

Reference Committee J

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-I-12

Subject: Single-Signature Contracts and Right to “Opt Out”
(Resolution 830-I-11)

Presented by: Steven J. Stack, MD, Chair

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

BACKGROUND

At the 2011 Interim Meeting, the AMA House of Delegates (HOD) referred Resolution 830-I-11 to the Board of Trustees. Resolution 830-I-11 was sponsored by the Organized Medical Staff Section (OMSS) and asked that the AMA adopt new policy that would: (i) support the right of a physician member of an independent practice association (IPA), physician-hospital organization (PHO), physician organization (PO), or other similar organization to “opt out” of a single-signature contract without repercussion or penalty from the organization; and (ii) support the right of a physician member of an IPA, PHO, PO, or other similar organization who does not wish to participate in a particular single-signature contract to retain membership in the organization without participating in that contract.

The resolution was prompted by concerns that under the governing instruments of PHOs, IPAs and other physician and physician practice organizations (collectively “physician organizations”—but not intended to include group practices), individual physicians typically have no ability to opt out of individual payer contracts entered into by the physician organization on behalf of all of its physician members (so-called “single-signature” contracts). As a result, if a physician finds the terms and conditions of a particular payer contract to be unacceptable, the physician has but two options: accept the contract as negotiated or resign from the organization, neither of which is an attractive alternative.

The resolution prompted concerns about whether vesting individual physician or practice members of a physician organization with authority to “opt out” of single-signature contracts, particularly payer contracts, might interfere with the bona fides of the clinical and/or financial integration of physicians in the organization that may be necessary to avoid antitrust risk associated with joint contracting with payers on behalf of physicians in the organization.

The reference committee recommended referral of Resolution 830-I-11, and the House voted for referral.

DISCUSSION

Single-signature contracts with payers are contracts negotiated and signed on behalf of all members of a physician organization, usually pursuant to a “physician organization participation agreement” between the organization and its members. The scope of the agent’s authority to do more than simply sign the contract on behalf of individual physician members, such as negotiate the fees and

1 other terms and conditions of the payer contract, is established by the physician organization
2 participation agreement signed by the physician.

3
4 The physician organization participation agreement will answer the question “who will be bound
5 by the single-signature contracts with payers, once negotiated by the physician organization?”
6 Some physician organization participation agreements allow physician members to opt out of
7 single-signature payer contracts negotiated by the physician organization, under specified and
8 sometimes limited circumstances. Other physician organization participation agreements require
9 the physician members to accept the single-signature payer contracts negotiated by the physician
10 organization and provide no opportunity for opt out.

11
12 If a physician joins a physician organization that binds all members to its single-signature
13 contracts, the physician is left with the choice of accepting all single-signature contracts negotiated
14 by the physician organization on behalf of its members, or resigning from the physician
15 organization. Accordingly, it is important for individual physicians to evaluate whether they are
16 willing to accept such an arrangement at the time they agree to join the physician organization.

17
18 The physician’s right to accept or decline payer contracts has obvious benefits for the physician: it
19 affirms the physician’s business autonomy and gives the physician a degree of control over the
20 economics of the practice. If a payer’s reimbursement schedule is deemed by the physician to be
21 economically disadvantageous, he or she would be able to decline the contract if that is in the best
22 interests of the economic health of the practice.

23
24 While the benefits of an opt out right may be clear for the individual physician participating in an
25 organization with single-signature authority, the opt out right may produce negative effects that
26 affect all of the physicians in the organization. Requiring all physicians to participate in every
27 payer contract signed by the organization can help the organization achieve important goals such as
28 a consistent network of physicians, high participation of physicians in clinical integration
29 programs, implementation of quality improvement and incentive programs across all physicians in
30 the network, and cost-effective reporting of performance and/or outcome measure. High opt out
31 rates in a network potentially could impair the efficiency, competitiveness and economic health of
32 the network.

33
34 Additionally, how the Federal Trade Commission (FTC) may apply the 1996 DOJ/FTC Healthcare
35 Antitrust Statements to IPAs, PHOs and other physician organizations needs to be considered. As a
36 general matter, joint negotiation of fees on behalf of physicians who compete with one another
37 exposes physicians to risk of price fixing claims under federal antitrust laws. Antitrust liability can
38 be avoided, however, if the organization conducting the joint contracting can demonstrate either
39 financial integration or clinical integration of the participating physicians. Under current antitrust
40 law, physician organizations that are not financially integrated (such as IPAs and PHOs) are
41 permitted to engage in joint contracting with payers only if the overall arrangement is deemed
42 likely to benefit consumers through increased efficiencies such as those gained by clinical
43 integration. Moreover, the joint contracting must be reasonably necessary to achieve the
44 efficiencies. The degree of clinical integration necessary to satisfy antitrust concerns and justify
45 joint contracting as a reasonable ancillary restraint has been subject of several FTC Advisory
46 Opinions and enforcement actions.¹

47
48 While the FTC has given conditional approval to joint contracting and single-signature authority
49 where the participating practices have demonstrated sufficient clinical integration, the FTC
50 Advisory Opinions do not make clear whether physicians’ right to opt out of payer contracts
51 executed under single-signature contract authority necessarily promotes or hinders clinical

integration. In a 2009 Advisory Opinion, however, the FTC expressed reservations about whether clinical integration can be achieved if physicians have the right to opt out of payer contracts. In that opinion, the FTC gave conditional approval to a PHO structure that prohibited physician members of the PHO from opting out of participating in individual contracts. The FTC noted that "...while it might be theoretically possible to have a program without joint contracting on behalf of all physicians in the program, such an approach appears likely to be far more difficult, and potentially could compromise [the PHO's] ability to effectively integrate its physician members' provision of care, and to achieve the program's potential efficiencies." See Letter from Marcus H. Meier, Assistant Director, Health Care Services and Products, Bureau of Competition, Federal Trade Commission, to Christi J. Braun, April 13, 2009, available at www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf

A physician organization with an "opt out" policy could find it difficult to demonstrate that its joint contracting was reasonably necessary to achieve efficiencies. Consequently, it is possible that a physician organization engaged in joint contracting could compromise its antitrust compliance if it allows its physician or physician practice members to opt out of individual payer contracts. Apart from the foregoing antitrust considerations, an "opt out" right could potentially impair the ability of physician organizations to contract effectively with third parties. An opt out right would deprive third parties of certainty as to who will be bound by a contract if, following completion of negotiations, individual physicians or practices have the ability to opt out.

The AMA has existing policy that, while not directly on point, urges that all hospital-employed or contracted physicians participate in or be informed about allocation of physician payment components of payments received by a hospital.

H-225.964 Hospital Employed/Contracted Physicians Reimbursement

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians.

The AMA also has policy that establishes principles that should be applied to contracts between hospitals and hospital-based physicians, including the right of physicians to negotiate their portions of agreements with managed care organizations and to reject or renegotiate unfavorable provisions.

H-383.997 Hospital-Based Physician Contracting

(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations. (b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations. (c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty. (d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably., (e) The failure of physicians to reach an agreement with managed care organizations should not constitute a breach of its agreement with the hospital,

nor serve as grounds for termination. (f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks. (g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments. (h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price. (i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting. (j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation. (k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians.

(2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.

(3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals.

Policies H-225.964 and H-383.997 are focused on hospital-based physicians and are not directly pertinent to single-signature contracts in the context of IPAs, PHOs and other similar physician organizations. While they may provide some directional guidance, there is insufficient data to allow a determination of whether, on balance, the right to opt out of contracts negotiated by IPAs, PHOs or other physician organizations, pursuant to single-signature authority, benefits or hurts physicians as a whole. The lack of data on this issue is compounded by the early stage evolution of various models of Accountable Care Organizations (ACOs). Depending on how ACOs are structured and clinically integrated, a participating physician's right to opt out of payer contracts may enhance or impair the performance of the ACO. Therefore, more data is needed before the AMA can make a determination of whether it should support physicians' opt out rights in settings where the physician has granted single-signature authority to the organization.

RECOMMENDATION

In the absence of clearer information about the effect of physician opt out rights across all physician organizations, the Board of Trustees recommends Policies H-225.964 and H-383.997 be reaffirmed in lieu of Resolution 830-I-11 and the remainder of the report be filed.

Fiscal Note: None

REFERENCES

¹ See FTC Staff Letter regarding MedSouth, Inc. (June 18, 2007), *available at* <http://www.ftc.gov/bc/adops/070618medsouth.pdf>; FTC Staff Letter regarding Greater Rochester Independent Practice Association, Inc. (September 17, 2007), *available at* <http://www.ftc.gov/bc/adops/gripa.pdf>; FTC Staff Letter regarding Suburban Health Organization, Inc. (March 28, 2006), *available at* <http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf>; FTC Staff Letter regarding TriState Health Partners, Inc. (April 2009), *available at* <http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf>

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-12)
Cost-Sharing for Specialty Drugs
(Resolution 802-I-11)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2011 Interim Meeting, the House of Delegates referred Resolution 802, which was introduced by the American College of Rheumatology. The Board of Trustees assigned this resolution to the Council on Medical Service for a report back to the House of Delegates at the 2012 Interim Meeting. Resolution 802-I-11 asked that our American Medical Association (AMA) assist in passing federal and/or state legislation to reverse insurance policies that increase co-pays/coinsurance by a percentage for a subset of patients that need to have these critical medications, and update the previous Council reports on tiered drugs to specifically analyze how higher insurance co-pays/coinsurance not only decrease access to care but cost society in the long run with lost days of employment, long term disability and the overall cost of the support of patients with chronic illnesses needing these drugs.

While pharmacy benefit designs are often used with the goal of controlling the costs of prescription drugs, the Council believes that a key goal of pharmacy benefit designs should be to improve patient treatment and adherence. The purpose of cost-sharing for prescription drugs in general should be to encourage the judicious use of health care resources, rather than simply shifting costs to patients.

Adherence by patients to treatments involving specialty drugs is especially critical, because noncompliance with their treatment regimens can lead to worsening of symptoms or disease, hospitalizations and other costly interventions. As advocated by AMA policy, pharmacy benefit designs should prioritize value in health care spending using targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions. The Council notes specialty drugs are particularly suited to targeted benefit design, which would promote their efficient and effective use.

Health plan transparency is important for physicians and patients, who need price and out-of-pocket cost information about prescription drugs prior to making prescribing decisions. In addition, patients need education and assistance with health plan selection so that they are aware of covered services, cost-sharing obligations, out-of-pocket limits, lifetime benefit caps, and excluded services.

The Council recommends reaffirming AMA policies related to targeted benefit design, the appropriate use of cost-sharing arrangements for prescription drugs, health plan transparency, and patient education and assistance.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-12

Subject: Cost-Sharing for Specialty Drugs
(Resolution 802-I-11)

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

At the 2011 Interim Meeting, the House of Delegates referred Resolution 802, which was introduced by the American College of Rheumatology. The Board of Trustees assigned this resolution to the Council on Medical Service for a report back to the House of Delegates at the 2012 Interim Meeting. Resolution 802-I-11 asked:

That our American Medical Association (AMA) assist in passing federal and/or state legislation to reverse such insurance policies that increase co-pays/coinsurance by a percentage for a subset of patients that need to have these critical medications; and

That our AMA update the previous Council reports on tiered drugs to specifically analyze how higher insurance co-pays/coinsurance not only decrease access to care but cost society in the long run with lost days of employment, long term disability and the overall cost of the support of patients with chronic illnesses needing these drugs.

This report provides background on specialty drugs, outlines pharmacy benefit design strategies to control the costs associated with the coverage of specialty drugs, provides a summary of legislative and regulatory activity, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Patients, physicians, employers and health plans are facing the increasing financial burden posed by specialty drugs, including biologic medications and chemotherapies. Specialty drugs are used to treat chronic and complex conditions including cancer, rheumatoid arthritis and multiple sclerosis. Most specialty drugs are biologic in nature – derived from living sources such as humans, animals or microorganisms. Whereas most specialty drugs have historically been administered by infusion or injection, a growing number of oral and inhaled drugs have entered the specialty drug category. In 2008, spending on specialty medications (in 2010 dollars) averaged \$11,746 per user of such drugs covered by a group of large commercial health plans. The reported spending included both patient cost-sharing and health plan payment. On the whole, prescription drugs account for approximately 10 percent of total health spending, and biologics make up nearly 20 percent of drug spending.

Overall prices for specialty drugs are higher resulting from the high risk and expense of manufacturing the drugs, the special handling and administration required for the drugs, and an overall lack of competition in the marketplace. Within most therapeutic categories in which specialty drugs are offered, there are often few or no substitutes, and the available substitutes tend

to be imperfect. Currently, drug manufacturers have 12 years of market exclusivity for innovator products. Innovator drugs also have additional patent protection that generally exceeds the market exclusivity period by a few years. Because manufacturers normally pass on some development costs to patients, the reality that a small percentage of patients are in need of specialty drugs translates into these patients absorbing a higher percentage of development costs per user.

Specialty drugs are covered under both the pharmacy and medical benefits of commercial and government health plans. Specialty drugs that are self-administered are usually covered under the pharmacy benefit of health plans, including Medicare Part D. However, specialty drugs that are furnished and administered by physicians in clinical settings are covered under the medical benefit, including Medicare Part B. Specialty drugs covered under the medical benefit account for a substantial share of total spending on such drugs. In commercial health plans, approximately 55 percent of total spending on specialty drugs is spent under the medical benefit. Under Medicare Part B, spending for prescription drugs was approximately \$18.6 billion in 2010. The drugs with the highest Part B spending were biologic drugs.

Specialty drugs account for a larger proportion of prescription drug spending by both commercial plans and Medicare, despite the low percentage of enrollees receiving such drugs. Twelve to 16 percent of commercial health plan prescription drug spending is directed toward specialty drugs, while such drugs are prescribed to only one percent of health plan enrollees. Monthly spending in a commercial health plan per patient usually is greater than \$1,200 for a specialty drug. In 2007, drugs eligible for the specialty tier in Medicare Part D plans accounted for 10 percent of prescription drug spending under the plans.

TIERING VS. VALUE-BASED BENEFIT DESIGN

Government and private health plans are using various benefit design strategies to control their costs associated with the coverage of specialty drugs. One of the leading strategies, four-tier pharmacy benefit design, is common in Medicare Part D, and many employers have followed suit. With a four tier design, many specialty drugs are assigned to the fourth tier, also called a “specialty tier,” which generally has much higher cost-sharing for patients. Patients in need of fourth tier drugs commonly have to pay coinsurance – and pay a percentage of the total drug costs – versus defined copayments. Coinsurance in the fourth tier can range from 10 percent to 35 percent of the cost of the specialty medication. Although out-of-pocket maximums are often in place, and some subsidies may be provided by drug companies, transitioning from the third to the fourth tier represents a significant increase in cost-sharing for patients.

According to the 2011 Employer Health Benefits Survey from the Kaiser Family Foundation and the Health Research and Educational Trust (KFF/HRET), 77 percent of covered workers are in plans with three or more tiers of cost-sharing for prescription drugs. Fourteen percent of covered workers are in plans with four or more tiers of cost-sharing. Of the workers in plans with four or more cost-sharing tiers, 36 percent have copayments for fourth-tier drugs and 24 percent have coinsurance. The average copayments in plans with three or four tiers are \$10 for first-tier drugs, \$29 for second-tier drugs, \$49 for third-tier drugs, and \$91 for fourth-tier drugs. The average coinsurance for a fourth-tier drug is 29 percent.

The four-tiered design is the most common approach to tiered cost-sharing for prescription drugs under Medicare Part D. In Medicare Part D, specialty tiers are used for those drugs with expenses of at least \$600 per month. In 2011, among enrollees in Part D plans that use tiered cost-sharing, 94 percent of enrollees in Part D stand-alone prescription drug plans were in plans with a specialty tier, and 100 percent of enrollees in Medicare Advantage prescription drug plans were in plans with

1 a specialty tier. CMS limits the coinsurance rate for drugs on specialty tiers to 25 percent, but
2 plans can have higher coinsurance amounts for drugs in the specialty tier if such cost-sharing is
3 offset by a lower deductible. Therefore, coinsurance rates in specialty tiers under Part D range
4 from 25 to 33 percent. In 2011, roughly half of enrollees in stand-alone Medicare Part D plans and
5 more than three-fourths of enrollees in Medicare Advantage prescription drug plans were in plans
6 with a coinsurance rate for specialty drugs of 33 percent in the initial coverage period.

7
8 A leading alternative to cost-based, four-tier pharmacy benefit design is the use of value-based
9 benefit design for prescription drug cost-sharing. While patients have to pay more for more
10 expensive specialty drugs under four-tier pharmacy benefit design regardless of a drug's value and
11 effectiveness, patient cost-sharing under value-based benefit design is based on the clinical value of
12 the specialty drug. As outlined in CMS Report 1-I-07, Cost-Sharing Arrangements for Prescription
13 Drugs, which established Policy H-110.990, value-based benefit design considers the effect of
14 patient compliance on health outcomes. Using varying levels of out-of-pocket cost-sharing to
15 reward compliance by patients with chronic conditions, value-based benefit design averts costly
16 adverse outcomes. Therefore, patient cost-sharing for prescription drugs could be reduced or
17 eliminated to encourage treatment adherence for those drugs deemed to have high value.

18
19 To date, however, value-based benefit design has primarily focused on services and medications
20 that have clear value. For example, value-based benefit design has been used to reduce or
21 eliminate the cost-sharing for insulin to manage diabetic patients. The Council recognizes that
22 expanding the use of value-based benefit design to all specialty drugs requires the development of
23 criteria that determine which specialty drugs have high value, and the patients for which said drugs
24 would have high value. Therefore, the value of specialty drugs would depend partly on patient
25 characteristics, including clinical indication, disease severity and comorbidities. The Council
26 believes that comparative effectiveness research, including research funded by the Patient-Centered
27 Outcomes Research Institute (PCORI), has the potential to play a key role in determining which
28 specialty drugs work best for which patients.

29
30 The Council notes that value-based benefit design could also be incorporated into a four-tier
31 pharmacy benefit design. In such a scenario, specialty drugs of high value could be moved from
32 the fourth to the second cost-sharing tier, whereby patient cost sharing could change, from
33 potentially paying a percentage of total drug costs in the form of coinsurance, to a more modest
34 copayment. Alternatively, there could be fourth and fifth tiers of specialty drugs. The fourth tier
35 would be dedicated to specialty drugs with high value, which therefore would have a lower
36 coinsurance rate than specialty drugs in the fifth tier, which would include more low-value drugs.

37
38 Another alternative is the use of income-based benefit design, whereby cost-sharing levels for
39 prescription drugs vary by patients' earnings so that cost-sharing for specialty and other
40 prescription drugs would be tied to what the respective patients can afford. Some employers that
41 have implemented income-based benefit design have added tiers of cost-sharing to their tiered
42 pharmacy benefits. For example, for second-tier drugs, employees with the lowest incomes pay
43 lower co-payments than their colleagues with higher incomes. Other variances in cost-sharing for
44 prescription drugs can include varying deductibles and out-of-pocket maximums based on income.
45 The Council notes that difficulties using this approach in the employer-sponsored insurance market
46 can arise as employers may be restricted to assigning their employees to cost-sharing tiers based on
47 their salaries versus their household incomes. However, lessons can be learned from employers
48 that have historically tied employee premium contributions to income.

1 Different manifestations of income-based benefit design exist in the Medicaid and Medicare
2 programs, as well as the health insurance exchanges that are scheduled to be implemented in 2014.
3 In the Medicaid program, individuals with incomes above 150 percent of the federal poverty level
4 (FPL) have the potential to pay as much as 20 percent of the cost of non-preferred drugs.
5 However, individuals with incomes at or below 150 percent FPL pay small copayments for non-
6 preferred drugs. In Medicare Part D, subsidies are provided to low-income Medicare beneficiaries
7 to limit Part D cost-sharing, which results in these individuals facing less cost-sharing for
8 prescription drugs than their higher-income counterparts. Finally, for qualified health plan
9 coverage offered through health insurance exchanges, cost-sharing subsidies will be provided to
10 eligible individuals and families with incomes between 100 percent and 400 percent FPL. These
11 cost-sharing subsidies would reduce their cost-sharing amounts and annual limits on cost-sharing.
12

13 LEGISLATIVE AND REGULATORY ACTIVITY

14
15 There has been legislative activity on the state and federal levels addressing specialty tiers. In
16 2010, New York became the first state to enact a law that prevents health insurance plans from
17 creating specialty drug tiers. A number of states have introduced or are considering introducing
18 legislation addressing specialty tiers as well as patient out-of-pocket liability for prescription drugs.
19 On the federal level, Representative McKinley (R-WV) has introduced H.R. 4209, the Patients'
20 Access to Treatments Act of 2012, which would require commercial health insurers to require
21 defined copayments rather than percentage coinsurance for specialty tier medications.
22

23 The Patient Protection and Affordable Care Act (ACA, PL 111-148, as amended by the Health
24 Care and Education Reconciliation Act of 2010, PL 111-152) contained some provisions
25 addressing the affordability of prescription drugs, including biologics. The law included provisions
26 that improve the affordability of prescription drugs for beneficiaries in the so-called Medicare Part
27 D "donut hole," with affected beneficiaries paying less in the donut hole until the donut hole is
28 eliminated by 2020. Additional provisions in the ACA address cost-sharing for health insurance
29 coverage and essential benefits, under which prescription drugs fall. The ACA limits the out-of-
30 pocket cost-sharing for essential benefits that individuals would be required to pay. The ACA
31 specified that the essential health benefits package must cover the category of prescription drugs.
32 The ACA caps the out-of-pocket liability for individuals and families with incomes between 100
33 percent FPL and 400 percent FPL based on income. Finally, eligible individuals and families with
34 incomes between 100 percent FPL and 400 percent FPL can receive cost-sharing subsidies for
35 coverage offered in health insurance exchanges.
36

37 In addition, the ACA included a subtitle (Biologics Price Competition and Innovation Act of 2009)
38 that establishes an abbreviated approval pathway for products that are "highly similar" (i.e.,
39 biosimilar) to, or further demonstrated to be "interchangeable" with a Food and Drug
40 Administration (FDA)-licensed biologic product. The AMA has consistently supported a set
41 period of FDA conferred market exclusivity for regulated drugs in order to incentivize innovation
42 and to allow reference manufacturers to recover their research costs and investment. While the
43 FDA had legal authority to approve generic drugs, it was not until the passage of the ACA that the
44 agency had legal authority to approve comparable or interchangeable biosimilars. The AMA was a
45 strong supporter of ACA provisions conferring the FDA with the authority to establish a biosimilar
46 approval pathway. The FDA is now working to establish an approval pathway for biosimilars. In
47 addition, the recently passed Biosimilar User Fee Act of 2012 (which was part of the Food and
48 Drug Administration Safety and Innovation Act (Public Law 112-144)) ensures adequate FDA
49 funding for timely review and approval, as appropriate, of biosimilar applications. The Obama
50 administration, in its fiscal year 2013 budget proposal, also proposed shortening the market
51 exclusivity period for biologics from twelve to seven years. (The foregoing, however, would

require a legislative solution.) The Office of Management and Budget estimates that reducing the exclusivity period for biological products that have lost patent protection would save \$3.8 billion over 10 years. In addition, the Congressional Budget Office estimates that biosimilar prices would be about 40 percent lower than their brand-name counterparts.

AMA POLICY

Council on Medical Service Report 4-I-06, an informational report, outlined issues associated with tracking and analyzing specialty drug utilization data, examined the use of specialty pharmacies, and summarized new information about the use of drug formularies. Previously, CMS Report 2-I-05 highlighted trends associated with the availability, cost, and utilization of specialty drugs; examined the use of tiered formularies; and explored other alternatives for managing the high cost of specialty drugs. The resulting policy expressed support for complete transparency of health care coverage policies related to specialty drugs, including co-payment or co-insurance levels and how these levels are determined (AMA Policy H-185.953).

Regarding cost-sharing arrangements for prescription drugs in general, CMS Report 1-I-07 examined factors influencing prescription drug prices, and trends in prescription drug spending and insurance coverage of drugs; presented information regarding the use of co-payments and coinsurance; discussed value-based benefit design as an alternative to traditional benefit design; and described the ways in which increased price transparency can encourage efficient and appropriate use of prescription drugs. The report established Policy H-110.990, which has served as the foundation for AMA advocacy concerning patient cost-sharing for prescription drugs, and states that our AMA:

- Believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
- Believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
- Supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition.

As part of its policy foundation addressing the tiering of prescription drug cost-sharing, Policy H-125.991 supports mechanisms, such as incentive-based formularies with tiered co-pays, to allow greater choice and economic responsibility in drug selection, but urges managed care plans and other third party payers to not excessively shift costs to patients. Policy H-330.899 states that a drug benefit under Medicare should include a tiered deductible and co-payment structure that encourages economically responsible behavior. Policy D-110.992 states that the AMA will work with the insurance industry to ensure that patients with catastrophic diseases have an upper limit on copayments and deductibles sufficient to keep therapy affordable.

Policy H-155.960 supports the use of targeted benefit design by third-party payers, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. The policy notes that consideration should be given to tailoring cost-sharing

requirements to patient income and other factors known to impact compliance. The Council will be reviewing the subject of value-based insurance design for a report that will be presented at the 2013 Annual Meeting.

With respect to physician payment for biologics, CMS Report 3-I-08, which modified Policy D-330.960, described the coverage and payment of biologic and pharmacologic agents, reviewed the impact of the average sales price (ASP) payment system on physician practices, discussed the viability of the competitive acquisition program as an alternative to the ASP-based payment system, and identified trends in patient access to care. Policy D-330.960 states that our AMA will actively support efforts to seek legislation to ensure that Medicare payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services. The policy also calls for the AMA to continue strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents. Policy D-70.970 supports efforts to ensure that infusion supervision codes appropriately reflect the complexity of the infusion service rendered, and that there are sufficient relative value units to such service provided, as well as attendant practice expense, so that patient access to infusion therapies remains uninterrupted.

Policy H-373.993 supports patient choice of health plan, which includes prescription drug coverage. Policy H-165.839 states that health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage, and that health plans participating in health insurance exchanges should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. Policy H-165.846 recognizes the need to educate patients and assist them in making informed health plan choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

DISCUSSION

While pharmacy benefit designs are often used with the goal of controlling the costs of prescription drugs, the Council believes that another key goal of pharmacy benefit designs should be to improve patient treatment and adherence. Adherence by patients to treatments involving specialty drugs is especially critical, as noncompliance with their treatment regimens can lead to worsening of symptoms or disease, hospitalizations and other costly interventions. The focus, therefore, should be on ensuring that patients can access and afford specialty drugs, as well as on the appropriate use of specialty drugs. The Council reiterates that comparative effectiveness research has the potential to play a key role in determining which specialty drugs work best for a subset of patients, helping to ensure that appropriate patients are being selected and have access to such treatments.

Cost-sharing for specialty drugs impacts patient use of and access to specialty drugs. Considering the medical conditions managed by specialty drugs and in the absence of therapeutic alternatives, pharmacy benefit designs that involve higher cost-sharing levels for specialty drugs compared with other drugs does not steer patients to more affordable alternatives. Instead, it transfers a larger financial burden to patients, who only have one treatment option for their medical conditions but may very well find the cost-sharing required for their needed specialty medication onerous and cost-prohibitive. Studies have shown that new users of specialty drugs are more sensitive to higher copayments than ongoing users, so that high levels of cost-sharing may have the effect of delaying or preventing patient access to needed treatments. Ongoing users may demonstrate cost-related non-adherence to specialty drugs by discontinuing the use of the specialty drugs.

1 The Council reiterates its commitment to achieve better value for health spending, and has
2 previously defined value as the best balance between benefits and costs, and better value as
3 improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. The Council notes
4 that pharmacy benefit designs have the potential to reduce value if they manipulate cost-sharing
5 without regard for therapeutic value, possibly posing a financial burden on patients who need
6 expensive but clinically effective specialty drugs. Instead, pharmacy benefit designs should
7 prioritize value in health care spending. As such, the Council reiterates its support for targeted
8 benefit design as outlined in Policy H-155.960, whereby patient cost-sharing requirements are
9 reduced for maintenance medications used to treat chronic medical conditions, particularly when
10 non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. This
11 policy also recognizes that consideration should be given to tailoring cost-sharing requirements to
12 patient income and other factors known to impact compliance. The Council notes specialty drugs
13 are particularly suited to targeted benefit design, which would promote the efficient and effective
14 use of specialty drugs.

15
16 Overall, the Council believes that Policy H-110.990 outlines a sound approach to appropriate cost-
17 sharing for specialty drugs. The purpose of cost-sharing for prescription drugs in general should be
18 to encourage the judicious use of health care resources, rather than simply shifting costs to patients.
19 The Council also views income-based pharmacy benefit design as an emerging trend, and believes
20 that this design strategy is supported by Policy H-110.990[2] that states that cost-sharing
21 requirements should be based on considerations including personal income. Increased adoption of
22 income-based benefit design has the potential to reveal its success in ensuring the affordability of
23 and compliance with specialty drugs, as well as its prospects for long-term financial stability and
24 sustainability as a benefit design option.

25
26 Policy H-110.990[3] underlines the importance of physicians and patients being able to determine
27 the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing
28 decisions, so that physicians and patients can work together to determine the most efficient and
29 effective treatment for the patient's medical condition. However, the Council notes that a need also
30 exists to educate patients and assist them in making choices during their health plan selection, as
31 outlined in Policy H-165.846, which highlights the need for transparency regarding covered
32 services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded
33 services. Patient awareness of out-of-pocket limits of health plans in this arena is essential, as in
34 most cases, health plans cover all of the costs they consider to be medically necessary beyond the
35 out-of-pocket maximum. As a result, with such transparency, patients will have the ability to select
36 a plan that meets their health care needs and is affordable.

37 38 RECOMMENDATIONS

39
40 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
41 802-I-11 and that the remainder of the report be filed:

- 42
43 1. That our American Medical Association (AMA) reaffirm Policy H-155.960, which supports
44 the use of targeted benefit design as a strategy to address rising health care costs. (Reaffirm
45 HOD Policy)
- 46
47 2. That our AMA reaffirm Policy H-110.990, which stresses that cost-sharing arrangements for
48 prescription drugs should be encourage the judicious use of health care resources, rather than
49 simply shift costs to patients. (Reaffirm HOD Policy)

- 1 3. That our AMA reaffirm Policy H-165.846, which stresses the importance of health plan
2 transparency and patient education and assistance in health plan selection. (Reaffirm HOD
3 Policy)

Fiscal Note: Less than \$500.

References are available from the AMA Division of Socioeconomic Policy Development.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-12

Subject: Medical Record and Reporting Standards
(Resolution 812-I-11)

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

At the 2011 Interim Meeting, the House of Delegates referred Resolution 812, “Medical Record and Reporting Standards” to the Board of Trustees. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2012 Interim Meeting. Resolution 812-I-11 was introduced by the Indiana State Medical Association (ISMA) and asked:

That our American Medical Association (AMA) work with the College of American Pathologists, the American Osteopathic College of Pathologists, the American Clinical Laboratory Association, the American Society for Clinical Laboratory Science, and other appropriate entities to produce a single standardized format for presentation of laboratory results. The standardized format should not only define where the test results and normal values will appear on the screen or the printed page, but also specify a consistent sequence for chemistry, hematology and other results; and

That our AMA work with the American College of Radiology, the American Osteopathic College of Radiology and other appropriate entities to improve the terminology in both the descriptive and impression sections of a radiology report, as well as work towards producing a standardized format for the presentation of these radiologic results; and

That our AMA encourage the federal government to set future standards for all electronic health/medical records allowing for an option to choose a standardized set of menus and medical information that has the same appearance regardless of vendor. However, the electronic health/medical record should also allow customization for the convenience of the user.

This report outlines physician concerns with inconsistent formats for presenting laboratory results, including radiology results; reviews activity to standardize the presentation of laboratory results; summarizes AMA advocacy and policy; discusses potential avenues for AMA advocacy and policy development; and presents recommendations.

BACKGROUND

Medical reports can be presented both electronically or printed on paper and in a variety of formats. Resolution 812-I-11 outlined concerns that the large variety of clinical laboratory and radiology report formats may impede the provision of quality patient care and impact patient safety. The lack of a standardized report format has the potential to increase interpretation errors and decrease

1 efficiency as physicians review unfamiliar reports with varying layouts. Examples of inconsistent
2 and confusing medical report formats include clinical laboratory reports containing multiple results
3 on each page of the report and lack of uniformity in the location of test results and normal values.
4 Radiology reports that use vague terms in the descriptive and impression sections of the report can
5 also lead to confusion. Inconsistencies in report formats and terminology have the potential to
6 impact patient safety because key medical information can be difficult to locate, interpret, and
7 therefore easily missed or misinterpreted upon review of the report. Based on these concerns,
8 Resolution 812-I-11 seeks the development of standardized report formats and terminology to help
9 clarify information, minimize error and improve the efficiency of reviewing medical reports.

10
11 While standardizing report formats and terminology hold the potential to reduce interpretation
12 errors, improve quality of care and promote patient safety, there are concerns that standardization
13 could overly simplify results and unintentionally omit critical information. Testimony on
14 Resolution 812-I-11 expressed the view that efforts to simplify and strengthen the functionality of
15 medical reports through the use of electronically presented information must be balanced with the
16 flexibility to ensure that relevant and appropriate information is reported.

17 18 MEANINGFUL USE REQUIREMENTS

19
20 Federal law supports reporting laboratory results in a standardized format that can be integrated
21 into electronic health records (EHRs). The American Recovery and Reinvestment Act of 2009
22 mandates incentives for Medicare and Medicaid providers for EHR adoption, specifically its
23 “meaningful use” incentive program. Consequently, in July 2010, the Department of Health and
24 Human Services (HHS) released the final rule for the Medicare and Medicaid EHR incentive
25 program, which defined meaningful use Stage 1 requirements and strongly signaled that subsequent
26 stages would focus on specific health care data exchange processes. In February 2012, HHS
27 released a proposed rule for meaningful use Stage 2 requirements that included details for
28 electronic reporting of standardized structured laboratory results.

29
30 In May 2012, in response to the proposed rule for meaningful use Stage 2 requirements, the AMA
31 and 100 state medical associations and national medical specialty societies commented on the
32 proposed HHS requirements, including the use of standardized laboratory formats in EHRs. The
33 joint comment letter to HHS highlighted that the standardized electronic interfaces between
34 laboratory systems and EHRs are predominately hospital-based and do not exist on a widespread
35 basis in ambulatory settings. Such systems are generally difficult and costly for physician practices
36 to implement, test and maintain, particularly in non-hospital settings. For these reasons, the AMA
37 along with the other commenting organizations, advocated that Stage 2 standards are too
38 aggressive and burdensome for physicians. It is anticipated that physician participation in the
39 meaningful use EHR program will remain low unless the Stage 2 requirements are made more
40 flexible and until all laboratory service providers are able to follow interface and transport
41 standards for sending results to an EHR system including successfully accepting such test results
42 into EHR systems as part of their certification. The comment letter urged changes to the
43 meaningful use program, including the proposed Stage 2 criteria and penalty programs, to ensure
44 that the meaningful use program lives up to its intended purpose – to help physicians adopt,
45 implement and meaningfully use EHRs.

46
47 In August 2012, HHS published the final rule for Stage 2 of the Medicare/Medicaid meaningful use
48 EHR program that is scheduled to start in 2014. The AMA has voiced significant concerns about
49 interoperability and costly lab interfaces of Stage 2 and remains concerned that physicians have to
50 meet all of the required measures since failing to meet just one measure would cause a physician to
51 miss out on incentives and even face financial penalties. The AMA will continue to work with the

administration to address the challenges that physicians are facing as they continue to adopt and meaningfully use EHRs.

ACTIVITY TO STANDARDIZE LABORATORY RESULTS

Organizations other than the AMA, such as certain federal entities, the College of American Pathologists (CAP), and Health Level 7 (HL7) are all intensely engaged in ongoing efforts to address usability and standardization issues. The AMA interacts with each of these organizations and continues to advocate for addressing patient safety and usability issues associated with the use of EHRs.

HHS Office of the National Coordinator (ONC) for Health Information Technology

The Office of the National Coordinator (ONC) for Health Information Technology is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The ONC also certifies EHRs for use in attaining incentives from the Medicare and Medicaid EHR Incentive Program.

The Health Information Technology Policy and Standards Committees make recommendations to the ONC for the development and adoption of a nationwide health information infrastructure, including standards for the exchange of patient medical information, and recommendations for certification and adoption of EHRs. The AMA communicates physician concerns through representation on various workgroups of the Health Information Technology Policy and Standards Committees. The AMA has commented, most recently in May 2012, and will continue to provide comments to ONC, as needed, regarding standards and usability requirements for certified EHR technology.

According to the ONC, most laboratory report results are not commonly sent electronically from the lab information system (LIS) to the EHR. When laboratory results are sent electronically, they are not sent in a standardized format. The ONC believes that electronic reporting of standardized laboratory results is critical to national objectives of improved care, quality measurement, and decision support. To address this concern, ONC's standards and interoperability framework (S&I) lab results interface (LRI) initiative will soon complete a draft implementation guide (IG), "Ambulatory Laboratory Results Reporting Implementation Guide for LRI, Release 1," which enables lab reporting to ambulatory primary care organizations.

College of American Pathologists

The College of American Pathologists (CAP) is the world's largest association composed exclusively of board-certified pathologists and is considered the worldwide leader in laboratory quality assurance. Correspondence from CAP to the Council indicated that it is unlikely that a single format for laboratory results will be feasible. CAP explained that reporting laboratory results is too nuanced and complex and the organization has concerns that a standard for a single format may introduce additional communication and patient safety problems. Rather, CAP envisions a set of guidelines and best practices to inform ONC EHR certification criteria. CAP communicated to the Council that it is poised to provide the domain expertise needed to lead this activity.

Health Level 7

Health Level 7 (HL7) is a standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information. The mission of HL7 is to provide standards for interoperability that improve care delivery, optimize workflow, reduce ambiguity and enhance knowledge transfer among health care providers, government agencies, vendors, and patients. The AMA is a member of HL7 and sends representatives to their meetings to participate in multiple workgroups.

RELATED AMA POLICY AND ADVOCACY

AMA policy advocates collaboration with federal entities to support the meaningful use of health information technology. The AMA will continue its involvement with the ONC's Health Information Technology Policy and Standards Committees urging the need for a process through which laboratory results can be communicated electronically. Policy D-260.995 supports the AMA becoming involved in the appropriate initiatives developing electronic standards and implementation guides for the electronic transmission of clinical laboratory results. Policy D-478.982 advocates working with federal entities to set realistic targets for meaningful use of electronic health records including laboratory results. This policy also supports improving the electronic health records incentive program requirements to maximize physician participation. In addition, Policy D-450.980[3] states that the AMA will continue to work with EHR system developers to ensure that the perspectives of practicing physicians are adequately incorporated, that standardization and integration of clinical performance measures are developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine. Policy D-478.995[2A] advocates for standardization of key elements of EMR user interface design during the ongoing development of this technology.

DISCUSSION

Testimony on Resolution 812-I-11 acknowledged a potential correlation between the large variety of laboratory report formats and patient safety and quality of health care. For example, physicians who work in more than one hospital or interface with more than one laboratory must often review confusing report formats that may compromise patient safety. However, given the detailed clinical nature of appropriate medical reporting for pathology and radiology information, the Council does not believe that the AMA is the best organization to lead standardization development efforts.

The Council suggests that efforts to develop standardized formats to present laboratory and radiology results be undertaken by the most appropriate, relevant organizations. Importantly, development and standards setting organizations with expertise in this domain, such as HL7, CAP and federal entities such as the Agency for Healthcare Research and Quality (AHRQ) and the National Institute for Standards and Technology (NIST) are already focused on EHR usability and patient safety including standardization of laboratory report results. Continuing their ongoing efforts to address usability and standardization of laboratory report results will help ensure patient safety by providing physicians and non-physician practitioners with information that is more user friendly at the point of care.

As for standardizing radiology report results, the Council suggests that the American College of Radiology, the American Osteopathic College of Radiology and other appropriate entities work to improve the terminology in both the descriptive and impression sections of a radiology report, as well as work toward producing a standardized format for the presentation of radiology report

results. These organizations should work with physicians who are the intended users of the reports to ensure relevance and ease of use. In order to improve quality of care, the user should be involved in determining the report format that would most clearly identify key information such as the diagnoses and test results.

As concluded in Board of Trustees Report 16-A-11, "Standardized User Interface for all Electronic Medical Records," in a highly competitive marketplace, EHR vendors will be motivated by their customers to build new user interface designs and improve their products to provide better solutions over time. Currently, attempts to standardize products have the potential to stifle product innovation. Just as medical practice has evolved, so will the EHR marketplace. Consistently, as CAP has explained, reporting laboratory results is complex and the organization has concerns that a standard for a single format may introduce additional communication and patient safety problems. Rather, CAP envisions a set of guidelines and best practices to inform ONC EHR certification criteria.

Resolution 812-I-11 advocated that the federal government set all future standards for electronic health/medical records. However, the Council believes that it is best for the AMA to continue working with state medical associations and national medical specialty societies to recommend the appropriate usability requirements for certified HIT products.

Policy D-260.995 includes reference to an outdated collaboration between the AMA and an EHR committee of the ONC, therefore, the Council suggests modified language to modernize this policy to reflect continued AMA involvement with the ONC's Health Information Technology Policy and Standards Committees.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 812-I-11 and that the remainder of the report be filed:

1. That our American Medical Association encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to continue their ongoing efforts to address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety. (New HOD Policy)
2. That our AMA encourage relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other appropriate entities to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results. (New HOD Policy)
3. That our American Medical Association modify Policy D-260.995 by insertion and deletion to read as follows:

Our AMA will: (1) continue its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees ~~Standards Panel's Electronic Health Record Technical Committee that is developing a process through which laboratory results can be communicated~~

- 1 ~~electronically~~; and (2) become involved in and/or provide input into policies involving
- 2 electronic transmission of clinical laboratory results. (Modify HOD Policy)

Fiscal Note: Less than \$500

References are available from the AMA Division of Socioeconomic Policy Development.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-12)
Face-to-Face Encounter Rule
(Resolutions 813-I-11, 716-A-12 and 723-A-12)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2011 Interim Meeting, the House of Delegates referred Resolution 813, which was introduced by the Indiana Delegation. The Board of Trustees assigned this resolution to the Council on Medical Service for a report back to the House of Delegates at the 2012 Interim Meeting. Resolution 813-I-11 asked that our American Medical Association (AMA) work to establish a unique billing code (G code) for completion of the face-to-face encounter form and reimbursement for the code, and investigate the possibility of incorporating the questions required for the face-to-face encounter into a new modified form 485 for the sake of simplicity and efficiency. The resolution specified that this new modified form should also have a higher level of reimbursement than the current form 485.

At the 2012 Annual Meeting, the House of Delegates referred two additional resolutions that addressed the face-to-face encounter requirement for certification of eligibility for Medicare home health services. Resolution 716-A-12, introduced by the Michigan Delegation, asked “that our AMA work with the Centers for Medicare and Medicaid Services (CMS) to study alternatives to the requirements for face-to-face interaction to certify the need for home health care services to better address the issue of patients who could benefit from these services but who may not be able to present at the doctor’s office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office.” Resolution 723-A-12, introduced by the Arizona Delegation, asked “that our AMA seek, through all appropriate means, to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care is responsible for completing the face-to-face encounter form.” The Board of Trustees assigned these resolutions to the Council so that they could be addressed as part of its report for the 2012 Interim Meeting.

The Council recognizes that payment for complex administrative services, including the face-to-face encounter requirement, remains insufficient for many physicians and their practices. The Council recommends that the AMA work with CMS to ensure that physicians understand the alternative means of compliance with Medicare’s face-to-face encounter policies and related payment policies, continue to work with CMS to educate home health agencies on the face-to-face documentation that is required as part of the certification of eligibility for Medicare home health services, and continue to monitor legislative and regulatory proposals to modify Medicare’s face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-12

Subject: Face-to-Face Encounter Rule
(Resolutions 813-I-11, 716-A-12 and 723-A-12)

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

At the 2011 Interim Meeting, the House of Delegates referred Resolution 813, which was sponsored by the Indiana Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2012 Interim Meeting. Resolution 813-I-11 asked:

That our American Medical Association work to establish a unique billing code (G code) for completion of the face-to-face encounter form and reimbursement for the code; and

That our AMA investigate the possibility of incorporating the questions required for the face-to-face encounter into a new modified form 485 for the sake of simplicity and efficiency. This new modified form should also have a higher level of reimbursement than the current form 485.

At the 2012 Annual Meeting, the House of Delegates referred two additional resolutions that addressed the face-to-face encounter requirement for certification of eligibility for Medicare home health services. Resolution 716-A-12, sponsored by the Michigan delegation, asked “that our AMA work with the Centers for Medicare and Medicaid Services to study alternatives to the requirements for face-to-face interaction to certify the need for home health care services to better address the issue of patients who could benefit from these services but who may not be able to present at the doctor’s office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office.” Resolution 723-A-12, introduced by the Arizona Delegation, asked “that our AMA seek, through all appropriate means, to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care is responsible for completing the face-to-face encounter form.” The Board of Trustees assigned these resolutions to the Council so that they could be addressed as part of its report for the 2012 Interim Meeting.

This report provides background on the face-to-face encounter requirement for Medicare home health services, outlines options for completing face-to-face encounter documentation, highlights billing and payment issues associated with the face-to-face encounter requirement, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Section 6407 of the Patient Protection and Affordable Care Act (ACA) established a face-to-face encounter requirement for certification of eligibility for Medicare home health services. Under such certification of eligibility, a Medicare participating physician must certify that:

- The patient needs or needed home health services because they are or were confined to the home;
- The patient needs or needed skilled home health services on a sporadic basis;
- A physician has established and reviewed a plan of care; and
- The patient is or was under the care of a physician when home health services are or were provided.

The Medicare face-to-face encounter requirement for home health services is one of the major face-to-face requirements of the Medicare program. The following table highlights the key Medicare face-to-face requirements with their intervals, including existing home health, hospice, and durable medical equipment requirements.

Key Medicare Face-to-Face Requirements and Intervals

Medicare Face-to-Face Requirement	Interval
Home health services	For initial certification of the home health benefit, face-to-face encounter is required to occur within the 90-day period prior to the start of care, or within 30 days after the start of care.
Hospice	Must have face-to-face encounter no more than 30 days prior to the 3 rd benefit period recertification. For every recertification thereafter, there must be a face-to-face encounter with the patient no more than 30 days prior.
Durable Medical Equipment (DME)	The ACA requires that an order for certain DME must be written by a physician or non-physician provider who has had a face-to-face encounter during the 6 months prior to the written order for each item or during such other reasonable timeframe as specified by the Secretary. Proposed regulations issued by the Centers for Medicare and Medicaid Services proposed that a face-to-face encounter must occur no more than 90 days before the order is written or within 30 days after the order is written. (Proposal does not include prosthetic devices, orthotics, and prosthetics that require a written order before delivery.)* For power mobility devices, a face-to-face encounter must occur within the 45-day period prior to the supplier receiving the written prescription, and before such device is delivered.

*CMS Proposed Rule CMS 1590-P. "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013." Posted July 7, 2012.

As noted in the table, the face-to-face encounter for certification of eligibility for Medicare home health services is required to occur within the 90-day period prior to the start of care, or within 30 days after the start of care. Of note, face-to-face encounter documentation is only required for the initial certification of the home health benefit. After a 60-day period, physicians must decide whether to recertify the patient for another 60 days.

Under this new requirement, physicians need to certify and document that they, or a non-physician provider with whom they work, have seen their patients in need of home health services, including through a telehealth service. Specifically, the ACA allows for the following non-physician providers to perform the face-to-face encounter with a patient:

- A nurse practitioner or clinical nurse specialist, collaborating with the physician as outlined in state law;
- A certified nurse-midwife as authorized by state law; and
- A physician assistant, who may, under the supervision of the physician, perform the face-to-face encounter and inform the certifying physician, who would then document the encounter as part of the certification of eligibility.

In subsequent rulemaking, as part of the calendar year (CY) 2012 home health prospective payment system (PPS) final rule, the Centers for Medicare and Medicaid Services (CMS) added that the physician who cared for the patient in an acute or post-acute facility, and who had privileges in such a facility, could also perform the face-to-face encounter and inform the certifying physician. The certifying physician would then document the encounter as part of the certification of eligibility. In addition, as part of its proposed rule addressing the home health PPS rate update for CY 2013, hospice quality reporting requirements, and survey and enforcement requirements for home health agencies, CMS proposed to allow a non-physician provider in an acute or post-acute facility to perform the face-to-face encounter in collaboration with or under the supervision of the physician who has privileges and cared for the patient in the acute or post-acute facility. The collaborating/supervising physician would then be allowed to inform the certifying physician of the patient's homebound status and need for skilled home health services.

Educational materials on the face-to-face encounter requirement, including "Home Health Face-to-Face Encounter Questions & Answers" of CMS and a MLN Matters® article, can be found on the AMA website at www.ama-assn.org/go/regrelief.

OPTIONS FOR COMPLETING FACE-TO-FACE ENCOUNTER DOCUMENTATION

Resolution 723-A-12 sought to require that the provider who actually discharges the patient from the hospital, rehabilitation facility or nursing home to home health care be responsible for completing the face-to-face encounter form. The Council notes that such a change in requirements would make the policy addressing the face-to-face encounter requirement more stringent. Current policy does not define the specific physician who should perform or certify the face-to-face encounter. The change proposed in Resolution 723-A-12, by specifying the particular physician who needs to perform or certify the face-to-face encounter, would therefore limit the physicians who could complete the face-to-face encounter documentation. Such a policy change also may restrict the ability of some physicians to order home health services. For example, if a patient of a primary care physician is admitted to the hospital, the primary care physician may rely on other physicians who have hospital privileges, including hospitalists, to care for the patient while admitted, and discharge the patient from the hospital. However, after the patient is discharged from the hospital, it may be the primary care physician who orders the home health care. The primary care physician may see the patient face-to-face within the 90-day period prior to the start of care, or within 30 days after the start of care – thus fulfilling the current face-to-face encounter requirements – even though the primary care physician is not the physician who cared for the patient in or discharged the patient from the hospital. The change proposed in Resolution 723-A-12 may prevent the primary care physician from being able to order home health services for the patient.

Resolution 716-A-12 sought to ensure that the face-to-face encounter process does not impede access to home health services by patients who are not able to present at the doctor's office because of severity of illness or short time interval between the discharge process and obtaining an appointment at a busy office. Under current law and regulations, there are options through which the face-to-face encounter requirement can be fulfilled:

- The patient's discharge summaries could be used by the certifying physician as documentation of the face-to-face encounter if they otherwise meet the requirements for face-to-face encounter documentation, including being clearly titled as face-to-face encounter documentation.
- The certifying physician may use documentation of a face-to-face visit that occurred during the 90-day period prior to the start of home health care services to fulfill the face-to-face encounter requirement, thereby removing the need for an additional face-to-face encounter with the patient after discharge.
- The certifying physician could conduct a house call to fulfill the requirements of the face-to-face encounter, which is a covered service under Medicare.
- As authorized under state law, a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant collaborating with or under the supervision of the physician could perform the face-to-face encounter, either in the office or at the patient's place of residence, and then the certifying physician could then document the encounter as part of the certification of eligibility.

BILLING AND PAYMENT FOR THE FACE-TO-FACE ENCOUNTER REQUIREMENT

Resolution 813-I-11 presumed that physicians are required to complete a unique face-to-face encounter form to satisfy the requirements of the face-to-face requirement. However, as a result of AMA advocacy, CMS does not require a particular form or format to be used to document the face-to-face requirement for home health services.

The regulatory text governing the face-to-face encounter requirement states that "the documentation of the face-to-face encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician." For patients admitted to home health following an acute or post-acute stay, the plan of care form, Form CMS-485, can satisfy the face-to-face encounter requirement if it includes an addendum containing the face-to-face encounter documentation requirements (e.g., include a brief narrative that supports the patient's homebound status and need for skilled services) signed by a physician who cared for the patient in the acute or post-acute setting, as long as all content requirements of the certification and face-to-face documentation are otherwise met. Discharge summaries may be used by the certifying physician as documentation of the face-to-face encounter if they otherwise meet all the documentation requirements for face-to-face documentation and are clearly titled and dated as face-to-face documentation.

The Indiana State Medical Association (ISMA) was invited to provide additional information to the Council concerning referred Resolution 813-I-11. In its response to the Council, ISMA stated that although clarifications have been made to the face-to-face encounter requirement, the review and certification of the face-to-face encounter still require additional time and cognitive effort on the part of certifying physician. Specifically, the ISMA made the following additional requests:

- 1 • Create unique billing codes (G codes) for review and certification of the face-to-face
- 2 encounter that would be billed in conjunction with the appropriate code for care plan
- 3 oversight.
- 4 • If separate G codes for review and certification are not developed, then increase payment
- 5 for care plan oversight (G0181 and G0182) to reflect the additional work related to the
- 6 face-to-face encounter.

7

8 In evaluating the new request by ISMA, the Council notes that “review” is not a service that is

9 typically covered for separate payment. “Review” typically describes the review of test(s) results

10 as a part of the larger medical decision-making process that is one of the three key components of

11 an E/M service. Also, “certification” is an action that is not typically reported by Current

12 Procedural Terminology (CPT®) codes, except in places like code 99080 (for special reports such

13 as insurance forms, more than the information conveyed in the usual medical communications or

14 standard reporting form). Completion of brief standard reports, including return to work forms and

15 hospital discharge summaries, are not reported separately, including the forms described in the

16 nursing facility assessment codes. In addition, the Council notes that the AMA does not advocate

17 directly for the creation of G codes. AMA Policy H-70.919 states that “the CPT Editorial Panel is

18 the proper forum for addressing CPT code set maintenance issues and all interested stakeholders

19 should avail themselves of the well-established and documented CPT Editorial Panel process for

20 the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and

21 modifiers.”

22

23 Currently, physicians may bill Medicare for certifying and recertifying all patients that are eligible

24 for the Medicare home health benefit. Code G0180 is used when a physician certifies an initial

25 plan of care for a home health patient, and code G0179 is used when a physician recertifies a home

26 health patient for a subsequent episode of care. Recertification must occur every 60 days.

27 Physicians may also submit claims for care plan oversight services provided to qualifying patients

28 (i.e., those with complex, multidisciplinary care needs requiring 30 minutes or more of care plan

29 oversight within a calendar month).

30

31 The performance of a face-to-face encounter typically requires a minimum of two of the three key

32 components of an E/M service: history, exam, and medical decision-making. These services are

33 typically reported with E/M codes based upon the site of service in which they are performed.

34

35 If physicians need to make a house call for a face-to-face visit, there are mechanisms through

36 which they can be paid by Medicare as part of regular E/M codes. Physicians can use codes

37 99341-99350 for new patients in their private homes and codes 99324-99337 for domiciliary care

38 facilities, such as assisted living facilities. Care plan oversight services for patients under the care

39 of a home health agency are reported with codes 99374-99380.

40 41 AMA POLICY

42

43 With respect to payment for more complex documentation and certification, Policy H-385.984

44 states that when more complex administrative services are required by third parties, such as

45 obtaining preadmission certification, second opinions on elective surgery, certification for extended

46 length of stay, and other authorizations as a condition of payer coverage, it is the right of the

47 physician to be recompensed for his incurred administrative costs. Policy H-70.953 states that the

48 AMA will work to assure that physicians are not subjected to excessive and unreasonable

49 documentation requirements when ordering laboratory services, home health and durable medical

50 equipment and/or when justifying a CPT code. Policy H-210.981 recognizes the importance of

51 removing economic, institutional and regulatory barriers to physician house calls, and urges CMS

1 to consider the adoption of criteria and methods that will strengthen the physician's role in
2 authorizing home health services, as well as how such criteria and methods can be implemented to
3 reduce the paperwork burden on physicians. Policy H-330.936 urges CMS and other payers to
4 require that durable medical equipment and home health and other outpatient medical services be
5 ordered by the physician responsible for the patient's care, with appropriate documentation of
6 medical necessity, before such services are offered to the patient or family. Policy D-160.945
7 advocates for timely and consistent inpatient and outpatient communications to occur among the
8 hospital and hospital-based providers and physicians and the patient's primary care referring
9 physician; including the physician of record, admitting physician, and physician-to-physician, to
10 decrease gaps that may occur in the coordination of care process and improve quality and patient
11 safety.

12 13 DISCUSSION

14
15 Physician responsibilities associated with fulfilling the face-to-face requirement for certification of
16 eligibility for Medicare home health services are part of a much larger concern that physicians have
17 with being paid for a variety of administrative responsibilities, such as filling out forms and
18 certifications. The Council recognizes that payment for complex administrative services, including
19 the face-to-face requirements highlighted in this report, remains insufficient for many physicians
20 and their practices. Policy H-385.984 reiterates the right of physicians to be compensated for more
21 complex administrative services. Also important is that physicians understand the alternative
22 means of compliance with Medicare's face-to-face encounter policies and related payment policies.
23 The Council believes it will be imperative for the AMA to continue to monitor legislative and
24 regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any
25 new unfunded mandatory administrative paperwork burdens for practicing physicians.

26
27 The Council recognizes that communication between hospital-based physicians and primary care
28 physicians is essential in the processes of performing and certifying the face-to-face encounter, to
29 ensure that patients are able to access the home health services they need. In that light, the Council
30 believes that the AMA needs to continue to advocate for timely and consistent inpatient and
31 outpatient communications to occur between the hospital and hospital-based providers and
32 physicians and the patient's primary care referring physician, including the physician of record,
33 admitting physician, and physician-to-physician, as outlined in Policy D-160.945.

34
35 There is also a need to ensure that the process of certifying eligibility for Medicare home health
36 services is streamlined and that physicians are not required to fill out unnecessary forms to
37 document the face-to-face encounter. The Council is cognizant that many physicians are being
38 required by home health agencies to complete a variety of different forms as part of the
39 certification of eligibility for Medicare home health services. In particular, some home health
40 agencies are requiring physicians to complete extra forms to meet the face-to-face requirement,
41 whereas the face-to-face documentation can be simply included on the certification itself or appear
42 on a separate addendum to the certification. Therefore, the Council believes there is a need for the
43 AMA to work with CMS to continue to educate home health agencies on the face-to-face
44 documentation that is required as part of the certification of eligibility for Medicare home health
45 services.

46 47 RECOMMENDATIONS

48
49 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
50 813-I-11, Resolution 716-A-12 and Resolution 723-A-12, and that the remainder of the report be
51 filed:

- 1 1. That our American Medical Association (AMA) reaffirm Policy H-385.984, which supports
2 payment for complex administrative tasks required by third-party payers. (Reaffirm HOD
3 Policy)
4
- 5 2. That our AMA reaffirm Policy D-160.945, which advocates for timely and consistent inpatient
6 and outpatient communications to occur among the hospital and hospital-based providers and
7 physicians and the patient's primary care referring physician to decrease gaps that may occur in
8 the coordination of care process and improve quality and patient safety. (Reaffirm HOD
9 Policy)
10
- 11 3. That our AMA work with the Centers for Medicare and Medicaid Services (CMS) and
12 appropriate national medical specialty societies to ensure that physicians understand the
13 alternative means of compliance with and payment policies associated with Medicare's face-to-
14 face encounter policies, including those required for home health, hospice and durable medical
15 equipment. (Directive to Take Action)
16
- 17 4. That our AMA work with CMS to continue to educate home health agencies on the face-to-
18 face documentation required as part of the certification of eligibility for Medicare home health
19 services to ensure that the certification process is streamlined and minimizes paperwork
20 burdens for practicing physicians. (Directive to Take Action)
21
- 22 5. That our AMA continue to monitor legislative and regulatory proposals to modify Medicare's
23 face-to-face encounter policies and work to prevent any new unfunded mandatory
24 administrative paperwork burdens for practicing physicians. (Directive to Take Action)

Fiscal Note: Less than \$4,580 to implement.

References are available from the AMA Division of Socioeconomic Policy Development.

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-12)
Strengthening Medicare for Current and Future Generations
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2012 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Substitute Resolution 126, which directed the AMA to refine its policy regarding Medicare financing reform, including a defined contribution program that would allow beneficiaries to purchase private health insurance coverage (Policy D-330.916). Policy D-330.916 also directed the AMA to consider mechanisms to adjust contribution amounts to ensure that health insurance coverage remains affordable for all Medicare beneficiaries. The Board of Trustees assigned Policy D-330.916 to the Council on Medical Service for a report back at the 2012 Interim Meeting.

The AMA has advocated for many years that the Medicare program needs to be strengthened in order to ensure that it remains a viable mechanism for providing health insurance coverage for America's seniors and disabled. Policy H-330.896, established in 2007, provides a strong foundation for the development of a comprehensive alternative to the current Medicare system. The policy identifies changes that must be made to strengthen the traditional Medicare program (i.e., restructuring beneficiary cost-sharing, including modifying Medigap rules, and changing the eligibility age to match Social Security), and expresses support for giving beneficiaries a choice of plans for which the federal government would contribute a standard amount (i.e., a "defined contribution") toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. The Council firmly believes that implementing a defined contribution system, with strong regulatory protections for patients, is a responsible and feasible approach to strengthening the Medicare program.

The Council recommends that the AMA support transitioning Medicare to a defined contribution program that would enable beneficiaries to purchase coverage of their choice through a Medicare exchange of competing health insurance plans. The following report proposes a set of nine principles that should be included in a defined contribution system, which are designed to ensure that Medicare remains a viable program for current and future generations, and that health insurance coverage remains affordable and accessible for the poorest and sickest beneficiaries.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-12

Subject: Strengthening Medicare for Current and Future Generations

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 The American Medical Association (AMA) has advocated for many years that the Medicare
2 program needs to be strengthened in order to ensure that it remains a viable mechanism for
3 providing health insurance coverage for America's seniors and the beneficiaries who are eligible
4 for Medicare because of disability or end-stage renal disease. Absent thoughtful efforts to
5 strengthen and preserve Medicare, current and future generations are likely to find themselves
6 increasingly vulnerable to eroding benefits and rising out-of-pocket costs.

7
8 At the 2012 Annual Meeting, the House of Delegates adopted Substitute Resolution 126, which
9 directed the AMA to refine its policy regarding Medicare financing reform, including a defined
10 contribution program that would allow beneficiaries to purchase private health insurance coverage
11 (Policy D-330.916). Policy D-330.916 also directed the AMA to consider mechanisms to adjust
12 contribution amounts to ensure that health insurance coverage remains affordable for all Medicare
13 beneficiaries. The Board of Trustees assigned Policy D-330.916 to the Council on Medical Service
14 for a report back at the 2012 Interim Meeting.

15
16 The Council on Medical Service began a process of re-evaluating the AMA's Medicare reform
17 policies prior to the 2012 Annual Meeting. At the 2011 Interim Meeting the House of Delegates
18 adopted the recommendations in Council on Medical Service Report 4-I-11, which called for
19 members of the House of Delegates and the Federation to provide comments to the Council
20 regarding the development of policy options for long-term Medicare financing reform. The report
21 described the financial challenges facing the Medicare program, reviewed current AMA policy
22 related to Medicare reform, and solicited input from members of the House and the Federation
23 regarding ways to strengthen health insurance options for current and future Medicare
24 beneficiaries. Comments received on Council Report 4-I-11 emphasized the need to advocate for
25 Medicare reforms that would allow patient choice, support the patient-physician relationship, and
26 preserve an efficient, affordable traditional Medicare coverage option for those who want it.

27
28 Following adoption of Policy D-330.916, the Council solicited additional feedback from the
29 Federation on issues directly related to the creation of a defined contribution program within
30 Medicare. The Council also met with Alice M. Rivlin, PhD, who co-chaired the Bipartisan Policy
31 Center's Debt Reduction Task Force with former Senator Pete Domenici (R-NM), and served on
32 the National Commission on Fiscal Responsibility and Reform, co-chaired by Erskine Bowles and
33 former Senator Alan Simpson (R-WY), both of which proposed transitioning Medicare to a defined
34 contribution system. The majority of comments from the Federation and Dr. Rivlin emphasized
35 that defined contribution amounts should be sufficient to ensure that all Medicare beneficiaries
36 could afford to purchase health insurance coverage, and that private health insurance plans should

1 be subject to regulations that protect patients and ensure the availability of coverage for even the
2 sickest patients.

3
4 The Council greatly appreciates the efforts of the individuals, state medical associations, and
5 national medical specialty societies that provided thoughtful testimony and written comments on
6 Council on Medical Service Report 4-I-11 and the development of a defined contribution program,
7 per Policy D-330.916.

8 9 THE URGENT NEED FOR CHANGE

10
11 The long-term viability of the Medicare program has been a significant and growing public policy
12 concern for many years. The spending projections for Medicare under current law manifest
13 mounting pressure on the federal budget with insufficient financing that will make it difficult to
14 fund full payment of currently scheduled benefits and growth in costs that is unsustainable in the
15 long-term. In addition, the repeated failure of Congress to repeal the Sustainable Growth Rate
16 (SGR) formula compounds federal budget problems, and perpetuates a state of instability in the
17 Medicare program that could ultimately jeopardize beneficiaries' access to care. Appendix A
18 provides background on the structure and financing of the Medicare Trust Funds, and describes the
19 relationship between Medicare's financial outlook and the national debt.

20
21 Heightened concerns about the federal deficit and the national debt limit have resulted in even
22 greater scrutiny of the Medicare program. Medicare expenditures currently account for 3.7 percent
23 of gross domestic product (GDP), and the Medicare Trustees project that Medicare spending will
24 reach 5.7 percent of GDP by 2030 (2012 Medicare Trustees Report). Key policymakers
25 acknowledge that any serious fiscal reform effort needs to confront the impact that Medicare's
26 financing and benefit structure has on the federal budget.

27
28 In addition to Medicare's fiscal troubles, there are weaknesses inherent in the program's benefit
29 design. Accordingly, changes are necessary to strengthen the program for the current generation of
30 beneficiaries as well. Although Medicare is a popular program, its shortcomings are evidenced by
31 the fact that nearly 90 percent of Medicare beneficiaries have some form of supplemental health
32 insurance (e.g., a Medigap policy or retiree coverage through a former employer), or are enrolled in
33 a Medicare Advantage (Part C) plan. Unlike most commercial health insurance plans, traditional
34 Medicare (i.e., Parts A and B) has no out-of-pocket spending limits, exposing beneficiaries to
35 unlimited financial risk unless they purchase a supplemental policy.

36
37 According to a 2012 analysis by the Kaiser Family Foundation, the benefit value of traditional
38 Medicare is less generous than what is typically offered under a large employer PPO program, or
39 under the most popular plan selected by Federal Employees Health Benefits Program (FEHBP)
40 enrollees, the Blue Cross/Blue Shield Standard Option. Furthermore, the current Medicare cost-
41 sharing structure involves several levels of deductibles and copayments across the various parts of
42 the Medicare program (i.e., Parts A, B and D), which makes it difficult for beneficiaries to predict
43 or even understand what their out-of-pocket obligations might be. As a result, most beneficiaries
44 purchase supplemental coverage that not only limits their out-of-pocket liability for catastrophic
45 costs, but also often eliminates all cost-sharing. Supplemental insurance provides beneficiaries
46 with "first dollar" coverage, which insulates them from the true cost of services, and facilitates
47 demand for increased volume of services, thus increasing federal government spending on the
48 Medicare program.

49
50 Twenty-five percent of Medicare beneficiaries choose to enroll in a Medicare Advantage (Part C)
51 plan. Medicare Advantage plans are offered by private insurers, and include HMOs, PPOs, and

private fee-for-service plans that provide all Medicare covered services in exchange for a per enrollee capitated payment from the federal government. Unlike traditional Medicare, Medicare Advantage plans cap out-of-pocket spending, and many offer enhanced benefits such as reduced cost-sharing or vision or dental benefits. Enrollment in Medicare Advantage plans has increased steadily since 2004, suggesting that beneficiaries value having the ability to choose coverage options and benefit designs offered by private insurers. However, true choice under Medicare Advantage remains limited. In particular, if plans are able to provide Medicare services less expensively than the capitated amount set by the federal government, they are required to provide enhanced benefits to beneficiaries (e.g., more generous cost-sharing), rather than lowering the overall cost of the insurance plan. In effect, beneficiaries are forced to pay for additional services regardless of whether they value those services.

The number of beneficiaries with supplemental insurance also includes the approximately 20 percent of Medicare beneficiaries who are eligible to receive assistance through the Medicaid program (i.e., dual-eligibles). For many low-income Medicare beneficiaries, Medicaid plays an important role in protecting them against unaffordable and potentially catastrophic out-of-pocket costs. For these beneficiaries, Medicaid provides premium and cost-sharing assistance, and most (77 percent) receive full Medicaid benefits (Kaiser Family Foundation, April 2012). However, not all low-income Medicare beneficiaries are eligible for Medicaid assistance. Nearly 60 percent of seniors with incomes below the federal poverty level (FPL), and 87 percent of seniors with incomes between 100 and 200 percent of FPL are not covered by Medicaid (Kaiser Family Foundation, March 2012). These individuals are likely unable to afford supplemental coverage, and yet are among the beneficiaries most in need of financial assistance under the traditional Medicare program design.

AMA POLICY

Over the years the AMA has developed policy that articulates specific reforms that are necessary to ensure that Medicare remains a viable mechanism for providing meaningful health insurance coverage. Policy H-330.896 supports several important modifications:

Policy H-330.896 – Strategies to Strengthen the Medicare Program

Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate:

1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services such as those recommended by the US Preventive Health Task Force should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure.
2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies

would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans.

3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits.

Several bipartisan deficit reduction and Medicare reform proposals include elements that are consistent with the reforms outlined in Policy H-330.896, including proposals developed by the Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin) and the National Commission on Fiscal Responsibility and Reform (Simpson-Bowles).

Policy H-330.896 calls for reforms that will better protect beneficiaries in the current Medicare program and allow for a more rational cost-sharing structure that simultaneously provides beneficiaries with financial security and encourages the efficient use of health care services. Policy H-330.896 also supports adjusting the Medicare eligibility age to more closely mirror current demographic trends. Like Social Security, Medicare was designed primarily to provide support to retirees. Medicare's eligibility age should be adjusted to reflect technological and scientific advances that have extended life expectancy, and concurrently, the number of productive working years. At a minimum, Medicare eligibility should transition to a tiered system, similar to Social Security, in which penalties and incentives are awarded based on the age at which benefit collection begins.

The reforms detailed in Policy H-330.896 must be addressed in order to repair fundamental flaws in the traditional Medicare program. Beneficiaries, particularly those with low incomes or high anticipated medical expenses, would be better served by a Medicare program that more closely resembles commercial insurance, with a single premium, deductible and copayment structure for all covered services. Yet there is a growing recognition that the magnitude of the financing and budgeting issues associated with meeting Medicare's obligation will require more substantial reforms. The challenge for any serious Medicare entitlement reform proposal is to identify ways to balance the nation's fiscal responsibilities with its social responsibility to ensure access to high quality health care for seniors and the disabled.

Longstanding Policy H-330.898 articulates the AMA's current vision for long-term Medicare reform. It calls for the Medicare program to be phased out and replaced by a self-funded, private sector approach that would require individuals to make minimum contributions into individually owned savings accounts dedicated to funding post-retirement medical care. Subsidies would be available for low-income individuals to ensure that their accounts receive minimum contributions annually. Council on Medical Service Report 4-I-11 included a detailed discussion of Policy H-330.898 and invited the House to use the policy as a starting point for considering the development of updated policy to address ways to strengthen the Medicare program over the long-term.

STRENGTHENING MEDICARE THROUGH DEFINED CONTRIBUTIONS

Policy H-330.896, which was established by the AMA in 2007, provides a strong foundation for the development of a comprehensive alternative to the current Medicare system or the self-funded approach called for in Policy H-330.898. Policy H-330.896 identifies changes that must be made to strengthen the traditional Medicare program (i.e., restructuring beneficiary cost-sharing, including modifying Medigap rules, and changing the eligibility age to match Social Security), and also expresses support for giving beneficiaries a choice of plans for which the federal government

1 would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or
2 another health insurance plan approved by Medicare.

3
4 Consistent with Policy H-330.896, Policy D-330.937 supports giving patients more control over
5 and responsibility for their health care spending by making Medicare a defined contribution
6 program. Traditional Medicare is a “defined benefit” program, under which the federal
7 government pays for a specific set of health care benefits, regardless of cost. However, unless
8 beneficiaries purchase supplemental coverage (or a Medicare Advantage plan), they are limited to
9 the single benefit package that the federal government has selected. Medicare’s defined benefit
10 structure restricts patient choice, and in so doing, removes incentives that could help limit spending
11 growth by leveraging private market innovation. Moving Medicare to a defined contribution
12 program would expand patient choice by giving beneficiaries an amount of money to be applied
13 toward the purchase of health insurance coverage provided under the traditional Medicare program,
14 or by a private insurer. Although insurers would be subject to certain regulatory requirements to
15 ensure beneficiaries are protected, a defined contribution system would allow private insurers the
16 freedom to design a range of plans that meet patient demand. The popularity of supplemental plans
17 in the current Medicare system – including Medicare Advantage plans – suggests that most
18 Medicare beneficiaries want benefit options that are not offered under traditional Medicare,
19 particularly related to cost-sharing and out-of-pocket spending limits.

20
21 A defined contribution system is likely to result in lower rates of health care spending growth,
22 since insurers would be competing on price as well as benefit design, and would be directly
23 accountable to patient demand for high-value, high-quality services. Under a defined contribution
24 arrangement, private insurers competing with traditional Medicare could offer plans with a wide
25 variation in premium charges. Beneficiaries would be responsible for paying the difference
26 between the defined contribution amount and the full premium of the plan they selected. In the
27 event that beneficiaries select a lower price plan, beneficiaries could keep the difference, possibly
28 in the form of a contribution to a health savings account. Giving beneficiaries a defined
29 contribution and allowing them to select the coverage of their choice creates an incentive for
30 patients to be cost-conscious when purchasing coverage, which, in turn creates an incentive for
31 insurers to find ways to improve the value of their plans.

32
33 The FEHBP, which covers federal employees, including members of Congress, is an example of a
34 defined contribution system that works very effectively for plan enrollees, while also effectively
35 managing program spending growth. Under the FEHBP, federal employees receive a defined
36 contribution to apply toward the purchase of a health insurance plan approved by the Office of
37 Personnel Management. Participating insurers offer a wide range of plan types, including preferred
38 provider and health maintenance organization options, point of service plans, high deductible plans,
39 and consumer-directed plans that offer health savings accounts.

40
41 A defined contribution system could offer a more predictable and sustainable way for the federal
42 government to continue providing assistance to Medicare beneficiaries. The transition from
43 defined benefit to defined contribution programs has been widely publicized with respect to
44 employment-based retirement programs. Some analysts anticipate that employers will soon begin
45 transitioning to defined contribution programs for employee health benefits as well, especially if
46 the health insurance exchanges created by the Affordable Care Act (ACA) are successful in
47 stimulating innovations in the private health insurance market.

1 DISCUSSION

2
3 Comments received on Council Report 4-I-11 indicated a preference for maintaining the traditional
4 Medicare program as an option for current and future beneficiaries, while also expanding coverage
5 options available to Medicare enrollees. Although the Council explicitly encouraged the House to
6 comment on the concept of phasing out Medicare in favor of a system of individually owned,
7 private savings accounts (as described in Policy H-330.898), the majority of comments focused on
8 expanding the options available under Medicare, rather than replacing the program altogether. The
9 Council believes that the AMA should build on existing policies (e.g., Policy H-330.896[2]) that
10 support making Medicare a defined contribution program, as suggested by Policy D-330.916.

11
12 Expanding health insurance choice and pluralism have been long-standing goals of the AMA.
13 Conceptually consistent with defined contributions, the AMA's health system reform proposal,
14 which was established in 1998 and has been refined since, advocates for the promotion of
15 individually selected and owned health insurance in a robust health insurance marketplace, using
16 refundable and advanceable tax credits that are inversely related to income so that patients with the
17 lowest incomes will receive the largest credits. In 2007, the AMA formally established policy
18 supporting a standard (defined) contribution system for the Medicare program (Policy
19 H-330.896[2]).

20
21 The Council firmly believes that implementing a defined contribution system, with strong
22 regulatory protections for patients, is a responsible and feasible approach to strengthening the
23 Medicare program. As noted, recent bipartisan proposals from Pete Domenici and Alice Rivlin,
24 and Erskine Bowles and Alan Simpson advocate for Medicare reforms that include giving
25 beneficiaries a defined contribution. Previously, the National Bipartisan Commission on the Future
26 of Medicare, led by Senator John Breaux (D-LA) and Representative Bill Thomas (R-CA) during
27 the Clinton administration, recommended implementing a defined contribution system.

28
29 The Council recommends that the AMA support transitioning Medicare to a defined contribution
30 program that would enable beneficiaries to purchase coverage of their choice through a Medicare
31 exchange of competing health insurance plans. Traditional Medicare would be an option in the
32 Medicare exchange. However, as noted, the traditional Medicare program has significant design
33 flaws, particularly with respect to cost-sharing obligations and out-of-pocket spending limits. The
34 AMA should continue to advocate for improvements to the traditional Medicare benefit design as
35 Medicare transitions to a defined contribution program, and traditional Medicare begins to compete
36 with private plans for enrollees.

37
38 Private health insurance plans participating in the Medicare exchange must be subject to
39 regulations and standards that help protect enrollees and ensure plan availability for all
40 beneficiaries. Specifically, plans should be required to meet guaranteed issue and guaranteed
41 renewability requirements, prohibited from rescinding coverage except in cases of fraudulent
42 representation, follow uniform marketing standards, and be subject to solvency requirements.

43
44 In addition, safeguards should be in place to ensure some minimum level of coverage is provided
45 by every plan. Although traditional Medicare's specific benefit design exposes beneficiaries to
46 unpredictable and potentially unlimited out-of-pocket costs, the Council believes that traditional
47 Medicare should be used as the reference point for acceptable levels of coverage. Specifically, the
48 Council suggests requiring plans to cover the "actuarial equivalent" of the benefit package
49 provided by Medicare. The actuarial value of a health insurance policy is the percentage of the
50 total covered expenses that the plan would cover for the average enrollee. Linking private plan
51 minimum coverage requirements to the actuarial value of traditional Medicare ensures that

1 Medicare beneficiaries are receiving at least the same level of insurance coverage, on average, as
2 they would in traditional Medicare. Importantly, plans can be actuarially equivalent and include
3 different benefit options and plan designs, so private plans would have the flexibility to develop
4 innovative coverage options for Medicare beneficiaries.

5
6 Transitioning Medicare to a defined contribution program requires that safeguards be in place to
7 ensure that coverage remains affordable to all Medicare beneficiaries, and that all beneficiaries
8 have a range of private options from which to choose. Risk adjustment methodologies must be
9 developed and implemented to ensure that private health plans can afford and are willing to provide
10 coverage for sicker beneficiaries and those with higher projected health care costs.

11
12 The Council is aware that determining the value of the defined contribution will be critical to
13 ensuring that it provides viable coverage alternatives for beneficiaries and a sustainable option for
14 the federal government. The Council concurs with feedback it received suggesting that the amount
15 of the defined contribution be based on the value of the government's contribution under traditional
16 Medicare. To ensure that health insurance coverage is affordable for all beneficiaries, adjustments
17 should be allowed to the defined contribution amount. Specifically, individual defined contribution
18 amounts should vary based on beneficiary age, income and health status, with older, lower income
19 and sicker beneficiaries receiving larger contributions. Through adjustments to the defined
20 contribution amounts, all Medicare beneficiaries will be able to afford to purchase health insurance
21 coverage through at least one of the plans in the Medicare exchange.

22
23 The Council agrees with feedback it received that the baseline defined contribution amount should
24 be adjusted annually to ensure that health insurance coverage remains affordable for all
25 beneficiaries over time. Annual adjustments should be based on changes in health care costs and
26 the cost of obtaining health insurance, rather than on gross domestic product (GDP) or other
27 indexes that are not directly tied to health care costs.

28
29 The Council is aware that implementing a Medicare defined contribution program should be done
30 gradually, using a phased-in approach. A complete transition will involve significant, coordinated
31 efforts by all stakeholders, including the federal government, private insurers, patient advocacy
32 groups, and the AMA.

33
34 In addition to supporting transitioning Medicare to a defined contribution program, the AMA
35 should continue to strongly advocate for related Medicare reforms. Policies related to balance
36 billing, private contracting, and the repeal of the Medicare Independent Payment Advisory Board
37 remain particularly relevant and should be reaffirmed. Similarly, the AMA should continue to
38 support incentives to encourage people to contribute to health savings accounts, and to promote
39 their use as a means to ensure access to high quality medical care. It is also critical that the AMA
40 continue to advocate for the other Medicare reforms articulated in Policy H-330.896, particularly
41 restructuring beneficiary cost-sharing in order to provide incentives for appropriate utilization
42 while discouraging unnecessary or inappropriate care, and increasing the Medicare eligibility age
43 to reflect increases in the average life expectancy in the United States.

44
45 Conversely, the Council believes that Policy H-330.898, which proposes replacing the Medicare
46 program with a self-funded, private sector approach to health insurance funding, should be
47 rescinded. The lack of feedback on Policy H-330.898 may suggest reluctance on the part of the
48 House of Delegates for the AMA to advocate this strategy, and the Council agrees that promoting
49 the elimination of the Medicare program is not appropriate in the current political or economic
50 environment. The Council notes that while the emphasis of Policy H-330.898 is on phasing out the

Medicare program, there are other components of the policy that remain relevant, all of which are articulated elsewhere in AMA policy. Appendix B provides a crosswalk of these policies.

The Council notes that funding for graduate medical education (GME) is currently tied to the Medicare program, and believes that safeguards should be in place to ensure that a transition to a defined contribution program does not adversely affect GME financing. A robust and stable funding stream for GME is necessary to train a well-educated and diverse physician workforce that is sufficient to provide care for all Americans, including Medicare beneficiaries. Any efforts to strengthen the Medicare program should ensure that mechanisms are in place for financing graduate medical education at a level that will provide workforce stability and an adequate supply of physicians to care for all Americans.

The AMA has long advocated for moving to an all-payer (i.e., federal, state and private payers) system to help strengthen the funding stream for GME (e.g., Policies H-310.917, H-305.929, D-305.967). At the 2012 Annual Meeting the House of Delegates referred Resolution 329, "Going Forward with Reforming GME Financing," which asked the AMA to craft a new model for sustainable GME funding that would include funding from Centers for Medicare and Medicaid Services and private funding sources. The Board of Trustees assigned this item to the Council on Medical Education, which will be presenting a report to the House at the 2013 Annual Meeting.

The Council also notes that reforms that address rising health care costs need to be pursued in tandem with other Medicare reforms. Several policies (e.g., Policies H-155.960, H-450.938, and H-165.838) support efforts to contain rising health care costs by reducing the burden of preventable disease, reducing administrative costs, making health care delivery more efficient, and implementing medical liability reforms to reduce the cost of defensive medicine. The ACA provides for a range of new pilot programs that are expected to result in major payment and delivery reforms in Medicare and, ultimately, the private sector. The AMA supports physician-led efforts to pursue payment and delivery reforms that promote improved patient access to high-quality, cost-effective care (Policy H-390.849), and supports local innovation and funding of demonstration projects that allow physicians to pursue practice changes that best fit local needs (Policy D-390.961). AMA resources are available at www.ama-assn.org/go/paymentpathways to help physicians understand options available under emerging payment and delivery models.

Finally, the Council recommends rescinding Policy D-330.917, which called for the Federation and members of the House of Delegates to provide comments on Medicare financing reform to the Council by January 6, 2012, for consideration in this follow-up report, and D-330.916, which called for the AMA to refine its policy regarding Medicare financing reform, including a defined contribution program.

RECOMMENDATIONS

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

1. That our American Medical Association support transitioning Medicare to a defined contribution program that would:
 - a. Enable beneficiaries to purchase coverage of their choice through a Medicare exchange of competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections.

- 1 b. Preserve traditional Medicare as an option within the Medicare exchange.
- 2
- 3 c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with
- 4 health savings accounts), as well as traditional Medicare, through the Medicare
- 5 exchange.
- 6
- 7 d. Require that private health insurance plans participating in the Medicare exchange
- 8 meet guaranteed issue and guaranteed renewability requirements, be prohibited
- 9 from rescinding coverage except in cases of fraudulent representation, follow
- 10 uniform marketing standards, meet plan solvency requirements, and cover at least
- 11 the actuarial equivalent of the benefit package provided by traditional Medicare.
- 12
- 13 e. Apply risk-adjustment methodologies to ensure that affordable private health
- 14 insurance coverage options are available for sicker beneficiaries and those with
- 15 higher projected health care costs.
- 16
- 17 f. Set the amount of the baseline defined contribution at the value of the
- 18 government's contribution under traditional Medicare.
- 19
- 20 g. Ensure that health insurance coverage is affordable for all beneficiaries by
- 21 allowing for adjustments to the baseline defined contribution amount. In
- 22 particular, individual defined contribution amounts should vary based on
- 23 beneficiary age, income and health status. Older, lower income and sicker
- 24 beneficiaries would receive larger defined contributions.
- 25
- 26 h. Adjust baseline defined contribution amounts annually to ensure that health
- 27 insurance coverage remains affordable for all beneficiaries. Annual adjustments
- 28 should reflect changes in health care costs and the cost of obtaining health
- 29 insurance.
- 30
- 31 i. Include implementation time frames that ensure a phased-in approach. (New HOD
- 32 Policy)
- 33
- 34 2. That our AMA advocate that any efforts to strengthen the Medicare program ensure that
- 35 mechanisms are in place for financing graduate medical education at a level that will
- 36 provide workforce stability and an adequate supply of physicians to care for all Americans.
- 37 (New HOD Policy)
- 38
- 39 3. That our AMA reaffirm Policies H-330.896, "Strategies to Strengthen the Medicare
- 40 Program," H-385.961, "Medicare Private Contracting," D-390.986, "Medicare Balance
- 41 Billing," H-165.833, "Amend the Patient Protection and Affordable Care Act (PPACA),"
- 42 and H-165.852, "Health Savings Accounts." (Reaffirm HOD Policy)
- 43
- 44 4. That our AMA rescind Policy H-330.898, "Long-Term Funding of Medicare," Policy
- 45 D-330.917, "Medicare Reform Financing," and Policy D-330.916, "Medicare Financing
- 46 Reform." (Rescind HOD Policy)

Fiscal Note: Less than \$500.

References for this report are available from the AMA Division of Socioeconomic Policy Development.

APPENDIX A: Medicare and the Federal Budget

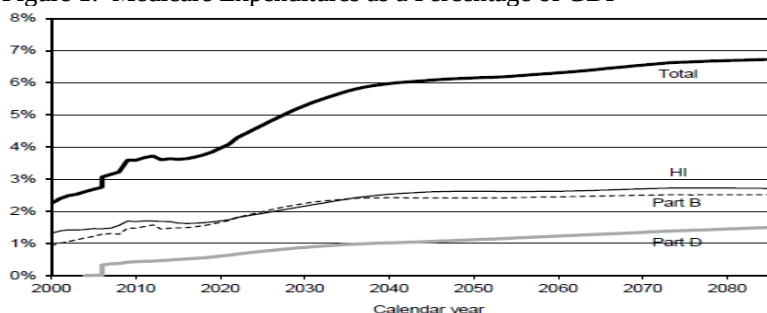
The Medicare Trust Funds

The Medicare program is supported by two separate trust funds. The Federal Hospital Insurance (HI) Trust Fund finances Medicare Part A, which covers hospital, home health, skilled nursing facility, and hospice care services. The primary source of income for the HI Trust Fund is a 2.9 percent payroll tax paid by employers and employees (1.45 percent each). Beginning in 2013, higher income workers will pay an additional 0.9 percent tax on their earnings into the HI Trust Fund. The Federal Supplementary Medical Insurance (SMI) Trust Fund finances Medicare Part B, which covers physician services, hospital outpatient services, some mental health services, durable medical equipment, ambulatory surgical center services, physician-administered drugs, some lab tests, and home health visits not covered under Part A. The SMI Trust Fund also finances Part D, which offers prescription drug coverage. Income to the SMI Trust Fund comes from federal general revenues (76 percent) and beneficiary premiums (24 percent).

The concept of Medicare “solvency” refers to the income and assets available in the HI Trust Fund. Payroll taxes paid by current workers are used to fund the benefits provided to current retirees. The declining ratio of workers contributing payroll taxes to the number of beneficiaries results in a decline in the amount of income available to fund program expenditures. The strain on available resources is exacerbated by the continual increase in health care costs throughout the health care system. A recent analysis by the Urban Institute shows that the cost of Medicare benefits received far exceeds the amount of Medicare taxes collected. For example, an average two-earner couple turning 65 in 2011 is expected to use \$357,000 in lifetime Medicare benefits, but only paid \$119,000 in Medicare taxes during their working years (Steuerle and Rennane, June 2011). As a result, HI expenditures have exceeded income annually since 2008, and funds have been drawn from the HI Trust Fund to cover the shortfall. Projections in the 2012 Medicare Trustees Report to Congress indicate that annual HI revenues will continue to fall below projected expenditures, necessitating annual payouts from the Trust Fund. Under current law, the Medicare Trustees project that the HI Trust Fund will be completely exhausted in 2024, leaving no contingency for financing benefit obligations that exceed annual dedicated sources of revenue.

In contrast to the HI Trust Fund, the SMI Trust Fund is always fully funded. By law, federal funds are allocated each year to ensure that projected Part B and Part D expenditures (less beneficiary premiums) are covered. As more people become eligible for Medicare, and as program costs increase, a greater portion of the federal budget must be diverted to the Medicare program. In 2011, SMI transfers from the Federal budget equaled 1.5 percent of GDP; transfers are projected to grow to 3.0 percent of GDP by 2086 (2012 Medicare Trustees Report). Figure 1 shows projected Medicare expenditures for all components as a percentage of GDP.

Figure 1: Medicare Expenditures as a Percentage of GDP



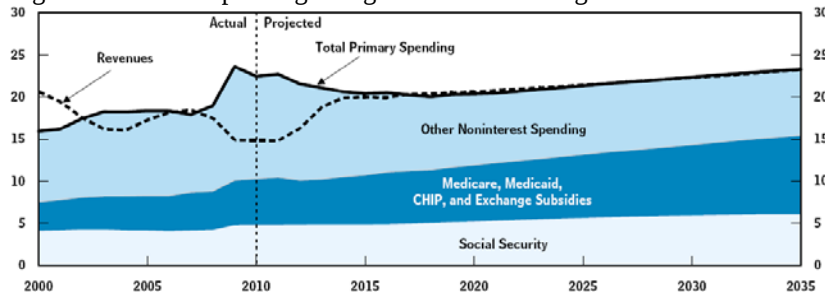
Source: 2012 Medicare Trustees Report

It should be noted that spending projections for the Medicare program are based on current law, which under the SGR formula requires an approximately 30 percent cut in physician payments in January 2013. Since Congress is unlikely to allow physician payments to be cut by nearly one-third, Medicare's future funding obligations are severely understated in the projections. Without significant tax and/or premium increases, revenues will not keep pace with program obligations, leading to insolvency (in the case of the HI Trust Fund) and an increasing demand on the federal budget.

Medicare and the Federal Budget

As Figure 2 from the Congressional Budget Office shows, health care spending is one of the largest portions of the federal budget.

Figure 2: Federal Spending Categories as a Percentage of GDP



Source: Congressional Budget Office 2011 Long-Term Budget Outlook, June 22, 2011

There is a direct relationship between expenditures for Medicare Part B and D services and the federal tax revenues that are allocated to the program on an annual basis. However, from a federal budget perspective, there is also a cost to drawing assets from the HI Trust Fund to provide Part A services. A trust fund typically holds assets to meet some future contingency, yet most government trust funds do not contain real assets. Instead, they represent a record of promises by the government to use future tax revenues to pay for future obligations as necessary. In the case of the HI Trust Fund, the earmarked revenues from payroll taxes are credited to the fund, but are effectively spent on current government activities. Until recently, annual income from payroll taxes has been sufficient to cover Medicare Part A expenditures, and the actuarial value of the HI Trust Fund has remained stable. As previously noted, however, since 2008 income from the Medicare payroll tax has been insufficient to cover current expenditures, and it has been necessary to redeem Trust Fund assets to meet the obligations to beneficiaries. Because the federal government has used the HI Trust Fund assets to fund ongoing consumption of other federal programs, Medicare expenditures that are scheduled to come from the trust fund must actually come out of the current budget resources. As policymakers struggle with budget deficits and the national debt level, they are acutely aware of growing costs associated with financing Medicare Part B and Part D services, and with “repaying” the loans that have been made from the HI Trust Fund over the past several decades.

Lawmakers also need to confront the \$325 billion funding deficit caused by their repeated failure to permanently replace the SGR. It is widely acknowledged that the SGR formula is fundamentally flawed and that it is based on assumptions about growth rates and spending baselines that are unrealistic in today's health care environment. Since 2002, Congress has intervened on 13 separate occasions to stop cuts in physician payment rates, and with a few exceptions has paid for the intervention by assuming even larger cuts in future years. The cost of funding the accumulated

cuts that have been deferred has been a major factor in the rising price of repealing the SGR, which has grown from about \$48 billion in 2005 to nearly \$325 billion today.

APPENDIX B: Policy H-330.898 Crosswalk

As described in the Discussion section of Council on Medical Service Report 5-I-12, the Council is recommending that Policy H-330.898, “Long-Term Funding of Medicare,” be rescinded. Portions of Policy H-330.898 that remain relevant to the proposed defined contribution option are expressed elsewhere in AMA policy, as described in this policy crosswalk.

Components of Policy H-330.898	Remaining Relevant AMA Policy
(1) Our AMA supports proposals to shift the funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory individually owned private savings, with a required minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical care. The government would provide a contribution to economically disadvantaged individuals making smaller than average contributions to their retirement accounts.	Council on Medical Service Report 5-I-12 articulates support for transitioning to a defined contribution program as a more viable Medicare reform option.
(2) Supports establishing incentives to encourage the use of accumulated balances in health savings accounts for the funding of post-retirement medical care.	Policy H-165.852 supports the use of health savings accounts, and is recommended for reaffirmation in Council on Medical Service Report 5-I-12.
(3) Recognizes that while private sector solutions can address a large portion of the long-term funding of Medicare, there will still be a need and responsibility for support from government or charitable organizations for the economically disadvantaged.	The defined contribution program articulated in Council on Medical Service Report 5-I-12 includes additional support for economically disadvantaged individuals.
(4) Continues to support modernization of the traditional Medicare program by combining the cost-sharing requirements of Parts A and B into a single deductible.	Policy H-330.896 supports restructuring beneficiary cost-sharing, and is recommended for reaffirmation in Council on Medical Service Report 5-I-12.
(5) Continues to support replacing Medicare’s systems of price controls with a system of price competition.	Policy H-165.985 supports price competition over price controls, and is recommended for reaffirmation in Council on Medical Service Report 5-I-12.
(6) Supports the premise that the FEHBP should be used as a model for restructuring Medicare. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that best meets their needs. Private retiree health insurance also should be integrated into any FEHBP-modeled system.	Council Report 5-I-12 articulates support for a transitioning Medicare to a defined contribution program, which would allow seniors to choose among competing private plans. This concept is also included in Policy H-330.896, which is recommended for reaffirmation in Council on Medical Service Report 5-I-12.

Components of Policy H-330.898	Remaining Relevant AMA Policy
(7) Supports the premise that during the transition from the current Medicare program to a system of pre-funding, workers would not only establish private savings accounts for their retirement expenses, but would also continue to support current and soon-to-be retirees through some level of taxation.	Council on Medical Service Report 5-I-12 articulates support for transitioning to a defined contribution program as a more viable Medicare reform option.
(8) Reaffirms that the fundamental goal of transforming Medicare should be to assure the health of the elderly and disabled populations. Patients must have access to high quality medical services. The best value in medical care can be achieved by ensuring that the medical profession has a central role in the design and implementation of a new Medicare program. Patients must also receive timely and accurate information on the necessity and important aspects of Medicare transformation.	The recommendations presented in Council on Medical Service Report 5-I-12 reflect a commitment to assuring the health of the elderly and disabled populations.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION AND THE COUNCIL ON
MEDICAL SERVICE (I-12)
The Structure and Function of Interprofessional Health Care Teams
(Reference Committee J)

EXECUTIVE SUMMARY

In June 2012, the Council on Medical Education and the Council on Medical Service agreed to develop a joint report on the structure and function of interprofessional health care teams. The impetus for the report came largely from the anticipated health care professional shortage in conjunction with projected gains in health care coverage due to the Patient Protection and Affordable Care Act (ACA).

According to recent analyses, the shortage of all physicians is estimated to reach 130,600 by 2025, whereas the shortage of registered nurses is expected to reach 260,000 by the same year. This health professional shortage is being exacerbated by an ever increasing demand for health care services. One factor influencing the demand includes a projected surge of about 30 million more insured Americans starting in 2014 due to the passage of the ACA.

Longstanding policy of the American Medical Association (AMA) in support of physician-led team-based care is building momentum in the context of budgetary constraints and the imbalance between the health care professionals shortage and increasing demand for care.

There are many examples from across the nation demonstrating that physician-led team-based care results in improved access to high-quality, cost-effective health care. From patient-centered medical homes to some of the nation's largest health care systems, physician-led interprofessional team-based health care has proven to be a successful model in the delivery of health care. As a result of the trend toward this delivery model, an increasing number of medical schools are shifting their educational focus to provide learning experiences with other future health care professionals in a team-based care environment.

The Council on Medical Education and the Council on Medical Service have collaborated to outline the practice of team-based medicine and the roles and responsibilities of health care professionals working in interprofessional health care teams. Such teams will likely be an important component of addressing anticipated access problems generated by the ACA.

This report provides background on the growing need for interprofessional team-based care, outlines the health professionals shortage and increasing demand for health care services, reviews quality and cost of health care, highlights key aspects of an interprofessional collaborative medical practice, and identifies interprofessional education programs. This report also summarizes relevant AMA policy, a new membership opportunity and discusses potential avenues for AMA advocacy and policy development, such as principles to guide physician leaders of health care teams.

JOINT REPORT OF THE COUNCIL ON MEDICAL EDUCATION
AND COUNCIL ON MEDICAL SERVICE

CME-CMS Joint Report I-12

Subject: The Structure and Function of Interprofessional Health Care Teams

Presented by: Mahendr S. Kochar, MD, Chair, Council on Medical Education
Donna E. Sweet, MD, Chair, Council on Medical Service

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Health care and how it is delivered in this country is evolving at a rapid pace. The delivery and
2 payment of health care has been transitioning for many years away from a fragmented system
3 toward interprofessional team-based delivery and payment models. The trends toward the “patient-
4 centered medical home” (PCMH) and “accountable care organizations” (ACOs) and increased
5 attention on “population health” have prompted a greater focus on the need for interprofessional
6 team-based care. Some physicians have been practicing in a team-based environment for decades,
7 but for others, interprofessional team-based health care poses a new way of practicing medicine.

8
9 Due to the potential complexity of the health care delivery system, independent practice by any
10 professional has become very difficult. Team-based health care is one step in ensuring that patients
11 receive the most patient-centered, highest quality care possible. All professions in a health care
12 team bring with them great strengths and unique perspectives that can be utilized when looking at
13 how to provide the safest, best possible care to patients.

14
15 The Council on Medical Education and the Council on Medical Service have collaborated to
16 outline the practice of team-based medicine and the roles and responsibilities of health care
17 professionals working in interprofessional health care teams. Such teams will likely be an
18 important component of addressing anticipated access problems generated by the Patient Protection
19 and Affordable Care Act (ACA).

20
21 This report provides background on the growing need for interprofessional team-based care,
22 outlines the health professionals shortage and increasing demand for health care services, reviews
23 quality and cost of health care, highlights key aspects of an interprofessional collaborative medical
24 practice, and identifies interprofessional education programs. The report also summarizes relevant
25 AMA policy and a new membership opportunity, discusses potential avenues for AMA advocacy
26 and policy development, and provides recommendations on interprofessional health care teams
27 including principles to guide physician leaders.

28
29 **INTERPROFESSIONAL TEAM-BASED CARE**

30
31 There is a growing need for interprofessional team-based health care. Numerous analyses of the US
32 health care system call for an integration of care to more effectively and efficiently provide health
33 care to the nation’s growing, aging and increasingly sicker population. At the time this report was
34 finalized, the Institute of Medicine (IOM), National Academy of Sciences, had developed a
35 discussion paper that was expected to be released in October 2012, which outlines the following

core principles to achieve high-value team-based health care: shared goals, clear roles, mutual trust, effective communication and measurable processes and outcomes. The IOM paper is intended to guide coordinated collaboration among health professionals to help accelerate interprofessional team-based care.¹ Regarding health care professionals' training, team-based care will be the focus of a new national health education center, the Coordinating Center for Interprofessional Education and Collaborative Practice, which was established in 2012 through the Health Resources and Services Administration (HRSA), and aims to accelerate the health care system's transformation to an integrated system of coordinated, collaborative, team-based care. At the time of this writing, HRSA is accepting applications and plans to award a five-year, \$800,000 grant by September 30, 2012.²

In March 2012, a legislative example of collaboration between physicians and nurses occurred in the state of Virginia, which enacted "Practice of Nurse Practitioners; Patient Care Teams Act." The Act was the result of a joint effort between the Medical Society of Virginia and the Virginia Council of Nurse Practitioners with an emphasis on collaboration and consultation between physicians and nurse practitioners who function in care teams as well as identifying opportunities to expand access to care.^{3,4} The Act specifies that nurse practitioners must practice as part of patient care teams and that health care teams be led and managed by a physician. It is anticipated that the new practice model will specifically benefit patients in medically underserved areas of the state as well as help address a future increase of patients with health insurance coverage. The Councils believe that this legislation can serve as a model for other states seeking to reinforce the important and long-standing relationships between physicians and nurses while improving access to care for their citizens. The AMA is developing a state-based campaign to assist states that wish to pursue similar legislation as Virginia's landmark new law.

HEALTH CARE PROFESSIONALS SHORTAGE AND INCREASING DEMAND FOR CARE

The ACA contains provisions for the expansion of health insurance coverage. However, obtaining health insurance does not ensure access to health care. There is mounting concern about the ability of the health care profession to handle the expected surge in patient volume given the shortage of both physicians and nurses for the foreseeable future. According to a 2010 analysis by the Association of American Medical Colleges (AAMC), the shortage of all physicians is estimated to reach 130,600 by 2025.⁵ According to a 2009 analysis, the shortage of registered nurses (RNs) is expected to reach 260,000 by 2025.⁶

The ACA attempts to address the shortage of physicians by increasing Medicaid payments for primary care services provided by primary care physicians (i.e., family medicine, general internal medicine or pediatric medicine) to 100 percent of the Medicare payment rates for 2013 and 2014. However, the increased payment may not be enough to sustain physician participation in Medicaid and it is questionable whether the enhanced payments will continue past 2014. The ACA also includes provisions that support graduate medical education as well as programs to increase the number of primary care health care providers. For example, the legislation authorizes appropriations for an additional \$1.5 billion to the National Health Service Corps and increased funding for Title VII and Title VIII health professions and diversity programs, which support the recruitment of primary care health care providers, including physicians and nurse practitioners to work in underserved areas.

The shortage of physicians and nurses is being exacerbated by an ever-increasing demand for health care services. Factors influencing the demand include a projected surge of about 30 million more insured Americans starting in 2014 due to the passage of the ACA; a growing and aging US population; increasing numbers of patients with chronic disease including those related to lifestyle

factors resulting in epidemics of obesity, diabetes, and hypertension; and patients' high expectations of the health care delivery system. In addition, many health care professionals have deferred retirement due to the recent global economic downturn, but they will be unable to do so indefinitely.

QUALITY AND COST OF HEALTH CARE

In 2011, the American Academy of Family Physicians (AAFP) commissioned a study by the University of Missouri to evaluate the quality of existing studies comparing primary care physicians with nurse practitioners, specifically evaluating health care outcomes and cost effectiveness. The authors found that while the evidence is insufficient to make conclusions about comparability of care, substituting independent nurses for primary care physicians is not sufficiently supported by current research either.⁷ In comparing the training of family physicians and that of nurse practitioners, the AAFP predicts that the differences would likely impact breadth and depth of patient care.⁸ The AAFP suggests that nurse practitioners should not work as independent health care providers, but instead, should be part of an integrated practice arrangement under the direction of a physician.⁹

There are many examples from across the nation demonstrating that physician-led integrated care results in improved access to high-quality, cost-effective health care. Community Care of North Carolina (CCNC), a physician-led patient-centered medical home model established in 1998, is one such example. CCNC includes 14 networks of 3,200 physicians covering 67 percent of the state's Medicaid population. The networks include physicians, case managers, hospitals, social service agencies and health departments. A 2011 assessment found that from 2007 to 2010 the cost savings attributable to the program was \$984 million. The analysis suggests that CCNC reduced North Carolina Medicaid costs through care management activities resulting in lower hospital and emergency room costs.¹⁰ Other examples are discussed below.

Most Americans agree that a physician-led team-based approach to care with each team member playing the role they are educated and trained to play is key to ensuring high quality care. Results from the AMA Advocacy Resource Center's 2012 Truth in Advertising survey indicate that patients want a physician to lead the health care team. Key findings include:

- Ninety-one percent of respondents said that a physician's years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency;
- Eighty-six percent said that patients with one or more chronic diseases benefit when a physician leads the primary health care team; and
- Eighty-four percent said that they prefer a physician to have primary responsibility for the diagnosis and management of their health care.

Furthermore, 79 percent of respondents stated that nurse practitioners should not be able to practice independently of physicians or run their own medical practices without physician supervision, collaboration, or oversight. According to a majority (885) of respondents, while nurse practitioners are critical to the health care team, they should assist the physician who should have the lead role in determining the type and level of care to be administered. These results, combined with a close look at interprofessional collaborative medical practices, show overwhelming support for physician-led, team-based health care.¹¹

INTERPROFESSIONAL COLLABORATIVE MEDICAL PRACTICE

A June 2011 American College of Surgeons study assessed the capacity of an interprofessional collaborative medical practice, including physicians, advanced practice nurses (APNs), and physician assistants (PAs), to meet the future demand for health care services. While the study concluded that efforts must be made to increase the output of physicians, APNs and PAs, it emphasized that strengthening the clinical practice infrastructure and facilitating the delegation of tasks to a broader spectrum of caregivers in new delivery models is key to addressing the access problems.¹¹ The study's suggestion is consistent with AMA support for a physician-led interprofessional team-based approach to providing care, which is already being implemented in many physician practices throughout the country and through some of the nation's leading health care systems.

The Centers for Disease Control and Prevention's National Center for Health Statistics reported in August 2011 that 49 percent of office-based physicians worked in practices that utilized nurse practitioners (NPs), certified nurse midwives (CNMs), or PAs. According to the report's data, from the 2009 National Ambulatory Medical Care Survey, the physicians most likely to work with NPs, CNMs, or PAs are aged 54 and younger and are concentrated in primary care, in larger and multi-specialty group practices, and in practices with a higher proportion of Medicaid revenue.¹²

Kaiser Permanente in California, Intermountain Healthcare in Utah, Geisinger Health System in Pennsylvania and the Mayo Clinic in Minnesota are four examples of the nation's largest health care systems.¹³ All are physician-led team-based health care systems that employ a mixture of health care professionals to create interprofessional teams focused on patient-centered care. All place accountability for patient care with the physician team leaders. These systems rely heavily on structured clinical protocols tailored to their health systems to improve the experience of care and health of their patient population as well as reduce the cost of health care. They embrace and depend upon the expertise that each health care practitioner brings to the team. The use of information technology such as electronic health records or centralized patient databases is viewed as vital to delivering efficient, high quality, clinical care. The incorporation of disease management, care coordination and social services focuses on the health of a population while also keeping the care patient-focused. In addition, these systems routinely use continuous quality improvement mechanisms such as tracking patient outcomes. All identify strong physician leadership and physician support of their organization's mission and team-based approach to care as being keys to success.

INTERPROFESSIONAL EDUCATION

In May 2011, the Interprofessional Education Collaborative (IPEC), sponsored by the Association of American Medical Colleges, American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, and the Association of Schools of Public Health, released its report, "Core Competencies for Interprofessional Collaborative Practice." The report emphasizes that teaching students to work effectively as members of clinical teams is a fundamental part of health care education. As such, the report outlines the following core competencies that all training programs should address: values/ethics, roles/responsibilities, communication, and teamwork/team-based practice. The IPEC aims to help schools develop interprofessional training programs to better prepare health care professionals for team-based care.¹⁴

1 An increasing number of medical schools are shifting their educational focus to provide learning
 2 experiences with other future health care professionals in a team-based care environment. The
 3 following are three examples:

- 4
- 5 • Loyola University Chicago is moving its nursing school to an adjoining building on the same
 6 campus as its medical school. Starting this fall, medical and nursing students will train together
 7 in a new, virtual six-bed hospital, learning to work as a team on simulated patients.¹⁵
 8
- 9 • New York University School of Medicine and College of Nursing are collaborating on a new
 10 inter-professional project that features team-based learning including real and virtual case
 11 studies on common clinical problems. In 2010, the two schools launched a pilot program that
 12 paired 15 medical students with 15 nursing students. The students were presented with
 13 different types of health crises and collaborated on treatment plans for the patients featured in
 14 simulations.¹⁶
 15
- 16 • The University of Toledo (UT) Colleges of Medicine, Nursing, Health Science & Human
 17 Service and Pharmacy have developed a series of interprofessional educational, clinical
 18 research and regional/global outreach programs over the past five years. The broad curricular
 19 impact of the UT Interprofessional Immersive Simulation Center (IISC) has also continued to
 20 enhance team-based education and clinical care. In addition, the multi-year experiences with a
 21 Team Leadership Curriculum, offered as a part of the Bridge to Clerkship Course to all medical
 22 students by the UT College of Business, has been well accepted.¹⁷ All of these curricular
 23 changes are assessed from a competency development perspective as well as a learner
 24 satisfaction view point.
 25

26 In August 2010, the Office of Academic Affiliations (OAA) issued a request for proposals to
 27 establish Centers of Excellence in Primary Care Education. As part of US Department of Veterans
 28 Affairs' (VA) New Models of Care initiative, the five centers that have been selected to participate
 29 will utilize VA primary care settings to develop and test innovative approaches to prepare
 30 physician residents and students, advanced practice nurse and undergraduate nursing students, and
 31 associated health trainees for primary care practice in the 21st Century. The purpose of the Centers
 32 will be to foster transformation of clinical education by preparing graduates of health professional
 33 programs to work in and lead patient-centered interprofessional teams that provide coordinated
 34 longitudinal care.¹⁸
 35

36 There are a number of studies about the positive outcomes of interprofessional education (IPE).
 37 However, there is concern about implementing IPE programs due to such things as differing
 38 schedules across programs, "packed" curricula that do not permit additional IPE experiences, and
 39 faculty and administrative resistance. Council on Medical Education Report 2-I-12, being
 40 considered by the House of Delegates at this meeting, provides more information about IPE,
 41 including a summary of current AMA policies and recommendations on medical education for IPE.
 42

43 IPE is also available for practicing physicians and other health care professionals. The Community
 44 Health Leadership Program at Duke University provides a three day intensive study with Duke
 45 Medical Center faculty and hands-on interactions with many Durham community organizations.
 46 Students complete the remainder of the program via distance-based learning, allowing them to
 47 return to work while gaining the knowledge and skills to design and implement innovative
 48 programs to serve the health needs of communities across the country.¹⁶ An example that brings the
 49 training to the practice setting, the Agency for Healthcare Research and Quality in collaboration
 50 with the Department of Defense, has been giving hospitals and practitioners a boot camp in team-

based care since 2006. The TeamSTEPPS program focuses on building up core competencies in teamwork.¹⁹

Physician leadership and management skills are becoming essential as primary care providers and a wide array of specialists become jointly responsible for the quality and cost of health care. Brody School of Medicine at East Carolina University has established a Physician Leadership Institute to foster the development of physician leaders. This continuing medical education program is designed to enhance and develop leadership knowledge, skills and abilities through group sessions, case studies, independent study, and practical application. Applicants to the program must possess aspiration for leadership and meet a set of criteria before they can participate in the program.²⁰

RELEVANT AMA POLICY

The AMA advocates that physicians maintain authority for patient care in any team care arrangement to assure patient safety and quality of care. The AMA believes that the ultimate responsibility for the individual patient's medical care rests with the physician. Physicians must be responsible and have authority for initiating and implementing quality-control programs for non-physicians delivering medical care in integrated practices. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency (Policies H-360.987[1,2,6], H-200.994 and D-35.985[5,6]). The AMA advocates that the appropriate ratio of a supervising physician to non-physician practitioners should be determined by the physician at the practice level, consistent with good medical practice, and state law where relevant (Policy H-35.975).

The AMA lacks policy regarding the specific clinical roles and responsibilities for certain members of health care teams. However, Policy H-360.983 states that in order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. Specifically, a registered nurse, qualified by education, experience and credentials, who follows a patient-specific protocol written by a qualified physician, should be allowed to adjust and discontinue catheter infusions.

The AMA has developed the following guidelines for the integrated practice of physicians and nurse practitioners (Policy H-160.950):

- (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
- (2) The physician is responsible for managing the health care of patients in all practice settings.
- (3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
- (4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
- (5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
- (6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.

- 1 (7) These practice protocols should delineate the appropriate involvement of the two
- 2 professionals in the care of patients, based on the complexity and acuity of the patients'
- 3 condition.
- 4 (8) At least one physician in the integrated practice must be immediately available at all times
- 5 for supervision and consultation when needed by the nurse practitioner.
- 6 (9) Patients are to be made clearly aware at all times whether they are being cared for by a
- 7 physician or a nurse practitioner.
- 8 (10) In an integrated practice, there should be a professional and courteous relationship between
- 9 physician and nurse practitioner, with mutual acknowledgment of, and respect for each
- 10 other's contributions to patient care.
- 11 (11) Physicians and nurse practitioners should review and document, on a regular basis, the care
- 12 of all patients with whom the nurse practitioner is involved. Physicians and nurse
- 13 practitioners must work closely enough together to become fully conversant with each
- 14 other's practice patterns.

15

16 The AMA has developed the following guidelines for the integrated practice of physicians and
17 physician assistants (Policy H-160.947):

18

- 19 (1) The physician is responsible for managing the health care of patients in all settings.
- 20 (2) Health care services delivered by physicians and physician assistants must be within the
- 21 scope of each practitioner's authorized practice, as defined by state law.
- 22 (3) The physician is ultimately responsible for coordinating and managing the care of patients
- 23 and, with the appropriate input of the physician assistant, ensuring the quality of health care
- 24 provided to patients.
- 25 (4) The physician is responsible for the supervision of the physician assistant in all settings.
- 26 (5) The role of the physician assistant in the delivery of care should be defined through mutually
- 27 agreed upon guidelines that are developed by the physician and the physician assistant and
- 28 based on the physician's delegatory style.
- 29 (6) The physician must be available for consultation with the physician assistant at all times,
- 30 either in person or through telecommunication systems or other means.
- 31 (7) The extent of the involvement by the physician assistant in the assessment and
- 32 implementation of treatment will depend on the complexity and acuity of the patient's
- 33 condition and the training, experience, and preparation of the physician assistant, as adjudged
- 34 by the physician.
- 35 (8) Patients should be made clearly aware at all times whether they are being cared for by a
- 36 physician or a physician assistant.
- 37 (9) The physician and physician assistant together should review all delegated patient services
- 38 on a regular basis, as well as the mutually agreed upon guidelines for practice.
- 39 (10) The physician is responsible for clarifying and familiarizing the physician assistant with
- 40 his/her supervising methods and style of delegating patient care.

41

42 AMA INTEGRATED PHYSICIAN PRACTICE SECTION (IPPS)

43

44 At its 2012 Annual Meeting, the AMA House of Delegates established the Integrated Physician
45 Practice Section (IPPS), acknowledging the physician-led integrated health care model as a specific
46 mode of practice. An outgrowth of the Advisory Committee on Group Practice Physicians, the
47 IPPS will represent doctors in physician-led, integrated health care organizations that coordinate
48 patient care across specialties and among physicians who share common records and clinical care
49 processes. Section membership includes two categories, Associate and Affiliate. Associate
50 membership is directed toward physician representatives from physician-led, integrated health
51 systems, while Affiliate membership allows for physician representatives from organizations

1 working toward becoming physician-led, integrated health care systems. The inaugural meeting of
2 the IPPS will be held in conjunction with the AMA's 2013 Annual Meeting of the House of
3 Delegates.

4 5 DISCUSSION

6
7 Given the combined impact of health care budgetary constraints at the state and federal levels, the
8 imminent coverage of up to 30 million more Americans starting in 2014, and shortages of both
9 physicians and nurses for the foreseeable future, recognition of and support for physician-led team
10 based care is building. Due to the potential complexity of the health care delivery system,
11 independent practice by any professional has become very difficult. The future of health care
12 delivery is patient-centered and focused on improving the experience of care, improving the health
13 of populations and reducing per capita costs of health care. This focus is possible through the use
14 of team-based models of health care delivery.

15
16 The Councils suggest defining "team-based health care" as the provision of health care services by
17 a physician-led team of at least two health care practitioners who work collaboratively with each
18 other and the patient and family to accomplish shared goals within and across settings to achieve
19 patient-centered, coordinated, high-quality care.

20
21 In a physician-led interprofessional team-based environment, the physician leader should be
22 empowered to perform the full range of medical interventions that she or he is trained and licensed
23 to perform. All members of a physician-led interprofessional health care team should be enabled to
24 perform medical interventions that they are capable of performing according to their education,
25 training and licensure and the discretion of the physician team leader in order to most effectively
26 provide quality patient care. Only when each practitioner, including the physician team leader, is
27 practicing according to these demonstrated competencies, can the team as a group provide the
28 highest quality care. As a result, the focus shifts toward what the team can do rather than what each
29 individual practitioner can do.

30
31 In this setting, there is greater responsibility for the physician team leader than for other team
32 members. Accordingly, the Councils have outlined a series of principles to guide physician leaders
33 of health care teams. The physician team leader should make clear the team's mission, vision and
34 values; direct and/or engage in collaboration with team members on patient care; be accountable
35 for clinical care, quality improvement, efficiency of care, and continuing education; focus the team
36 on patient and family-centered care; foster a respectful team culture and encourage team members
37 to contribute the full extent of their professional insights, information and resources; encourage
38 adherence to best practice protocols that team members are expected to follow; manage care
39 transitions by the team so that they are efficient and effective, and transparent to the patient and
40 family; promote clinical collaboration, coordination and communication within the team to ensure
41 efficient, quality care is provided to the patient and that knowledge and expertise from team
42 members is shared and utilized; support open communication among and between the patient and
43 family and the team members to enhance quality patient care and to define the roles and
44 responsibilities of the team members that they encounter within the specific team, group or
45 network; facilitate the work of the team and be responsible for reviewing team members' clinical
46 work and documentation; and review measures of "population health" periodically when the team
47 is responsible for the care of a defined group.

48
49 Given the greater efficiencies and quality of care that team-based health care has the potential to
50 provide, the Councils encourage independently practicing physicians and physicians in small
51 practices to seek opportunities to connect with similar sized practices to form team-based health

care networks. Such opportunities exist through independent practice associations, virtual networks or other networks of independent providers that may be practical given geographic and specialty specific circumstances. The use of more sophisticated information technology resources will likely facilitate communication among and between such networks and the teams of providers within them.

New delivery models, such as team-based health care, are resulting in new payment models, such as bundled payment methods and incentives that support and reward higher performance. The Councils believe that innovative payment mechanisms should appropriately compensate the team and all team members for team-based health care. In addition, the Councils believe that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members. The governance of the team needs to provide authority to the physician team leader. It is critical that the physician team leader, in addition to assuming greater responsibility, be given the authority to make management decisions about the team such as determining staffing needs, committing resources, constructing budgets, setting goals and objectives, evaluating performances, and distributing incentives.

Health care teams fall into several categories, such as medical care, care coordination and health care. Different teams provide different functions just as different team members provide different functions. While team-based care is a group effort, physicians, due to their training and expertise, are the natural leaders in overall care delivery.²¹ With this team leadership comes accountability, even if the physician is practicing in an established health care system. Care coordination teams often operate seemingly independently, with a designated team leader who most likely is not a physician. Even so, the care coordination team leader should be obligated to report to and collaborate with a physician team leader of the medical care team. Every medical procedure performed by non-physicians must ultimately be approved, whether according to an outlined protocol or by the physician reviewing and signing off on clinical notes. Patients interact with different teams according to any changes in their health conditions. The Councils believe that transitions between teams should be managed by the teams and be transparent to the patient.

In a physician-led interprofessional team-based model, the ratio of non-physician practitioners to the physician leader has been considered. The “optimum” ratio is outlined in state law and therefore varies across the country. Policy H-35.975 addresses the ratio issue in general, although the Councils recommend amendments to update this policy in order to modernize the terminology from “physician extenders” to “non-physician practitioners” and to include elements that should be taken into consideration when determining the appropriate ratio of consulting physician leader to non-physician practitioners, such as the specialty, physician’s panel size and disease burden of the patient case mix.

The Councils believe that Policy H-160.950, which provides guidelines for the integrated practice of physicians and nurse practitioners, and Policy H-160.947, which provides guidelines for the integrated practice of physicians and physician assistants are still relevant and should be reaffirmed.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) define “team-based health care” as the provision of health care services by a physician-led team of at least two health care

- 1 practitioners who work collaboratively with each other and the patient and family to
2 accomplish shared goals within and across settings to achieve coordinated, high-quality,
3 patient-centered care. (New HOD Policy)
4
- 5 2. That our AMA advocate that the physician leader of a physician-led interprofessional health
6 care team be empowered to perform the full range of medical interventions that she or he is
7 trained and licensed to perform. (New HOD Policy)
8
- 9 3. That our AMA advocate that all members of a physician-led interprofessional health care team
10 be enabled to perform medical interventions that they are capable of performing according to
11 their education, training and licensure and the discretion of the physician team leader in order
12 to most effectively provide quality patient care. (New HOD Policy)
13
- 14 4. That our AMA adopt the following principles to guide physician leaders of health care teams:
15
 - 16 a) Make clear the team's mission, vision and values.
 - 17
 - 18 b) Direct and/or engage in collaboration with team members on patient care.
 - 19
 - 20 c) Be accountable for clinical care, quality improvement, efficiency of care, and continuing
21 education.
 - 22
 - 23 d) Focus the team on patient and family-centered care.
 - 24
 - 25 e) Foster a respectful team culture and encourage team members to contribute the full extent
26 of their professional insights, information and resources.
 - 27
 - 28 f) Encourage adherence to best practice protocols that team members are expected to follow.
 - 29
 - 30 g) Manage care transitions by the team so that they are efficient and effective, and transparent
31 to the patient and family.
 - 32
 - 33 h) Promote clinical collaboration, coordination, and communication within the team to ensure
34 efficient, quality care is provided to the patient and that knowledge and expertise from
35 team members is shared and utilized.
 - 36
 - 37 i) Support open communication among and between the patient and family and the team
38 members to enhance quality patient care and to define the roles and responsibilities of the
39 team members that they encounter within the specific team, group or network.
 - 40
 - 41 j) Facilitate the work of the team and be responsible for reviewing team members' clinical
42 work and documentation.
 - 43
 - 44 k) Review measures of "population health" periodically when the team is responsible for the
45 care of a defined group. (New HOD Policy)
46
- 47 5. That our AMA encourage independent physician practices and small group practices to seek
48 opportunities to form health care teams with other practices, such as through independent
49 practice associations, virtual networks or other networks of independent providers. (New HOD
50 Policy)

- 1 6. That our AMA encourage innovative payment mechanisms that appropriately compensate the
2 team and all team members for team-based health care. (New HOD Policy)
3
- 4 7. That our AMA advocate that the structure, governance and compensation of the team should be
5 aligned to optimize the performance of the team leader and team members. (New HOD Policy)
6
- 7 8. That our AMA modify Policy H-35.975 by insertion and deletion to read as follows:
8
9 Our AMA endorses the principle that the appropriate ratio of physician to non-physician
10 ~~extenders~~ practitioners should be determined by physicians at the practice level, consistent with
11 good medical practice, and state law where relevant, taking into consideration the physician's
12 specialty, physician's panel size and disease burden of the patient case mix. (Modify Current
13 HOD Policy)
14
- 15 9. That our AMA reaffirm Policy H-160.950, which provides guidelines for the integrated
16 practice of physicians and nurse practitioners. (Reaffirm HOD Policy)
17
- 18 10. That our AMA reaffirm Policy H-160.947, which provides guidelines for the integrated
19 practice of physicians and physician assistants. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-12)

Introduced by: Medical Student Section
Subject: Prescription Refill Schedules
Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, The Centers for Disease Control and Prevention estimates that 1 out of every 2 adults
2 in the United States suffers from a chronic disease, which often requires multiple-medication
3 treatment; and
4

5 Whereas, A 2009 report of the New England Healthcare Institute established that patients who
6 do not take their medications as prescribed by their doctors cost the US health care system an
7 estimated \$290 billion in avoidable medical spending every year; and
8

9 Whereas, According to a 2011 report published by the *American Journal of Geriatric*
10 *Pharmacotherapy*, an increasing number of medications and the logistics of retrieving
11 prescriptions from a pharmacy are associated with decreased adherence; and
12

13 Whereas, Several state governments, including Minnesota and Connecticut, have already
14 begun exploring ideas to help achieve alignment of prescription refills; and
15

16 Whereas, Our AMA currently opposes restrictions on prescription refills that cause hardship on
17 patients (AMA Policy H-120.952); therefore be it
18

19 RESOLVED, That our American Medical Association encourage relevant organizations,
20 including but not limited to insurance companies and professional pharmacy organizations, to
21 develop a plan to implement prescription refill schedule strategies so that patients requiring
22 multiple prescription medications may reduce the travel barriers for prescription acquisition.
23 (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 08/24/12

RELEVANT AMA POLICY

H-120.952 Restriction on Prescription Refills - Our AMA opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions including, but not limited to: (1) restricting refill hours to less than usual pharmacy hours; (2) restricting refills to limited pharmacies rather than all participating pharmacies; (3) restricting refills for chronic medications to a less than 90-day supply; and (4) restricting the date of refill. (Res. 512, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-12)

Introduced by: Medical Student Section

Subject: Use of Integrated Electronic Patient Care Reports for Prehospital Providers

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

Whereas, Patient care reports are the standard documentation of care used by emergency medical services (EMS) personnel on a patient prior to hospital admission; and

Whereas, Many EMS providers are switching from paper-based patient care reports to electronic-patient care reports (e-PCR); and

Whereas, A 2010 study published in *Catheterization and Cardiovascular Interventions* illustrated that the use of e-PCR improves patient outcomes, such as the electronic transmission of prehospital ECGs to the receiving hospital improving door-to-balloon time and leading to better outcomes for ST-elevation Myocardial Infarction (STEMI) patients; and

Whereas, According to a *Modern Health Care* report, although a large number of EMS providers now utilize some form of electronic patient record, many hospital systems are not set up to allow integrated and advance reporting; and

Whereas, Although the Health Information Technology for Economic and Clinical Health Act incentivizes the adoption of Electronic Health Records, it does not offer financial motivation for ambulance services or hospitals to adopt prehospital electronic patient care reporting systems; and

Whereas, Our AMA is committed to improving, standardizing, and optimizing the flow of critical information across the complete spectrum of care (AMA Policy D-160.944); and

Whereas, Our AMA currently endorses the concept of appropriate medical direction of all prehospital medical services (H-130.976); therefore be it

RESOLVED, That our American Medical Association support legislation incentivizing the comprehensive use of integrated electronic patient care reports by EMTs and paramedics for better cross communication, and to standardize the flow of information from prehospital to hospital. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 08/24/12

RELEVANT AMA POLICY

D-160.944 Recognizing Transitions of Care for Performance Improvement - Our AMA will: (1) work to improve and standardize the flow of critical information across the spectrum of care through collaboration with long-term care stakeholders, including the American Medical Directors Association (AMDA); (2) work with other stakeholder organizations including the AMDA in an effort to develop standardized transfer forms and to promote educational initiatives that optimize transfer of information across the spectrum of care; (3) work with the Physician Consortium for Performance Improvement to develop specific measures appropriate for recognizing the work effort that assure transitions of care across the continuum of care to be safe, patient centered and outcome driven; and (4) work with other stakeholder organizations including the AMDA to develop educational initiatives and long-range projects to optimize the transfer of information across the spectrum of acute and long-term care. (Res. 702, A-08)

H-130.976 On-Site Emergency Care - (1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly. (BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-12)

Introduced by: Michigan Delegation

Subject: Billing Codes for Filling Out Forms

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

-
- 1 Whereas, Patients request their physicians to fill out various forms during their appointment; and
2
3 Whereas, Most of these forms require time and energy to complete correctly; and
4
5 Whereas, Filling out forms is free administrative work physicians carry out without proper
6 remuneration; therefore be it
7
8 RESOLVED, That our American Medical Association lobby the Centers for Medicare & Medicaid
9 Services and other national payers to reimburse those physicians who utilize billing code 99080
10 for filling out various forms requested by patients. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 08/28/12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-12)

Introduced by: Florida Delegation

Subject: Telemedicine

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, The permissibility of telemedicine varies among the states, but even in most states
2 that allow telemedicine, there is no requirement that the service be reimbursed; and
3

4 Whereas, There needs to be a uniform approach to telemedicine among the states, including a
5 requirement that any physician that provides a primary interpretation of any diagnostic test or
6 procedure that is to be utilized for the diagnosis or treatment of a disease process or medical
7 condition of a patient, be licensed to practice medicine in the same state in which the patient is
8 located; and
9

10 Whereas, Most state definitions of telemedicine can be improved upon; therefore be it
11

12 RESOLVED, That our American Medical Association encourage individual state boards of
13 medicine to regulate telemedicine and to work with individual state legislatures to seek full
14 licensure for intrastate telemedicine practice and to seek appropriate reimbursement for
15 physicians who provide telemedicine services. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/26/12

The topic of this resolution is currently under study by the Board of Trustees.

RELEVANT AMA POLICY

H-480.974 Evolving Impact of Telemedicine - Our AMA: (1) will evaluate relevant federal legislation related to telemedicine; (2) urges CMS and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship; (3) urges medical specialty societies involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine; (Reaffirmed by CME/CMS Rep. A-96) (4) encourages the CPT Editorial Board to develop CPT codes or modifiers for telemedical services; (5) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms; (6) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and (7) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. (CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11)

H-480.968 Telemedicine - The AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery. (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-480.961 Teleconsultations and Medicare Reimbursement - Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(I-12)

Introduced by: Florida Delegation

Subject: Pay for Consultation Via Telephone and Electronic Communications

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, Many professionals, i.e., accountants, financial advisors, lawyers, etc., charge a fee
2 for telephone and electronic communications; and
3

4 Whereas, Telephone and electronic communications are an effective means to improve
5 patient/physician communication and access to care, while reducing the cost of care; and
6

7 Whereas, Medicare has a CPT code for telephone and electronic communications, but it is a
8 non-reimbursable CPT code; therefore be it
9

10 RESOLVED, That our American Medical Association petition the Centers for Medicare &
11 Medicaid Services to provide a fee for the existing codes for reimbursement to physicians for
12 telephone and electronic communications. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/26/12

RELEVANT AMA POLICY

H-480.961 Teleconsultations and Medicare Reimbursement - Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

H-385.919 Payment for Electronic Communication - Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians. (CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11)

H-390.859 Reimbursement for Telephonic and Electronic Communications - (1) The policy of our AMA is that physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail or other forms of communication. (2) Our AMA presses CMS and other payers to separately recognize and adequately pay for non-face-to-face electronic visits. (Res. 810, A-00; Reaffirmation I-04; Reaffirmation A-05; Reaffirmation A-07; Reaffirmation A-08; Modified: CMS Rep. 1, A-10; Reaffirmed in lieu of Res. 705, A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-12)

Introduced by: American College of Cardiology
Heart Rhythm Society
Society for Cardiovascular Angiography and Interventions

Subject: Transparent Development of Clinical Coverage Policies by Private Carriers
and Benefit Management Plans

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, Private insurance carriers and benefit managers frequently utilize national and local
2 Medicare coverage determinations to establish their own coverage policies; and
3

4 Whereas, Private insurance carriers frequently customize coverage policies; and
5

6 Whereas, Changes in clinical policies are not usually created in a formal, public process, and
7 are therefore developed without input from the relevant specialty organizations and practicing
8 clinicians; and
9

10 Whereas, Many private insurers and benefit management plans do not routinely make their
11 clinical policies publicly available on their websites, preventing physicians, specialty
12 organizations and patients from seeing the rationale used to determine a service's coverage
13 eligibility; therefore be it
14

15 RESOLVED, That our American Medical Association work with specialty and service
16 organizations to advocate that private insurance plans and benefit management companies
17 develop public, formal processes to write / revise clinical coverage policies; that those
18 processes should include outreach to the relevant national physician organizations; and that
19 clinical coverage policies should be easily and publicly accessible on their websites, just as
20 Medicare national and local coverage determinations are publically available. (Directive to Take
21 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/28/12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-12)

Introduced by: Iowa Delegation

Subject: Surveying Actual Costs of Medical Practice

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, In his AMA presidential inaugural address, Dr. Jeremy Lazarus said the Sustainable
2 Growth Rate should be replaced with a system “that reflects the actual costs of medical
3 practice”; and
4

5 Whereas, Physician practice costs have been rapidly increasing and, for example, practice cost
6 reports from Federally Qualified Health Centers show that their mean practice expenses were
7 \$1.5 million per year per physician; and
8

9 Whereas, There is a lack of accurate measurement of details for physician practice expenses,
10 especially for regional differences in price inputs; and
11

12 Whereas, The last AMA PPI survey in 2006 was limited by the number of responses and did not
13 break down the cost categories into details that were accurate for Medical Economic Index
14 (MEI) cost share weighting; therefore be it
15

16 RESOLVED, That our American Medical Association ask the Centers for Medicare & Medicaid
17 Services to help fund a survey that would accurately measure physician practice expenses and
18 cost share weights for use in determining the Medical Economic Index and regional differences
19 in practice costs. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/28/12

RELEVANT AMA POLICY

D-390.963 Improving the Medicare Economic Index - Our AMA will urge the Centers for Medicare and Medicaid Services and the Medicare Payment Advisory Commission to review the Medicare Economic Index productivity offset and consider eliminating it or revising it so that it more accurately reflects the effects of productivity increase in medical practice. (CMS Rep. 6, I-08; Reaffirmed in lieu of Res. 122, A-12)

D-400.985 Geographic Practice Cost Index - Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues. (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12 and Res. 122, A-12)

H-406.992 The AMA's Medical Practice Survey Research Program - Our AMA: (1) continues to be the world's leader in obtaining, synthesizing and disseminating information on medical practice to physicians by continually evaluating and considering enhancements to its Socioeconomic Monitoring System data collection program; (2) continues to monitor and study the impact of changes in the socioeconomic environment on physicians and medical practices; (3) continues to pursue proactive news management to mitigate negative press treatment of physician income data; (4) considers studying the impact of changes in the socioeconomic environment on women, minorities, and physicians in settings not currently covered by the Socioeconomic Monitoring System survey; and (5) will survey separate family practice from general practice physician data. (BOT Rep. 4, I-99; Reaffirmed: CLRPD Rep. 1, A-09)

H-400.966 Medicare Payment Schedule Conversion Factor - (1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (CMS Rep. B, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 6, I-08; Reaffirmed: CMS Rep. 1, I-11)

H-400.984 Geographic Practice Costs - 1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic payment areas for use in the new Medicare physician payment system. 2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices. (Sub. Res. 25, A-90; Modified: Sunset Report, I-00; Reaffirmation A-09; Modified: CMS Rep. 4, A-11; Reaffirmed and Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-12)

Introduced by: American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists, American Society for Gastrointestinal Endoscopy, Renal Physicians Association, Society of Hospital Medicine, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont Delegations

Subject: Medicaid Expansion

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, The Supreme Court decision of June 28, 2012 determined that it is OPTIONAL for
2 states to expand Medicaid eligibility to 133% (138% including application of an 5% “disregard”)
3 of the Federal Poverty Level (FPL) as provided by the Affordable Care Act (ACA); and
4

5 Whereas, The national federal poverty level (FPL) for a family of four in 2012 is \$23,018;¹ and
6

7 Whereas, An estimated 15.1 million people would become eligible for Medicaid under the
8 Medicaid expansion;² and
9

10 Whereas, Hospitals in every state will lose millions of dollars as a result of the ACA's \$14 billion
11 cut in Medicaid disproportionate share hospital (DSH) payments and \$22 billion reduction in
12 Medicare DSH payments from 2014 to 2019 (based on the assumption that uncompensated
13 care would be reduced as Medicaid coverage is expanded); and
14

15 Whereas, In states where the current Medicaid eligibility level is less than 100% of the FPL (e.g.
16 as low as 11%), individuals and families with incomes above the state Medicaid eligibility level
17 but below the poverty level will NOT have access to health insurance under either Medicaid or
18 Health Insurance Exchanges; and
19

20 Whereas, Uninsured care in doctor's offices and in hospitals produce huge financial burdens on
21 physicians and healthcare providers who are already having difficulty meeting increased
22 expenses with declining reimbursements under Medicare and private insurance; and
23

24 Whereas, The Medicaid expansion under the ACA will be funded initially 100% by federal
25 dollars and gradually will be reduced to 90% by 2020 with the state responsible for 10%; and
26

27 Whereas, No funds or tax credits are available to physicians to reimburse them for providing
28 uncompensated care to patients not covered by Medicaid or other insurance; therefore be it

¹ U.S. Dept. of Commerce, Bureau of the Census. Preliminary Estimate of Weighted Average Poverty Thresholds for 2011. (Last revised 25 June 2012). Accessed 8/17/12 at <http://www.census.gov/hhes/www/poverty/data/threshld/index.html>

² Urban Institute. Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage? Aug 2012. <http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf>

1 RESOLVED, That our American Medical Association work with state and specialty medical
2 societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL
3 including the income disregard) of the Federal Poverty Level as authorized by the ACA
4 (Directive to Take Action); and be it further

5
6 RESOLVED, That our AMA advocate for an increase in Medicaid payments to physicians and
7 improvements and innovations in Medicaid that will reduce administrative burdens and deliver
8 healthcare services more effectively, even as coverage is expanded. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/28/12

RELEVANT AMA POLICY

H-290.986 Medicaid and Efforts to Assure it Maintains its Role as a Safety Net

The AMA supports the position that the Medicaid program maintain its role as a safety net for the nation's most vulnerable populations. (Sub. Res. 204, A-96; Reaffirmation A-05; Reaffirmation A-07)

H-290.997 Medicaid - Towards Reforming the Program

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of the existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions. (BOT Rep. UU, A-88; Reaffirmed: CMS Rep. G, A-93; Reaffirmation I-96; Reaffirmation A-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-05; Reaffirmed: Res. 804, I-09)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-12)

Introduced by: American Society of Clinical Pathology
American Society of Cytopathology
College of American Pathologists
National Association of Medical Examiners
United States and Canadian Academy of Pathology

Subject: Medicare Quality and Resource Use Reports

Referred to: Reference Committee J
(Veronica J. Dowling, MD, Chair)

1 Whereas, The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and
2 2010 Patient Protection and Affordable Care Act requires CMS to develop a “value-based
3 modifier” that adjusts Medicare Physician Fee Schedule payments based on a medical
4 professional’s performance on both quality and resource use¹; and
5

6 Whereas, The Medicare Quality and Resource Use Reports (QRURs) were made available to
7 physicians in Missouri, Kansas, Iowa, and Nebraska in March of 2012, who billed Medicare fee-
8 for- service claims in 2010; and
9

10 Whereas, The AMA developed a workgroup comprised of state and specialty societies to
11 address concerns about the report; and
12

13 Whereas, CMS uses QRUR cost measurements that are based on Medicare spending for
14 patients that is often not related to any action of the individual attributed physician; and
15

16 Whereas, There is evidence that the reports that CMS is developing and testing poorly
17 represents the quality of care provided and the resources used by pathologists; and
18

19 Whereas, It is likely that other hospital-based and specialty physicians QRUR reports likely do
20 not accurately reflect the quality of care or the resources utilized by these physicians; and
21

22 Whereas, CMS has acknowledged the limited quality of these reports however nonetheless
23 intends to expand the program beyond the original four states this fall, without significant
24 redesign of the reporting tool; and
25

26 Whereas, Current AMA Policy H.390.849 supports payment methodologies that redistribute
27 Medicare payments among providers based on outcomes, quality, and risk-adjustment
28 measures only if these measures are scientifically valid, verifiable, accurate, and based on
29 current data, a policy that serves as an important reminder to the Centers for Medicare and
30 Medicaid Services (CMS) as they prepare to broadly implement Quality Resource Use Reports
31 nationally; and

¹ Accessed 08/24/12 http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/downloads/2010_QRUR_FAQ.pdf

1 Whereas, The intended purpose of the reports are to improve overall care provided to patients
2 and improve efficiency, the reports, as is, hold pathologists and other specialty physicians
3 accountable for the action/inaction of other individual physicians when they have no control over
4 the other provider's actions or in many cases, have no reasonable connection to the services
5 being measured; therefore be it

6
7 RESOLVED, That our American Medical Association continue to work with CMS on a more
8 appropriate design, content, and performance indicators included in the QRURs for pathologists
9 and other applicable specialty physicians, so that the reports reflect the quality and cost data
10 associated with these physicians in calculating Value-Based Payment Modifiers (Directive to
11 Take Action); and be it further

12
13 RESOLVED, That our AMA continue to advocate, educate and seek to delay this program
14 which is set to take effect in 2013. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/28/12

RELEVANT AMA POLICY

H-390.849 Medicare Physician Payment Reform

1. Our AMA will advocate for the development and adoption of Medicare physician payment reforms that adhere to the following principles: a) promote improved patient access to high-quality, cost-effective care; b) be designed with input from the physician community; c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions; d) not require budget neutrality within Medicare Part B; e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice; f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process; g) make participation options available for varying practice sizes, patient mixes, specialties, and locales; h) use adequate risk adjustment methodologies; i) incorporate incentives large enough to merit additional investments by physicians; j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols; k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization; l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services. 2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients. 3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data. 4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-12)

Introduced by: Colorado Delegation
Subject: Administrative Simplification
Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, Studies show US doctors spend 66% more than other benchmark countries on
2 administrative related costs; and
3

4 Whereas, Studies further estimate that a minimum of \$55 billion is wasted annually in
5 unnecessary administrative costs; and
6

7 Whereas, Studies also link excessive administrative burdens with increased care redundancy,
8 as well as preventable errors; and
9

10 Whereas, Studies demonstrate that administratively simple and transparent care delivery
11 systems enhance care efficiency, value, and outcomes; and
12

13 Whereas, Informed patients are empowered to consider the economic ramifications of various
14 health care choices before they make their treatment decisions, and to settle their personal
15 financial responsibility for the care they receive before they leave the physician's office or
16 healthcare facility; and
17

18 Whereas, The Supreme Court has upheld the structural components of system reform that will
19 assure a central role of the private health plans in care delivery in both public and private
20 sectors; and
21

22 Whereas Surveys of Colorado physicians as well physicians across the country measure
23 alarming levels of career-threatening burnout as a consequence of these pervasive "hassle
24 factors"; and
25

26 Whereas, The AMA has occupied a national leadership role in developing model standards to
27 reverse this trend and provide for system-wide administrative simplification such as the prior
28 authorization process for both paper and electronic processes, as well as state of art standards
29 for physician-plan contracts; and
30

31 Whereas, The AMA developed and initiated a highly regarded national "Health Insurer Report
32 Card' that has directly influenced positive changes in health plan operations that both directly
33 and indirectly has produced administrative efficiencies and measurable savings of 8 billion
34 dollars in 2012 alone; and
35

36 Whereas, Physicians that automate their claims revenue, working with trading partners that are
37 fully functionally compliant with all these transactions, have demonstrated significant cost
38 savings; and

1 Whereas, The AMA has convened the major health plans to develop a consensus approach to a
2 prior authorization process and garnered their support for a national pilot to test those
3 standards; therefore be it
4

5 RESOLVED, That our American Medical Association continue its strong leadership role in
6 automating, standardizing and simplifying all administrative actions required for transactions
7 between payers and providers (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA continue its strong leadership role in automating, standardizing, and
10 simplifying the claims revenue cycle for physicians in all specialties and modes of practice with
11 all their trading partners, including, but not limited to, public and private payers, vendors, and
12 clearinghouses (Directive to Take Action); and be it further
13

14 RESOLVED, That our AMA prioritize efforts to automate, standardize and simplify the process
15 for physicians to estimate patient and payer financial responsibility before the service is
16 provided, and determine patient and payer financial responsibility at the point of care (Directive
17 to Take Action); and be it further
18

19 RESOLVED, That our AMA continue to use its strong leadership role to support state initiatives
20 to simplify administrative functions, such as The Colorado Clean Claims Taskforce (Directive to
21 Take Action); and be it further
22

23 RESOLVED, That our AMA expand its Heal the Claims process™ campaign as necessary to
24 ensure that physicians are aware of the value of automating their claims cycle. (Directive to
25 Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/28/12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-12)

Introduced by: Colorado Delegation

Subject: Shared Decision Making Resource Centers

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

Whereas, Shared decision-making has been shown to reduce costs¹; and

Whereas, Shared decision-making improves patient experience and decision-making; and

Whereas, Well informed decisions are higher quality decisions; and

Whereas, Our AMA supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions(AMA Policy H-373.997); and

Whereas, Our AMA supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice (H-373.997); and

Whereas, Our AMA supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures (H-373.997); and

Whereas, Section 3506 of the Affordable Care Act calls for the establishment of independent standards for patient decision aids for preference sensitive care; and

Whereas, Section 3506 also calls for a program to develop and update patient decision aids to assist health care providers and patients; and

Whereas, Section 3506 further calls for grants to support shared decision making implementation including funding of shared decision making resource centers and shared decision making participation grants for providers; therefore be it

RESOLVED, That our American Medical Association support legislation to fund section 3506 of the Affordable Care Act. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 9/28/12

¹ Arterburn, et al Health Affairs 31, No. 9 (2012): 2094-2104

RELEVANT AMA POLICY**H-373.997 Shared Decision-Making**

Our AMA: 1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice; 2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions; 3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation; 4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice; 5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and 6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area. (CMS Rep. 7, A-10; Reaffirmed in lieu of Res. 5, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-12)

Introduced by: Society of Hospital Medicine
Society of Critical Care Medicine
American College of Emergency Physicians

Subject: Hospital Based Physicians and the Value Based Payment Modifier

Referred to: Reference Committee J
(Veronica K. Dowling, MD, Chair)

1 Whereas, It is a goal of our AMA to serve the needs of diverse specialties and practice settings
2 of the membership; and
3

4 Whereas, Hospital based specialties comprise unique disciplines that practice primarily in the
5 hospital or other institutional settings; and
6

7 Whereas, The Patient Protection and Affordable Care Act (ACA) directs the Centers for
8 Medicare & Medicaid Services (CMS) to provide information to practitioners about resource use
9 and the quality of care they provide to Medicare beneficiaries; and
10

11 Whereas, Section 3007 of the ACA mandates that, by 2015, CMS apply a Value Based
12 Payment Modifier (VBPM) under the Medicare Physician Fee Schedule (MPFS); and
13

14 Whereas, Due to the uniqueness of hospital-based and post-acute facility practice and the
15 absence of relevant performance measurements for such providers; therefore be it
16

17 RESOLVED, That our American Medical Association conduct a study to identify and evaluate
18 appropriate metrics at the physician and physician group practice level for use by hospital based
19 specialties within the Value Based Payment Modifier (VBPM) initiative (Directive to Take
20 Action); and be it further
21

22 RESOLVED, That during the course of this study, attention is given to a mix of both physician
23 and facility performance metrics not only for the purpose of more accurately capturing hospital-
24 based practice but also for the potential to achieve a greater level of physician-hospital
25 alignment when and if appropriate to reduce costs and improve the quality of patient care
26 (Directive to Take Action); and be it further
27

28 RESOLVED, That our AMA work closely with hospital based professional societies to construct
29 a program that complies with the Patient Protection and Affordable Care Act VBPM mandate
30 and that will validly evaluate hospital based physicians at the individual and group practice level.
31 (Directive to Take Action)

Fiscal Note: Estimated cost of \$32,250 to implement.

Received: 9/28/12

RELEVANT AMA POLICY

H-390.849 Medicare Physician Payment Reform

1. Our AMA will advocate for the development and adoption of Medicare physician payment reforms that adhere to the following principles: a) promote improved patient access to high-quality, cost-effective care; b) be designed with input from the physician community; c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions; d) not require budget neutrality within Medicare Part B; e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice; f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process; g) make participation options available for varying practice sizes, patient mixes, specialties, and locales; h) use adequate risk adjustment methodologies; i) incorporate incentives large enough to merit additional investments by physicians; j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols; k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization; l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services. 2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients. 3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data. 4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12)

H-450.947 Pay-for-Performance Principles and Guidelines

(1) The following Principles for Pay-for-Performance and Guidelines for Pay-for-Performance are the official policy of our AMA. **PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS** Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles: 1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards. 2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns. 3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up. 4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting. 5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians. **GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS** Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an

assessment of specific PFP programs. **Quality of Care** - The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings. - Evidence-based quality of care measures must be the primary measures used in any program. 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties. 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program. 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession. 4. Performance measures should be scored against both absolute values and relative improvement in those values. 5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities. 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years. 7. Performance measures must be selected for clinical areas that have significant promise for improvement. - Physician adherence to PFP program requirements must conform with improved patient care quality and safety. - Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation. - PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation. - PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team. - Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties. - Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship - Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount. - Programs must not create conditions that limit access to improved care. 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients. 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas). - Programs must neither directly nor indirectly encourage patient de-selection. - Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design. **Physician Participation** - Physician participation in any PFP program must be completely voluntary. - Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer. - Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices. - Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice. - Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT). 1. Programs should provide physicians with tools to facilitate participation. 2. Programs should be designed to minimize financial and technological barriers to physician participation. - Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities. - Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs. - Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards. - Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis. **Physician Data and Reporting** - Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA). - The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner. 1. Programs should use accurate administrative data and data

abstracted from medical records. 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices. 3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator. - Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program. - Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible. - Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting. 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives. 2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings. - If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated. - The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings. - PFP programs must have defined security measures to prevent the unauthorized release of physician ratings. Program Rewards - Programs must be based on rewards and not on penalties. - Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation. - Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program. - Programs must finance bonus payments based on specified performance measures with supplemental funds. - Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals. - Programs must not reward physicians based on ranking compared with other physicians in the program. - Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation. - Programs must not financially penalize physicians based on factors outside of the physician's control. - Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients. (2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11)