of interest and protect patient relationships.

In 2013, the AMA and RAND studied professional satisfaction and found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate).[4] Work controls and opportunities to participate in strategic decisions were found to mediate the effect of practice ownership on overall professional satisfaction. In 2015, the AMA and RAND collaborated again to focus on the effects of health care payment models on physician practices.[5]

The AMA and the American Hospital Association (AHA) held a joint leadership conference in October 2013 on new models of care to initiate discussions about integrating the administrative and clinical aspects of health care delivery. The conference, which was the first formal meeting between these two organizations in more than 35 years, was an opportunity to better understand how physicians and hospitals interact and the ways in which they can become more collaborative. Conversations centered on the need for greater physician-hospital collaboration to move toward a reformed system and to achieve the Triple Aim of better health, better health care and lower costs. These discussions laid the foundation for identifying solutions to aid physicians and hospital executives in working together and in adapting to an ever changing health care environment, including financial, cultural and operational changes. In 2015, the AMA and AHA jointly released "Integrated Leadership for Hospitals and Health Systems: Principles for Success.[6]" These principles provide a guiding framework for physicians and hospitals that choose to create an integrated leadership structure but are unsure how to best achieve the engagement and alignment necessary to collaboratively prioritize patient care and resource management.

As more physicians became employed by hospitals and health systems, the AMA developed the Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement[7] to assist in the negotiation of employment contracts. AMA Principles for Physician Employment (Policy H-225.950) address some of the more complex issues related to employer-employee relationships. Conflicts of interest, advocacy for patients and hospital/medical staff relations are some of the topics addressed in these principles. Further guidance on conflicts of interest can also be found in Conflict of Interest Guidelines for Organized Medical Staffs and the AMA *Code of Medical Ethics*.

The AMA is developing a leadership program for physicians regardless of career stage or practice setting. Under development in 2015, the program will aim to prepare physicians to lead successfully and to manage in a strategic and efficient manner, with the goal of creating a better health care system for patients and physicians alike.

LONG TERM EFFECTS OF PHYSICIAN EMPLOYMENT

Policy D-225.976 specified five questions to include in the study the potential long-term effects of trends in physician employment on patients and on the medical profession. Accordingly, the Council identified and reviewed available data related to the questions and found a paucity of data.

a) What factors have contributed most to increases in the proportion of physicians who are employed?

   The AMA Benchmark Survey queried physicians about their motivations for recent hospital ownership and found that, among physicians in hospital-owned practices where the practice was acquired in 2005 or later, "improve practice financial stability" was listed as a very important motivator by 59 percent of respondents, and "prepare for payment and delivery reform" was indicated by 43 percent of respondents. In comparison to 2012, 2014 data showed an increased mention of being approached by a hospital (41 percent) and the desire to better implement HIT (35 percent) as very important motivators. Additional motivators included: "achieve a better work/life balance" (31 percent); "improve quality of care" (24 percent); "improve clinical care coordination" (23 percent); and "access to more patients" (21 percent).

   Results from the 2015 AMA-RAND study on the effects of health care payment models on physician practice identified similar factors contributing to practice mergers and hospital ownership: the need for capital investment under new payment models; seeking improved negotiating positions with health plans; and the perception of a greater sense of security in changing or unfamiliar payment models.

b) How do employment and concomitant increases in rates of physician "turnover" affect continuity of care and patients' perceptions that the physicians who treat them are dedicated to their long-term well-being?

   Empirical findings delineating these effects on continuity and patient well-being could not be located. A report under development by the AMA Council on Ethical and Judicial Affairs (CEJA) has begun looking at the challenges of providing continuity of care in complex health systems, which may identify effects on the patient experience of, for example, seeing different providers at each visit.

c) In what other ways might a physician's employment status potentially affect the patient-physician relationship, and how might these effects, if problematic, be mitigated?

The Council is well aware of longstanding concerns among physicians about preserving professional autonomy under employment models and the rippling effects that limited autonomy could have on their patients. The forthcoming CEJA report may provide insights on this question as well.

d) How do increasing rates of employment affect the physician-hospital/health system relationship?

Although studies delineating this relationship could not be located, the AMA and AHA are currently developing guidance on collaborations and partnerships between physicians and hospital or health system executives, including key attributes that would foster successful, integrated leadership. Physician and hospital integrated leadership supports a change in the management structure of hospitals and health systems by having more physicians in the boardroom and in key roles at the executive level so hospitals can succeed in the reformed models for health care delivery and payment.

e) How does employment affect physicians' understanding of and will to engage in advocacy on issues that have historically been of significant importance to physicians, such as medical liability reform and physician reimbursement issues (e.g., SGR)? What effect will employment ultimately have on the collective voice of the medical profession?

Data regarding the effect of employment on physicians' understanding of and willingness to engage in advocacy, could not be found. However, AMA Policy H-225.950[2] asserts that employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

AMA POLICY

The AMA has substantial policy on physician employment. Policy H-385.926[2] affirms AMA support for the freedom of physicians to choose their method of earning a living. Policy D-225.977 directs the AMA to continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations. Furthermore, Policy H-285.954 states that certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting. Policy H-285.910 endorses the insertion into physician employment agreements of language guaranteeing physician independence.

The inviolability of the patient-physician relationship is a recurrent theme throughout the AMA *Code of Medical Ethics*. Opinion 8.131 in the *Code of Medical Ethics* states that physicians in leadership positions within health care organizations have an ethical responsibility to ensure that practices for financing and organizing the delivery of care recognize physicians' primary obligation to their patients. It is also the policy of the AMA to strongly condemn any interference by outside parties that causes a physician to compromise his or her medical judgment (Policy H-5.989). Policies H-285.910 and H-285.951 promote independent patient advocacy as fundamental to the patient-physician relationship and thereby free from interference.

AMA Principles for Physician Employment (Policy H-225.950) are intended to help physicians, those who employ physicians, and their respective advisors identify and address some of the unique challenges employment presents to professionalism and the practice of medicine. Conflicts of interest are addressed in these principles, which make clear that patient welfare must always take priority over an employer's economic interests.

The AMA has also established policy addressing payment variations across outpatient sites of service, most recently through the adoption of the recommendations contained in Council on Medical Service Report 3-A-13 (Policy D-240.994), which advocated equal or lower coinsurance for lower-cost sites of service; and Council on Medical Service Report 4-A-14, which modified Policy H-330.925 to advocate that CMS use the hospital market basket index to annually update ambulatory surgical center payment rates, rather than the Consumer Price Index for all Urban Consumers. Based on the policy established with these reports, an advocacy briefing document entitled "Payment variations across outpatient sites of service" was that can be downloaded from the Council's website: www.ama-assn.org/go/cms.

The AMA has equally strong policy on organized medical staff affairs (e.g.: Policies H-235.963, H-235.990, H-235.992, H-235.999), including a physician's right to exercise independent judgment in all matters regarding patient care, the profession, health care in the community and medical staff matters, and to incorporate the independent exercise of medical judgment into physician employment and contracting agreements (Policy D-225.978). Policy H-225.957 outlines principles for strengthening physician-hospital relationships. Finally, AMA Policy H-285.983 supports the establishment of self-governing medical staffs in other health care delivery systems, similar to those that exist in hospitals.

DISCUSSION

The Council concurs with the premise of Resolution 607-I-14, the genesis of Policy D-225.976, which expresses caution regarding the unknown consequences of physician employment. The preamble of Resolution 607-I-14 acknowledges that increased employment among physicians is a result of their choosing to do so. The Council recommends reaffirming Policy H-385.926[2], which supports the freedom of physicians to choose their method of earning a living,

In this report, the Council has summarized a variety of AMA resources that aim to help employed physicians and those considering employment by hospitals or other corporations to preserve independent decision-making, avoid conflicts of interest and protect patient relationships.

For those physicians who choose employment with a hospital or health system, the Council recommends a series of guiding principles regarding characteristics of the employment arrangement. The recommended principles reflect the joint AMA/AHA document "Integrated Leadership for Hospitals and Health Systems: Principles for Success."

In its examination of the enumerated effects of long-term employment provided by Policy D-225.976, the Council found a lack of empirical data and published research. The delivery reforms promoted by the ACA and MACRA are likely to influence the ways hospitals and physicians work together in the future. The Council believes that these alterative models of payment and delivery provide a natural experiment and a rich body of data that should continue to be studied for their effects on patients and the medical profession. Acknowledging the ongoing changes in physician employment, the Council looks forward to data on emerging models (e.g., physician cooperatives, independent physician associations, and specialty-specific physician practice management companies).

Finally, the Council recommends rescinding Policy D-225.976, which calls for the study that has been accomplished by development of this report. Acknowledging the rapid emergence of payment and delivery innovations, the Council will continue to study new models.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-385.926[2], which supports the freedom of physicians to choose their method of earning a living. (Reaffirm HOD Policy).

2. That our AMA encourage physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles:
    a. Physician clinical autonomy is preserved.
    b. Physicians are included and actively involved in integrated leadership opportunities.
    c. Physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure.
    d. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care.
    d. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care.
    e. A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. (New HOD Policy)

3. That our AMA encourage continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession. (New HOD Policy)

4. That our AMA rescind Policy D-225.976, which requested this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] See, for example, Elliot VS. Doctors describe pressures driving them from independent practice. American Medical News [Internet]. Chicago (IL): American Medical Association; 2012 Nov 19. [downloaded July 27, 2015]. Available from: http://www.amednews.com/article/20121119/business/311199971/2/

[2] Kane, Carol K. Policy Research Perspectives Updated Data on Physician Practice Arrangements: Inching Toward Hospital Ownership. AMA, 2015 [accessed July 30, 2015] file:///C:/Users/vcarpent/Downloads/prp-practice-arrangement-2015%20(1).pdf

[3] AMA. Advocacy with Congress. AMA, 2015. [accessed July 30, 2015] http://www.ama-assn.org/ama/pub/advocacy/federal/advocacy-with-congress.page

[4] RAND. Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND, 2013 [accessed July 30, 2015] http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf

[5] RAND. Effects of Health Care Payment Models on Physician Practice in the United States. RAND, 2015 [access July 30, 2015] http://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR869/RAND_RR869.pdf

[6] American Hospital Association and AMA. Integrated Leadership for Hospitals and Health Systems: Principles for Success. AHA and AMA, 2015 [accessed September 23, 2015] http://www.ama-assn.org/resources/doc/about-ama/x-pub/ama-aha-integrated-leadership-principles.pdf

[7] AMA. Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement. AMA. [accessed July 30, 2015] http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/organized-medical-staff-section/helpful-resources/physician-employment-agreements.page