Alabama Medicaid: The Move to a Managed-Care Program
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Contents

From the President .......................................................... 6
Great Achievements Met for Providers with Extraordinary Vaccination Coverage Rates ................. 9
Alabama Medicaid: The Move to a Managed-Care Program ................................................. 10
Medicaid Regional Care Organization – Turning the Clock Back 20 Years ......................... 16
Congress Takes Aim at SGR ........................................................................................................ 18
Family Physicians Moving Out of Maternity Care, Rural Areas Suffer ................................................. 19
Is Your Practice Ready for ICD-10? ..................................................................................... 19
Allopathic, Osteopathic Medical Communities Announce Transition to Unified GME Accreditation .......................................................... 20
Annual Meeting and Scientific Symposium ........................................................................... 21
Classifieds ................................................................................................................................. 22
Consultants Directory .............................................................................................................. 22

Advertisers
Alabama Department of Public Health, Immunization Division ................................................. 8
Belk & Associates, Inc. ................................................................................................................ 15
Children’s of Alabama ............................................................................................................. 7
Coastal Insurance Company, Inc. ................................................................................................... 23
Healthcare Workers’ Compensation Self-Insurance Fund ................................................. 15
MagMutual .................................................................................................................................. 13
Medicus Insurance Company ................................................................................................ 4
Physicians’ Alliance of America ............................................................................................... 3
ProAssurance Group .................................................................................................................. 2
Southeast Alabama Rural Health Associates ........................................................................ 15
The University of Alabama College of Community Health Sciences ......................................... 24

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Feel the Need, But Don’t Have the Time?

If you are like me, you are looking forward to the longer days and warmer weather. According to our local weatherman, this has been the third-coldest winter in Alabama on record. The short days, combined with the cold weather, have kept us indoors for several months. If your mood has suffered, along with your waistline, you’re not alone. This winter has increased our risk for developing seasonal affective disorder, known by the acrostic SAD. Fatigue and moodiness are common in SAD, and so are hypersonmolence, social withdrawal, weight gain and anxiety. Mimicking SAD is burnout. Common signs of burnout include exhaustion, lack of motivation, cynicism, difficulty concentrating, interpersonal problems and decreased satisfaction. Sound familiar?

Burnout has affected more family physicians than any one other single career group. One article cited 40 percent of generalists had signs of serious burnout. Burnout usually starts in people with high ambition who intend to prove themselves in their career. They take on more work because they see this as being responsible. Anything less is just not acceptable to their superego, as Freud might say. Since they must work to prove themselves worthy and honor their commitments to their patients and profession, they ignore their personal needs. It’s not unusual for family physicians to slowly replace the fun things in life with more responsibilities related to the profession of medicine. The ability to get involved abounds in medicine. You can serve on committees, councils, associations, community boards and even national societies. The more visible you become, the more offers you get to be involved in yet another project or serve on another committee. Soon, you are living the Paredo 20/80 rule: 20 percent of the people do 80 percent of the work. Not to mention that medicine has become the highest-regulated profession in the world. You are likely implementing an electronic health record; converting your practice into a Patient-Centered Medical Home; trying to figure out PQRS, ICD-10, meaningful use, the restructuring of Medicaid and whether or not you’re a pain clinic; and trying to keep up with your board certification requirements — you know, those SAMs and Part IV modules. You also likely have family and religious obligations requiring your daily attention. Now that you’ve completed those weekly obligations, you might want to see the 120-plus patients needing their doctor. Wait, what about the labs, X-ray reports, home health certifications, medication refills, progress notes, phone calls, prior approvals, disability forms, family leave act forms and messages that go along with patient care? Did I forget to mention the emails, texts, tweets and Facebooking that many of you do? It’s no wonder that at least 40 percent of us are burned out. What’s the cost of burnout? Destroyed personal health, lost marriages, children who don’t know their parent, lost friendships, isolation, decreased productivity, loss of income, depression and, worse yet, suicide.

Interestingly, we usually don’t recognize the signs in ourselves, and we discount the concerning comments made to us by others. Our approach to problem-solving is to just try harder. It’s always worked in the past. When you got a bad grade on a test, the next time, you studied harder to bring it up. When you didn’t win the race, the next time you trained harder and placed higher. We’ve proven to ourselves that success is determined by how hard we work. Unfortunately, we fail to apply the Frank-Starling curve to our lives. If you don’t stretch yourself, you have little gain; if you stretch yourself optimally, then you have the greatest gain; however, if you overstretch yourself, your gains fall off, even to the point of complete failure.

How do you know if you are heading for burnout or in the midst of it? Ask yourself some questions. Are you tired all of the time, even after a few days off? Do you dread the day ahead most days of the week? Do you feel depressed, sad or pessimistic? Do you not have any real friends? Do you not spend time with your family? Do you long for a vacation? Do you have trouble relaxing if
you do go on vacation? Do you have someone who you value tell you that he or she is worried about you? Do you want to change jobs or just want to quit altogether? Yes to more than one or two of these should alert you to burnout. Still in denial?

What can you do to prevent burnout or to reverse the effects if you are experiencing burnout? First, if you have severe burnout — that is, you are depressed, self-prescribing anti-depressants, drinking too much alcohol, having major marital problems or having serious health concerns related to stress, then seek professional help immediately. See your own family physician, counselor or clergy. If you don’t have anyone to turn to, then call me or Jeff Arrington, and we will help you find someone, or call the Alabama Physician Health Program. This program is by physicians, for physicians, and is highly successful and fully confidential. The number is 334-954-2596.

Finding a balance in family; personal time; professional life; and social, civic and religious responsibilities is essential. The very first word to learn is “no.” As family physicians, we have trouble telling people, “No.” We want to be liked, to be respected and to be thought of as Superman — you know, invincible. The truth is we are just as human as our patients. There’s no reason that you can’t have a full life, but allowing your life to control you instead of you controlling your life is the beginning of the end.

Start with writing down your priorities — that is, what is most important to you. Be reasonable; everything can’t be most important. Choose one item from each of the areas of your life mentioned in the preceding paragraph. You can have a very rewarding life and do more by doing less. I do believe it’s necessary to be involved in more than just patient care in order to have a full life, but you don’t have to be involved in everything. Once you’ve decided what is most important, then say no to everything else, and don’t feel guilty when you do. Next, get a daily calendar, and schedule your life. The first thing that goes on the schedule is your personal time. You need time to exercise, read, rest, meditate and reflect, then schedule other events in your life. As opportunities present themselves, and they will, ask yourself if it fits on your most important list. If not, then say no. If it is most important, do you have time, and can you drop something off of your list that is no longer important? If the answer is no to either of these questions, then maybe it’s not as important as you first thought.

Your life balance is completely up to you and determined by your ability to prioritize and to say no. If you can’t do this yourself, find someone who can do it for you. Find a blame agent if you can’t tell people no. Just say, “I’d love to do that, but my wife/husband/manager would have a fit if I obligated myself to another project.” I don’t need to tell you how important it is to get enough sleep, have good nutrition, exercise and occasionally do something that you enjoy. This is called putting margin in your life. Margin is that space that allows us to cope with the unexpected. Without margin, any emergency can end in personal and professional disaster. We all know that, to be financially successful, we have to start planning early in our career and to pay as we go. The same is true for personal success. The earlier that you learn to plan your life and keep paying into it, the longer it will last after you retire.
What is the Vaccines for Children Program?

The Vaccines for Children (VFC) program provides vaccines to eligible children without vaccine cost to the provider. All routine childhood vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) are available through this program. The program saves parents and providers out-of-pocket expenses for vaccine purchases.

What are the benefits of the VFC program?

You can provide necessary vaccines to uninsured children and others who cannot get recommended vaccinations without financial assistance—and, you will not incur any additional costs. You can also...

- Reduce referrals of eligible children to the public clinics for vaccination, thus allowing them to stay in their medical homes and ensuring the continuity of care.
- Save money on your vaccine purchase because you will receive public-purchased vaccines under the program.
- Receive technical assistance to help improve your vaccination rates, such as record-keeping, vaccine handling, and vaccination opportunities.

How can I enroll as a provider in the VFC program?

Enrolling in the VFC program is easy! Call the Alabama Department of Public Health's Immunization Program. Then...

1. Request a provider enrollment package.
2. Complete and return the enrollment form.
3. Return the Provider Profile form, as required, to ensure you receive the amount of vaccine needed for your office.

Your strength is the ability to provide.
Great Achievements Met for Providers with Extraordinary Vaccination Coverage Rates

The Immunization Division of the Alabama Department of Public Health (ADPH) is proud to present the results of the 2013 Vaccines for Children (VFC) site visits for those clinics that achieved vaccine coverage levels of 100 percent, more than 90 percent and more than 80 percent. During 2013, ADPH staff members performed VFC-AFIX quality improvement visits to VFC provider clinics. These visits allowed ADPH staff members to determine if VFC providers are following VFC guidelines, to offer education and CEU credits for clinic staff, and to determine vaccine coverage levels of the clinic. The ADPH Immunization Division congratulates these VFC providers for an extraordinary accomplishment in 2013.

100 Percent Vaccination Coverage Rates
2-Year-Olds Completely Immunized
Cullman Medical & Pediatric Associates
Mainstreet Medical
IMC – Family Medical of Jackson

Adolescents Ages 13-15 Completely Immunized
Dr. Sarah Styers
Ivy Creek

90 Percent Vaccination Coverage Rates
2-Year-Olds Completely Immunized
Pediatrics East – Trussville
Midtown Pediatrics
Horizon Pediatrics
Birmingham Healthcare – Marks Village
ABC Pediatric Clinic
Athens Limestone Pediatric Clinic
Hamilton Pediatric Clinic
Dr. Jeffrey Hull
Internal Medicine and Pediatrics of Cullman
Drs. James and Kathryn Mize
Shoals Pediatric Group
Highlands Family Medicine
Marshall County Pediatrics – Boaz
Brightstarts Pediatrics
Pediatric Associates – Alex City
Southeastern Pediatrics – East
Baptist Health Center – Dekalb
Cherokee Health Clinic

Adolescents Ages 13-15 Completely Immunized
Family Health Associates, P.C.
Infants’ & Children's Clinic #1
Infants’ & Children’s Clinic #2
Winfield Children’s Center
Madison Valley Pediatrics
Central North Alabama Health Services Huntsville
Extended Family Care Medical Clinic
FPHC – Maysville Medical Center
Mobile County Health Department – School Based Clinic
Coosa Valley Pediatrics
Chisholm Family Health Center
Greene County Physician Clinic
Eastern Health Center
Alabama Department of Youth Services – Vaca
Alabama Clinical Schools
West End Health Center
Western Health Center
Central Health Center

80 Percent Vaccination Coverage Rates
2-Year-Olds Completely Immunized
Tots N’ Teens Pediatrics
Pediatrics East Deerfoot
Acton Road Pediatrics
Pell City Pediatrics
Dr. Muhamad Festok
Birmingham Healthcare Medical Plaza
Primary Care Service
St. Vincent’s Pediatrics – Oneonta
Kidstown Pediatrics of Decatur
Valleyview Family Medicine
QOL – Health Complex
Northeast Alabama Pediatrics #1
Northeast Alabama Pediatrics #2
Dr. Mark Cooper Family Practice

Dr. N.R. Thotakura – Madison
Magnolia Springs Pediatrics
Primary Care Center of Monroeville
Southwest Alabama Health Services
USA Department of Pediatrics
USA Family Practice Center
IMC – Pediatric & Adolescent Medicine
South Alabama Medical Center
Mobile County Health Department – Southwest
Wetumpka Family Rural Health
Butler County Health Department
Wilcox County Health Department
St. Clair County Health Department

Adolescents Ages 13-15 Completely Immunized
Tuscaloosa Pediatrics
Simon – Williamson Clinic
Greenvale Pediatrics – Hoover
Growing Up Pediatrics – Bessemer
Hope Health Center
Pediatrics Plus
Drs. Dabbs & Hyland, P.C.
Kidstown Pediatrics of Athens
Lakeshore Pediatrics – Sheffield
Dr. Wayne Thomas
West Limestone Family Care
Capstone Rural Health Center
Cullman Pediatrics
QOL – J.W. Stewart
QOL – Pro-Care Colley Homes
Phenix City Children’s
Southside Family Center
Growing Up Pediatrics
Dr. Dale Robbins
Bessemer Health Center
Morris Health Center

The Alabama VFC Program appreciates the knowledge, skill and experience the above providers exhibit in their daily preventive health care practices. Thank you for your outstanding performances in keeping Alabama children safer and healthier!

Alabama Academy of Family Physicians
On May 17, 2013, Gov. Bentley signed into law Act 2013-261, Ala. Code §§ 22-6-150 et seq. (the Act), which changes the Alabama Medicaid system from a fee-for-service to a managed-care program. This historic legislation will result in nearly 1 million Alabama Medicaid beneficiaries receiving care from new entities called regional care organizations (RCOs). Each RCO will receive a capitated per-member per-month fee from the Medicaid Agency in return for providing health care services to beneficiaries assigned to the RCO. RCOs must be established no later than October 1, 2014, with the provision of care starting October 1, 2016.1 The new managed-care program is estimated to save Alabama and the federal government between $748 million and $1.079 billion over five years.2

Following is a summary of the key elements of the Act, along with a discussion of regulations and other guidance issued by the Alabama Medicaid Agency (the Agency). To date, only a few regulations have been issued, and therefore much of what is known about RCOs and the Medicaid managed care program is taken from the Act itself.

**Formation of RCOs**

According to a report by the Alabama Medicaid Advisory Commission3 issued in January 2013, for the calendar year 2011, approximately 22 percent of Alabama citizens qualified for Medicaid services at least a portion of the year. For that same time period, Medicaid covered 53 percent of births, 47 percent of children and almost two-thirds of nursing-home residents.5 In fiscal year 2012, total Medicaid expenditures were $5.63 billion, with the state contributing $1.835 billion and the remaining funds coming from the federal government.6 Medicaid enrollment growth, medical inflation, benefit changes, federal match rate changes and utilization are all cited as factors causing an increase in Medicaid spending during the last five years.7

To combat the increasing state costs associated with Medicaid, the Act creates a new managed-care program. The program will be administered by RCOs, which are corporate entities to be formed by health care providers, including physicians and hospitals. Each RCO will contract with the Agency “to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state,” excluding long-term care and dental care, which will continue under the current Medicaid payment system.8 An RCO will provide services in an assigned region of the state through its owners and contracts with other health care providers.

The Agency will enroll Medicaid beneficiaries in each RCO.9 If, however, more than one RCO operates in a region, the beneficiary can choose which RCO to join. If the beneficiary does not make a choice, he or she will be assigned to an RCO by the Agency. Limitations will be placed on beneficiaries moving between RCOs in the same region.

**Alabama Regions**

Alabama Administrative Code § 560-X-37-07 divides the state into five RCO regions. The regions were chosen to maintain existing referral patterns and to keep health systems together when possible. Each region has been determined capable of supporting at least two RCOs. The five RCO regions are as follows:

- **Region A:** Colbert, Cullman, Franklin, Jackson, Lauderdale, Lawrence, Limestone, Madison, Marshall and Morgan counties
- **Region B:** Blount, Calhoun, Cherokee, Chilton, Cleburne, Clay, Coosa, Dekalb, Etowah, Jefferson, Randolph, Shelby, St. Clair, Talladega, Tallapoosa and Walker counties
- **Region C:** Bibb, Choctaw, Fayette, Greene, Hale, Lamar, Marengo, Marion, Perry, Pickens, Sumter, Tuscaloosa and Winston counties
- **Region D:** Autauga, Barbour, Bullock, Butler, Chambers, Crenshaw, Coffee, Covington, Dale, Dallas, Elmore, Geneva, Henry, Houston, Lee, Lowndes, Macon, Montgomery, Pike, Russell and Wilcox counties
- **Region E:** Baldwin, Clarke, Conecuh, Escambia, Mobile, Monroe and Washington counties

**RCO Capitation Contracts with Medicaid**

Subject to approval by the Centers for Medicare and Medicaid Services (CMS),11 the Agency will enter into a capitated risk contract with each RCO to provide medical care to Medicaid beneficiaries assigned to the RCO. Capitated rates can vary between RCOs, even those operating in the same region. A risk contract will only be executed if, in the judgment of the Agency, “care of Medicaid beneficiaries would be better, more efficient, and less costly” than the existing fee-for-service payment system. Even though an RCO assumes risk for paying for health care services, under the Act, an RCO will not be considered an insurance company.
The initial contract between the Agency and each RCO will be for three years, with the option for the Agency to renew the contract for not more than two additional one-year periods. The Agency will obtain an independent evaluation of the cost savings, patient outcomes and quality of care provided by each RCO in order to determine whether to enter into another multiyear contract with the RCO or change to another regional care organization.

Pursuant to the Act, the Agency shall establish rules for terminating a contract with an RCO for nonperformance or for failure to meet quality benchmarks, standards or statutory requirements. In connection with a planned termination, an RCO shall have the right to a hearing before an impartial, third-party hearing officer appointed by the Agency.

The RCO Governing Body
An RCO is governed by a Board of Directors comprised of 23 members. The Board membership, along with its bylaws, rules and procedures, are subject to approval by the Agency. Special-interest groups had significant influence over the Act, resulting in a rather convoluted Board comprised of the following members:

- Twelve members representing “risk-bearing” participants in the RCO. A participant bears risk by contributing cash, capital or other assets to the RCO. A participant also bears risk by contracting with the RCO to treat Medicaid beneficiaries at a capitated rate.
  - A total of three primary care physicians, with one from a Federally Qualified Health Center appointed jointly by the Alabama Primary Health Care Association and the Alabama Chapter of the National Medical Association and the other two physicians appointed by a caucus of county boards of health in the RCO region.
  - One optometrist appointed by the Alabama Optometric Association, or a successor organization.
  - One pharmacist appointed by the Alabama Pharmacy Association, or a successor organization.
- Three members shall be community representatives who are not “risk-bearing” participants and who are not employees of risk-bearing participants. These members are comprised of the following:
  - The chair of the RCO Citizens’ Advisory Committee, discussed below. This committee advises the RCO on providing quality care to Medicaid beneficiaries.
  - Another member of the Citizens’ Advisory Committee who is a representative of an organization that is part of the Disabilities Leadership Coalition of Alabama or Alabama Arise, or their successor organizations.
  - A business executive, nominated by the chamber of commerce in the region served by the RCO and who works in that region.

In addition, a majority of the Board members may not represent a single type of provider, such as hospitals or physician practices. Any vacancy on the RCO Board is filled by the caucus of county boards of health in the RCO region, the Citizens’ Advisory Committee and the optometric and pharmacy associations. The Agency also has the power to fill a Board seat left vacant for more than three months.

The Act does not specify how many Board members must be present at a meeting in order to take action (a quorum) and does not specify whether a majority vote (or some higher percentage) is needed for the Board to make decisions. The Act, however, does provide a veto right to certain physician members of the Board. Specifically, the RCO Board may not take any action unless at least one physician appointed by a caucus of county boards of health votes on the prevailing side. It is interesting to note that there are only two Board physicians appointed by the county boards of health.

**RCO Solvency and Financial Reporting Requirements**
To guarantee payment for health care in its region, each RCO is required to meet minimum solvency and financial requirements at the following levels:

- Restricted reserves of $250,000 or an amount equal to 25 percent of the RCO’s total actual or projected average monthly expenditures, whichever is greater
- Capital or surplus, or any combination thereof, of $2.5 million

As an alternative to the above, an RCO may obtain a bond in an amount equal to the above financial reserves to guarantee its performance. The bond must be issued by an insurer authorized to do business in Alabama and approved by the Medicaid Commissioner. No assets of the RCO can be pledged or encumbered for the payment of the performance of the bond.

To evaluate RCO operations, each RCO is required to submit to the Agency financial reports and information in a manner consistent with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Agency will use the data to perform or contract for financial audits of each RCO to be conducted at least every three years, or more frequently if requested by the Agency.

**RCO Provider Networks and Provision of Care**
Each RCO is required to establish a network of health care providers in order to deliver care to its enrollees. The network can include physicians, hospitals, pharmacies, podiatrists, chiropractors, psychologists, dentists, therapists, social workers, rural health clinics and other health care providers. Instead of contracting directly with a provider, an RCO can also contract with a managed-care organization to provide health care services. At a minimum, a provider must comply with applicable licensing requirements and maintain a Medicaid provider number and must not be excluded from the Medicare or Medicaid programs. An RCO is required by the Act to contract with any willing hospital, physician or other provider to offer services to beneficiaries in the RCO region if the provider is willing to accept the same payment and contract terms offered by the RCO to other comparable providers. Payments by the RCO to a provider may be on a capitated or fee-for-service basis, and the RCO can implement value, performance and other payment methodologies. If an RCO decides not to credential a provider in its network, the RCO must give the affected provider written notice of the reason for its decision. Other RCO credentialing requirements are addressed in CMS regulations that the Act incorporates by reference.
expected that RCO providers will be required to use a “continuity of care record” as part of the HIE in order to standardize medical records among Medicaid beneficiaries.

Provider, Enrollee and RCO Grievances and Appeals

The Act requires that the Agency develop rules of appeal by RCO enrollees and providers to address approvals or denials of care, billing and payment issues, and the provision of health care services. In particular, enrollees and providers will be afforded four levels of appeal:

- **Level 1:** An immediate appeal to the RCO medical director, who must be a primary care physician. The medical director will consider information submitted on the matter and provide the appeal participants the right to oral argument. The rules of evidence shall not apply, which means that the medical director must consider written documentation and oral arguments presented during the appeal even if such information would not be admissible in a court of law. The decision of the medical director will be binding on the RCO.

- **Level 2:** If an enrollee or provider is dissatisfied with the decision of the medical director, an appeal may be made to a peer review committee of at least three physicians in the same specialty in the region in which the services or matter is at issue. If three physicians cannot be found, then the physicians may be selected from outside of the region. The peer review committee’s decision will be binding on the RCO.

- **Level 3:** If an enrollee or provider is dissatisfied with the decision of the peer review committee, an appeal may be made to the Agency. The appeal shall consist of a full evidentiary hearing, and, like the prior levels of appeal, the Agency’s decision will be binding on the RCO.

- **Level 4:** If an enrollee or provider is dissatisfied with the decision of the Agency, an appeal can be filed in the circuit court in the county in which the enrollee resides or the county in which the provider renders services.

The Act also requires that the Agency develop rules of appeal by an RCO to address grievances. The procedures shall include an opportunity for a fair hearing before an impartial hearing officer in accordance with the Alabama Administrative Procedures Act (AAPA). The Medicaid Commissioner shall appoint one or more hearing officers to conduct the fair hearing. After a hearing, the hearing officer(s) will issue written recommendations to the Medicaid Commissioner, who will make a final decision. A party dissatisfied with the decision may file an appeal in accordance with the AAPA.

Alabama Administrative Code § 560-X-37-.01 provides that RCOs must comply with certain state and federal laws in addition to the Act and its regulations. These additional requirements apply to contract provisions, RCO provider and enrollee participation, and quality assurance requirements, to name a few. While a detailed discussion of the additional state and federal law requirements are outside the scope of this paper, the laws incorporated by reference for application to RCOs are as follows:

- The Alabama State Plan for Medical Assistance, the Alabama Medicaid Administrative Code, the Alabama Medicaid Provider Manual and/or operational protocols, all other guidelines of the Medicaid program, and any federally approved waivers in effect in the geographical areas of the State in which the RCO operates.
• The federal regulations found at 42 CFR §§ 430, 432, 434, 438, 440, and 447, as promulgated in 67 Fed. Reg. 40988 (June 14, 2002) and 68 Fed. Reg. 3586 (Jan. 24, 2003), as may be subsequently amended. Each RCO contract must also provide for compliance with the requirements of 42 CFR § 422.128 regarding advance directives.


Collaborators

In order to establish the new Medicaid structure and create RCOs, collaboration among payers, providers, consumers, and governmental entities regarding the delivery of health care and the payment for health care is a necessity. Therefore, the Act statutorily recognizes that any such collaboration is in the best interest of the public and will displace competition in order to achieve “a coordinated system of health care for the public benefit.”

In order to avoid antitrust implications normally associated with such collaboration, the Act specifically exempts from state antitrust laws and provides immunity from federal antitrust laws, through the “state action doctrine,”13 those “collaborators” who cooperate, negotiate or contract to bring Medicaid services to Alabama beneficiaries under the terms of the Act. A collaborator is defined by the Act as a “private health carrier, third party purchaser, provider, health care center, health care facility, state and local governmental entity, or other public payers, corporations, individuals, and consumers who are expecting to collectively cooperate, negotiate, or contract with another collaborator or regional care organization in the health care system.”

In order to achieve antitrust exemption and immunity, collaborators must apply to the Agency for a Certificate to Collaborate through an online process.14 During the application process, the applicant must provide background information regarding the applicant and the persons who may collaborate on the applicant’s behalf, describe the intent of the collaboration (e.g., whether the collaborator intends to establish an RCO, enroll as a provider with an RCO, or engage in other activities), identify the relevant RCO region, describe entities and/or persons the applicant intends on collaborating or negotiating with and the effects of the negotiations and collaborations (e.g., improve quality health care services to Medicaid beneficiaries, contain cost in providing health care services, enhance technology, or maintain competition in the health care services market), and certify that the collaboration is in good faith and necessary in order to carry out the provisions of the Act. The Agency may request additional information as it deems appropriate.
If the application for a Certificate to Collaborate is denied, the decision is deemed to be the final decision of the Agency, and the applicant can appeal the denial directly to the circuit court. Alternatively, the applicant may submit an amended application for review by the Agency.

If the application is approved, a Certificate to Collaborate will be issued, which will allow for collective negotiation, bargaining, and cooperation concerning payment and health care delivery. However, a Certificate to Collaborate will only be issued if the applicant has sufficiently shown that the collaboration is necessary in order to facilitate the arrangement and establishment of RCOs or health care payment reforms. The Certificate to Collaborate is effective immediately upon issuance and will expire on October 1, 2016. The Certificate will only extend to those persons listed on the application as having the authority to collaborate on behalf of the applicant.

A Certificate may be revoked if the holder violates any of the certifications made in the application. Further, the holder of the Certificate must inform the Agency of any substantial or material corrections or updates to the information submitted with the application. Such corrections or updates will be considered an amended application and, following review, an Amended Certificate to Collaborate may be issued.

In order to promote state action immunity under state and federal antitrust laws, the Agency will monitor and supervise the negotiations and collaborations among those who have received a Certificate to Collaborate. In accordance with such supervision, among other things, collaborators will be required to submit periodic reports to the Agency containing the following information: description of the collaboration activities during the reporting period, description of entities and persons with whom the collaborator negotiated or bargained with during the reporting period, description of concerns or problems encountered during the collaborative process, description of future collaboration activities, and certification that the collaboration and bargaining was done in good faith and is necessary to carry out the provisions of the Act. Additional information for those collaborators who intend to establish or develop an RCO may also be required. Failing to make a periodic report to the Agency is grounds for revocation of a Certificate to Collaborate.

The names and addresses of all holders of a Certificate to Collaborate are posted on the Agency’s website. A number of Certificates have already been issued by the Agency, both to individual and business entity applicants.

From a legal standpoint, in order to avoid antitrust concerns, obtaining a Certificate to Collaborate before discussing, negotiating, and bargaining in a manner that can be perceived as anti-competitive is extremely important. However, Certificates are not automatically granted to all who apply, as certain requirements and qualifications must be satisfied. Therefore, health care providers should start the application process before entering into any discussions, negotiations or bargaining arrangements and should seek appropriate guidance regarding the application process and the requirements for the issuance of a Certificate to Collaborate.

References
1. No later than April 1, 2015, an RCO must demonstrate to the Alabama Medicaid Agency that it has in place an adequate provider network, and no later than October 1, 2015, an RCO must meet solvency and financial requirements.
3. The Alabama Medicaid Advisory Commission was established by Gov. Bentley through Executive Order 35, dated October 12, 2012, to make recommendations on revamping the Alabama Medicaid program. The Commission is comprised of various representatives of the Agency, several Alabama legislators and representatives from the consumer, provider and payer community. Dr. Donald E. Williamson, the Alabama state health officer, serves as chairman of the Commission.
5. Id.
6. Id.
7. Id.
8. Long-term care is defined by the Act as: (i) nursing facility services or services in intermediate care facilities for the developmentally disabled, (ii) home- and community-based support services provided to individuals who might otherwise require such services, or (iii) such other long-term care services as the Agency may determine by regulations.
9. The Act calls for the Agency to evaluate the existing long-term and dental care systems for Medicaid beneficiaries and issue a report to the Alabama Legislature and Governor no later than October 1, 2015, regarding their possible inclusion in the RCO managed care program.
10. Individuals in long-term care facilities or utilizing home- and community-based waiver services, as well as the developmentally disabled, will not participate in an RCO. In addition, certain individuals who are eligible for both Medicaid and Medicare (dual-eligible members) will not be included in the RCO program until 2019.
11. By letter dated May 17, 2013, the state requested CMS approval to implement the RCO program. Approval was sought in the form of a “1115 Waiver,” which is a federal program used to test new ways to deliver and pay for health care services provided through the Medicaid program.
12. The Alabama Pharmacy Association has raised a concern about enrollees in one RCO region obtaining pharmacy services “out-of-region” due to the transient nature of patients who use a pharmacy based on convenience and the need to use certain specialty pharmacies. For example, an enrollee works in Birmingham and fills his/her prescription in a Birmingham pharmacy, but lives in Chilton County, a different RCO region. This sort of “out-of-region” service could detrimentally effect the pharmacy payment. Accordingly, the Pharmacy Association has asked that pharmacy services be removed from the RCO managed care payment system. Gov. Bentley was due to receive a report on the issue no later than December 31, 2013.
13. Generally speaking, the state action doctrine provides immunity from the federal antitrust laws to actions of a state even if the conduct unreasonably restrains trade. When a state delegates responsibilities to others, the allegedly anticompetitive actions are also immune from federal antitrust attack if taken pursuant to a clearly articulated and expressed state policy and if the activity is supervised by the state.
15. A list of current holders of a Certificate of Collaboration is available at www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx.
Physicians who were practicing in the 1990s were involved in numerous attempts to organize themselves in order to be able to participate in and even financially survive the onslaught of managed-care delivery systems. The new systems were attempting to shift the risk of increasing costs from insurance carriers to the providers themselves. The logic was that, if physicians were costing themselves money by ordering more tests, performing more expensive procedures or hospitalizing patients, they would be incentivized to practice medicine more conservatively.

This idea caught on, and health maintenance organizations (HMOs) began developing different methods of putting physicians at risk. Many sought to simply reduce fees paid for procedure; others tried to directly capitate physicians by paying them a flat fee per month for either their own medical care to the HMO subscribers or by paying the physician more but making the physician liable for all of the care provided by physicians in other specialties who received the subscriber on referral.

Conflict arose when physicians signed provider contracts that uniformly stated the HMO was merely agreeing to pay for the care of its subscribers but was not practicing medicine or influencing the independent medical judgment of the physician. Given the physician’s fiduciary obligation to a patient under the physician-patient relationship, malpractice liability for providing insufficient care to a patient was effectively shifted exclusively to the physician.

Recognizing the Catch-22, they began to explore opportunities to organize negotiations with HMOs for two basic purposes. First, physicians rightly believed if costs were to be saved and profits increased to HMOs by changes in physician behavior, then physicians should be able to share in those profits. Second, physicians wanted to ensure if clinical guidelines were to be imposed to standardize care and reduce cost, then the physicians who bore the malpractice risk for inadequate care were the ones who developed and implemented those clinical guidelines.

Now, regional care organizations (RCOs) mandated by recent changes in the Alabama laws governing Medicaid will be implementing these same managed-care changes on a massive scale in which physicians will have no choice but to participate if they wish to continue to treat Medicaid patients. As we pointed out in our previous article (see page 10), each RCO will negotiate with Medicaid to deliver all of the covered Medicaid services to Medicaid patients in their region for a flat fee. The individual RCOs, just like HMOs, will then have to negotiate provider contracts with each provider in their region to provide services to Medicaid patients while keeping total costs within the amount they have negotiated with Medicaid. This will include not only physician providers but also all other professional and institutional providers as well, all competing for a limited amount of funds.

Many physicians will want to organize again, just as in the 1990s, for the same reasons: to negotiate with RCOs for the provision of medical services to Medicaid patients. Many of the old acronyms of the 1990s will be dusted off and given new life in this century.

In the 1990s, physicians organized themselves into three primary alternative delivery systems. First were independent practice associations (IPAs), in which physicians integrated either partially or fully their practices into a separate entity that not only negotiated with the HMOs but also provided the medical care to the subscribers of the HMO. Second were preferred provider organizations (PPOs), in which a hospital formed a separate entity with members of its medical staff to negotiate and provide both hospital and physician services to HMO subscribers.

The greatest impediments to these new alternative delivery systems were the antitrust laws. Federal antitrust laws include the Sherman Act, the Clayton Act and the Federal Trade Commission Act.

Section 1 of the Sherman Act, 15 U.S.C. §§ 1-7, provides that “[e]very contract, combination ... or conspiracy, in restraint of trade or commerce ... is declared to be illegal.” While this provision purports to prohibit every contract in restraint of trade, the Supreme Court does not interpret the statute literally, instead interpreting the statute to prohibit only unreasonable restraints.

Section 7 of the Clayton Act, 15 U.S.C. §§ 12-27, 29 U.S.C. §§ 52-53, prohibits mergers if “in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly.”

Turning the Clock Back 20 Years

by John T. Mooresmith and April McKenzie Mason, Burr & Forman, LLP

Physicians who were practicing in the 1990s were involved in numerous attempts to organize themselves in order to be able to participate in and even financially survive the onslaught of managed-care delivery systems. The new systems were attempting to shift the risk of increasing costs from insurance carriers to the providers themselves. The logic was that, if physicians were costing themselves money by ordering more tests, performing more expensive procedures or hospitalizing patients, they would be incentivized to practice medicine more conservatively.

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Under antitrust laws, physicians are considered horizontal competitors since they compete with each other for patients. This makes physicians prime candidates for the application of the antitrust laws. Some types of antitrust violations are considered so injurious to competition as to warrant sanctions regardless of the intended purpose of the competitors. These are deemed *per se* illegal violations and include price-fixing among horizontal competitors. However, *per se* analysis “is reserved for only those agreements that are ‘so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality.’” Where *per se* analysis is not applied, the rule of reason is used to determine whether a particular contract or combination is unreasonable. Under the rule of reason, the fact-finder “weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition.” Relevant factors considered in the analysis include specific information about the relevant business; the restraint’s history, nature and effect; and whether the business at issue has market power. A key purpose of the rule of reason is to “distinguish between restraints with anticompetitive effects that are harmful to the consumer and restraints stimulating competition that are in the consumer’s best interest.”

The antitrust laws are enforced by the Antitrust Division of the Department of Justice (DOJ), the Bureau of Competition of the Federal Trade Commission (FTC) or by private individuals or organizations. They provide for trebled damages and an award of attorneys’ fees if a violation is found, and are extremely expensive to defend usually costing even a successful defendant seven figures in attorneys’ fees. It is critical for physicians to move carefully and with experienced legal counsel before even considering to organize themselves.

Recognizing that physicians would need the opportunity to organize themselves to negotiate with the new Medicaid RCOs, MASA worked with Medicaid, the governor’s office and the Legislature to provide as much antitrust immunity for physicians as possible. While the antitrust laws apply to the concerted actions of horizontal competitors, they do not apply to legitimate actions of the state.

In order to be considered actions of the state, a two-pronged analysis is used: (i) the challenged restraint must be “one clearly articulated and affirmatively expressed as state policy” and (ii) the policy must be “actively supervised” by the state itself.

In order to satisfy the first prong of the test, it is not necessary that a legislature “expressly state in a statute or its legislative history that the legislature intends for the delegated action to have anticompetitive effects.” Rather, if it is apparent that the “legislature contemplated the kind of action complained,” the first prong will be satisfied.

The Alabama Legislature stated that “collaboration among public payers, private health carriers, third party purchasers, and providers to identify appropriate service delivery systems and reimbursement methods in order to align incentives in support of integrated and coordinated health care delivery is in the best interest of the public. Collaboration pursuant to [Alabama’s laws on RCOs] is to provide quality health care at the lowest possible cost to Alabama citizens who are Medicare eligible. The Legislature, therefore, declares that this health care delivery system affirmatively contemplates the foreseeable displacement of competition, such that any anti-competitive effect may be attributed to the state’s policy to displace competition in the delivery of a coordinated system of health care for the public benefit. In furtherance of this goal, the Legislature declares its intent to exempt from state anti-trust laws, and provide immunity from federal anti-trust laws through the state action doctrine to, collaborators, regional care organizations, and contractors that are carrying out the state’s policy and regulatory program of health care delivery.”

The second prong of the test, active state supervision, is more difficult to establish. MASA staff and attorneys have consulted with Medicaid attorneys to enact regulations that we believe will satisfy this test, but will require careful attention by physicians to both qualify for and maintain the immunity. A single misstep in following the requirements of the Medicaid Regulations will result in a loss of the immunity and leave the physician vulnerable to the types of antitrust challenges discussed in this article. Physicians will need to ensure that staff are trained in the requirements and will need continuing legal monitoring to ensure compliance.

References
3. Id. at § 18.
4. Id. at § 45.
5. See, e.g., Texaco Inc. v. Dagher, 547 U.S. 1, 3 (2006).
6. Id. (quoting National Soc. of Professional Engineers v. United States, 435 U.S. 679, 692 (1978)).
7. Id.
9. Id. at 885-86.
10. Id. at 886.
15. Id. at 44 (quoting Lafayette, 435 U.S. at 415).
The AAFP has announced it is supporting pending legislation in Congress that would repeal the Medicare sustainable growth rate (SGR) payment formula and create a payment system that encourages quality improvements instead of the current emphasis on volume. In a letter sent to House and Senate leaders in February, AAFP Board Chair Jeff Cain, M.D., of Denver, outlined the Academy’s support for the bill.

“In Congress is well aware of the troublesome history of this (SGR) payment formula, since Congress has had to override the reductions in the physician payment rate mandated by the current formula,” said Cain. “These perennial reductions threatened the stability of the Medicare program and the access of seniors to Medicare benefits. The looming threat of frequent reductions also stifles innovation in care delivery and hinders the transformation of primary care practices.”

According to the legislation, annual increases would continue through 2018 for all physicians, and then the rates would be frozen through 2023. The legislation would replace the fee-for-service model with two different payment models that give priority to value and quality of care. The first model is a merit-based incentive system scheduled to be introduced in 2018. It will grade physicians in several categories. Depending on how well a physician measures up to the quality standards, he or she could earn an additional 1 percent increase in the payment rate.

In the second model, physicians who choose to participate in APMs, such as the patient-centered medical home (PCMH), would be exempt from the reporting and performance thresholds established by the merit-based system. If they are part of a PCMH that has been certified as maintaining or improving quality without increasing costs, they are eligible for an annual 5 percent bonus from 2018 to 2023.

Although the legislation represents a significant step toward paying for quality improvements, Congress still needs to identify a means to pay for the bill. Previously, measures taken to compensate for projected SGR cuts called for reductions in payments to other Medicare providers, such as hospitals, nursing homes and home health agencies.

“We applaud legislation that repeals the flawed Medicare sustainable growth rate formula that has jeopardized the health security of elderly and disabled Americans,” said AAFP President Reid Blackwelder, M.D., of Kingsport, Tenn., in a prepared statement. “For more than a decade, the SGR has threatened our most vulnerable patients’ access to care by requiring drastic cuts in payment for medical services.”

If the legislation is adopted, family physicians will be able to make long-range plans, fully implement team-based care, improve coordination among a patient’s health team members via electronic health records, extend office hours and make other changes that are key components of the PCMH, according to the AAFP.

The AAFP also supports the bill’s validation of the additional Medicare payment for care coordination, which will compensate eligible physicians for services provided outside a traditional face-to-face encounter that are particularly important to patients with more than one chronic condition. The Academy supports making PCMH practices eligible for these payments, as well.

“By establishing alternative payment that supports comprehensive and coordinated care through models such as the patient-centered medical home, this legislation has paved a way for better care and less cost,” said Blackwelder. “Multiple studies have shown the PCMH improves the quality of care, reduces preventable hospitalizations and other intensive services, and helps lower the cost to the patient, the community and the health care system.”

The legislation also appropriates $40 million annually for five years to help small physician practices make the transition to new payment methods, another provision for which the AAFP expressed strong support. By taking this step, Congress recognizes the significant investment physician practices must make as they transition to the PCMH model or an accountable care organization, said Cain.

Reprinted from the AAFP
Family physicians play a vital role in the health care of rural communities. From birthing babies and performing routine physicals to addressing the problems that come with age, family doctors are trained to care for most of the health needs of their patients.

Despite that training, the number of family physicians providing maternity care, or obstetrics, is declining, a trend that is concentrated in rural, underserved areas. As of 2012, only about 10 percent of these doctors are offering obstetrics, says Dan Avery, MD, professor and chair of the Department of Obstetrics and Gynecology at The University of Alabama College of Community Health Sciences.

Avery and associate professor John McDonald, MD, also in the Department of Obstetrics and Gynecology, address the issue of why family physicians have stopped providing maternity care and offer suggestions on how to alleviate the problem in their report, “The Declining Number of Family Physicians Practicing Obstetrics: Reasons, Recommendations and Considerations.”

“Half of the counties in the United States have no OB provider,” Avery says. “That leaves some 10 million women in the reproductive age with no local access to OB services. These women might not be able to afford to take off work or have transportation to travel to a town that does offer maternity care, so they don’t get adequate care.”

Not only are there economic factors at play, but not having a local obstetrics provider makes getting prenatal care, as well as delivery, challenging, increasing the risk of premature delivery and complications at pregnancy he adds.

While fewer medical students are choosing OB/GYN as a career, even fewer are choosing to locate in rural, underserved areas when they finish their residencies. These smaller communities, because of their demographics, typically cannot support specialty practices.

“The only practical answer is to increase the number of family docs practicing OB,” Avery says.

The College, which also functions as a regional campus of The University of Alabama School of Medicine, founded one of the nation’s first obstetrics fellowships, Avery says. The fellowship was created in 1986 to provide additional OB training for family physicians in large part because of a lack of maternity care in rural Alabama.

There are several reasons family physicians have stopped practicing obstetrics, but some of the more common ones include the fear of being sued, psychological stress, a more demanding schedule and financial concerns. In addition, some small hospitals have dropped obstetrical services, while other hospitals have made it difficult for family physicians to obtain privileges to deliver babies by implementing policies that, for example, require family physicians to have completed a three-year residency program specializing in obstetrics and gynecology.

Fear of litigation is a concern for many medical practitioners, but especially those who practice obstetrics, Avery says. Most OB/GYNs in Alabama report they have been sued at least once, which results in higher costs for malpractice insurance. On the other hand, family physicians in Alabama are rarely sued and their malpractice insurance is a fraction of what OB/GYNs pay, he adds.

“It just makes good business sense for family physicians to practice obstetrics,” Avery says. “Whereas a small community may not financially be able to support an OB/GYN, it might be able to support two or three family physicians that also practice obstetrics.”

“We really need to encourage medical students who are interested in doing OB,” Avery adds. “We need to encourage medical students and residents alike, nurture their interest … because having family medicine physicians do obstetrics is the only answer for addressing the obstetrics need in rural, underserved areas in Alabama.”

Is Your Practice Ready for ICD-10?

Let your Academy get you prepared! Join us April 22 at 12:30 p.m. for the first in a series of webinars. This webinar identifies the implementation issues associated with ICD-10-CM for family practice, from budgeting to education to practice management system considerations. Examples will be given on contrasting documentation and coding in ICD-9-CM and ICD-10-CM. This member benefit is free to all Academy members and will be archived in case you or your billing manager cannot attend. More information to come April 1.
After many months of discussion and negotiation, leaders of the U.S. allopathic and osteopathic medical communities announced that they will transition to a single graduate medical education (GME) accreditation system.

In a joint press release issued Feb. 26, the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine said the move to a single system would help ensure that Americans have access to safe, high quality health care.

“The commitment to a single accreditation system comes at a watershed moment for medical education in the (United States),” said ACGME CEO Thomas Nasca, M.D., in the release. “This uniform path of preparation for practice ensures that the evaluation of and accountability for the competency of all resident physicians — M.D.s and D.O.s — will be consistent across all programs.

“A single accreditation system provides the opportunity to introduce and consistently evaluate new physician competencies that are needed to meet patient needs and the health care delivery challenges facing the (United States) over the next decade,” Nasca added.

Admittedly, the move to a single accreditation system will not happen overnight; rather, the new system will be phased in during a span of five years from July 1, 2015, to June 30, 2020. During that extended transition process, AOA-accredited programs can apply to receive ACGME recognition and accreditation.

As a plus for newly graduated physicians, M.D.- and D.O.-trained physicians who have met prerequisite competencies will have opportunities to easily transfer between accredited programs without having to repeat coursework. The melding of the two accreditation systems into one also will put an end to dually accredited or parallel-accredited allopathic and osteopathic medical residency programs.

In an interview with AAFP News, Stan Kozakowski, M.D., director of the AAFP Division of Medical Education, called that out as a positive. “This will streamline the accreditation process,” said Kozakowski. “And the creation of one system also will reduce costs for residency programs that currently are dually accredited. This is really about the quality of education.”

Kozakowski cautioned against thinking that this accreditation train is moving full-steam ahead. The transition is intended to be slow and steady, he said. “Everyone believes it is immediate. It is not. This is a five-year phase-in program.”

During a conference call on Feb. 27, leaders of the three collaborating organizations discussed the transition and answered questions from members of the media. According to Nasca, the organizations are most interested in fulfilling the educational needs that residents must achieve to meet the future health needs of the public.

“We also believe it will give us the opportunity to demonstrate to the American public that we are efficiently using the resources the government provides in graduate medical education, and, from that platform, then (we can) argue for further support for graduate medical education positions to meet the projected needs of the American public,” said Nasca.

AOA President Norman Vinn, D.O., noted that nearly 60 percent of graduates in osteopathic medicine go into primary care. “That orientation will not change,” said Vinn. “We hope in this agreement to further codify and enhance our (osteopathic) principles and retain an osteopathic focus in training programs.”

Furthermore, Vinn said he anticipated growth in program opportunities that would include work in community-based hospitals and that would "further our longstanding commitment to rural and underserved communities.”

Reprinted from the AAFP
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### Two-Day Conference Registration Fees

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Business Breakfast for Members only: I will attend _______ I will not be able to attend _______ $ FREE

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