REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-10

Subject: Protecting the Patient-Physician Relationship

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Referred to: Reference Committee G
(James Chris Fleming, MD, Chair)

At the 2009 Annual Meeting, the House of Delegates adopted amended Resolution 709 (Policy D-165.944, AMA Policy Database), which called for the American Medical Association (AMA) to prepare a report on the health of the patient-physician relationship addressing the impact of new methods of health care financing, third party judgments of physician quality, and third party directed use of comparative clinical effectiveness research data on the patient-physician relationship. Resolution 709 (A-09) also called for the report to recommend specific strategies to protect the patient-physician relationship. The Board of Trustees assigned this item to the Council on Medical Service (CMS) for a report back to the House of Delegates at the 2010 Annual Meeting.

As discussed in this report, the techniques of bundled payments, physician profiling, and comparative effectiveness research (CER) represent the key critical elements highlighted in Resolution 709 (A-09). This report summarizes previous Council consideration of the patient-physician relationship; identifies methods that have been proposed for health insurers to restrain costs using the identified techniques; reviews AMA advocacy and policy; outlines strategies to protect the patient-physician relationship; and presents policy recommendations.

BACKGROUND

Council on Medical Service Report 7-I-99, "Socioeconomic Factors Influencing the Patient-Physician Relationship," previously considered the patient-physician relationship. The report reaffirmed policy advocating for the viability of individually owned health insurance (Policy H-165.920). As directed by Policy H-140.920, the AMA continues to monitor infringements on the patient-physician relationship and respond with policy development and advocacy initiatives that are both timely and appropriate.

In the ten years since the Council prepared its Report 7-I-99, health system reform has become a key political issue. A focus of political concern has been the limited evidence base for medical procedures that impacts the quality of care and the fragmentation of services that undermine integrated care, all of which drive health care spending. One school of thought, primarily held by health insurers, proposes a variety of methods for insurers to restrain costs, including bundled payment methods, statistical oversight of physicians' practices (physician profiling), and the consideration of treatment options utilizing payment and coverage exclusions based on comparative effectiveness research (CER) findings. Concerns have been raised that these specific techniques threaten to override the individual physician's judgment of their patients' needs.

BUNDLED PAYMENTS

Serious consideration is being given to bundled payment arrangements and other innovative models due to concerns that the current fragmented health care system leads to a lack of care coordination and accountability. The Patient Protection and Affordable Care Act, signed into law in March 2010, (P.L. 111-149) calls for new pilot programs and establishes a new Center for Medicare and Medicaid Innovation within CMS to promote more rapid development and testing of these new payment models. Under a bundled payment approach, the health care services related to the management of a specific medical condition would be grouped together in an episode of care and a single payment would be made. The services could relate to the activities of a single physician (or other health care provider) or to services provided by multiple physicians and providers. Medicare already uses bundled payments for certain services and is engaged in a Medicare Acute Care Episode (ACE) Demonstration to determine if a greater alignment of the financial incentives between hospitals and physicians will result in improvements in the quality, coordination, and efficiency of care.

Proponents believe that bundled payment methods will promote care coordination resulting in increased quality and efficiency while controlling costs. However, the potential impact on the patient-physician relationship is a concern because bundled payment arrangements base payment on a pre-determined treatment plan for a specific medical condition. Accordingly, they may adversely impact a physician's decision-making ability and jeopardize individualized therapy and patient autonomy for those patients whose conditions are more complex or varied. In addition, such methods could create disincentives for diagnosing and treating new conditions or components of a disease that may not fall under the bundled services, thereby hindering coordination and quality of care.

AMA ADVOCACY AND POLICY ON BUNDLED PAYMENTS

AMA advocacy and policy have focused on the impact of bundled payment methods on the practice of medicine including the potential effect on the patient-physician relationship. In part as a response to Policy D-385.967, the AMA has developed a white paper, "Accountability with Autonomy: Enabling Physicians to Succeed under Healthcare Payment and Delivery Reforms," regarding the organizational arrangements and legal issues involved in a variety of innovative physician payment models. The paper addresses how physicians participating in these approaches can receive and distribute bundled payments without becoming hospital employees. It provides guidance on how physicians can partner with hospitals in bundled payment arrangements without giving up their professional autonomy, as well as how smaller medical practices can begin to engage in payment models such as gainsharing, accountable care organizations, medical homes, and pay-for-performance models. The paper also addresses legal issues, barriers and opportunities arising from antitrust and self-referral laws and regulations.

Council on Medical Service Report 6-A-09, "Medicare Physician Payment Reform," directed the AMA to work with relevant entities to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians (Policy D-390.961[6]). The AMA has closely monitored the inclusion of bundled payment methodologies in health system reform legislation and has provided comments consistent with AMA policy. In addition, the AMA will closely monitor the results of Medicare demonstration projects that include a bundled payment methodology to ensure that they are rigorously studied and to prevent the adoption of unproven or potentially harmful payment models into Medicare payment policy.

PHYSICIAN PROFILING

A physician profiling program is any system that compares, rates, ranks, measures, tiers, or classifies a physician's or physician group's performance, quality, or cost of care against objective or subjective standards. The Patient Protection and Affordable Care Act of 2010 contains troubling elements of physician profiling in the Medicare program that the AMA will work to change.

While the AMA neither supports nor opposes physician profiling *per se*, when it is done, patients and physicians should be given the information necessary to understand how the profiles are developed and should have an expectation that the results accurately reflect aspects of the physician practice. Inaccurate physician rankings and the publication of erroneous information can disrupt patients' longstanding relationships with physicians they have known and trusted for years. It can impact the continuity of care if the profiling information results in a decision to end a relationship. In addition, incorrect and misleading information is unfair to patients who may be considering it seriously when choosing a new physician.

AMA ADVOCACY AND POLICY ON PHYSICIAN PROFILING

The preponderance of AMA policy on physician profiling is contained in the principles for the public release and accurate use of physician data and policy regarding the release of claims and payment data from government health care programs (Policies H-406.991 and H-406.990). AMA policy primarily focuses on safeguarding physicians in the context of profiling programs. The principles describe the needs of patients for information that is accurate and transparent and supports the continuation of the patient-physician relationship. The principles advocate that effective safeguards should be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data; limitations of the data sources used to create physician profiles should be clearly identified and acknowledged in terms understandable to consumers; and the capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians should be publicly revealed in understandable terms to consumers (Policy H-406.991[2,3]). The AMA will continue its extensive efforts to educate the public about the potential risks and liabilities of public reporting programs that are not consistent with AMA policies, principles, and guidelines (Policy H-406.989[5]).

In addition, Policy H-450.941 addresses interference in the patient-physician relationship by strongly opposing the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients toward, certain physicians primarily based on cost of care factors.

COMPARATIVE EFFECTIVENESS RESEARCH

The purpose of CER is to provide more rigorous evidence about which treatments work best for which patients by comparing different diagnostic or treatment options for diagnosing or managing a specific health problem, condition or disease. The American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provided $1.1 billion funding for CER coordinated on a national level. The Patient Protection and Affordable Care Act of 2010 establishes an independent entity with a governing body that includes representatives of practicing clinicians to support and coordinate CER.

An organized effort to make comparative information readily available should help patients and physicians benefit from prioritized research and timely dissemination of information about the relative effectiveness of treatments for diseases or medical conditions for specified patient populations. Appropriate uses for CER include clinical registries, which can be used to generate or

obtain outcomes data, decision support programs, and best practice guidelines. A major caveat of those concerned that CER may over-reach, is that the primary goal of CER should not be used to contain costs. Rather, the goal of CER should be to enhance physician clinical judgment and foster the delivery of quality patient-centered care. There are concerns that research findings would be used to restrict the availability of care options by health insurers through payment policies. If used in this manner, CER could limit patient choice of treatment and personal autonomy by incentivizing the available options for a given medical condition, compromise physician's decision-making abilities, and interfere in the patient-physician relationship.

AMA ADVOCACY AND POLICY ON COMPARATIVE EFFECTIVENESS RESEARCH

The AMA recognizes the need for increased research to help improve medicine's understanding about best practices and optimize the balance between medical outcomes and treatment costs (Policy H-155.960[4]). Council on Medical Service Report 5-I-08, "Comparative Effectiveness Research," contained principles to guide AMA advocacy efforts on CER and for creating a federal CER entity (Policy H-460.909). While the principles mainly focus on guiding the creation of a centralized comparative effectiveness research entity, the policy includes the following principle, which addresses the patient-physician relationship:

> Patient Variation and Physician Discretion: Physician discretion in the treatment of individual patients remains central to the practice of medicine. CER evidence cannot adequately address the wide array of patients with their unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition, patient autonomy and choice may play a significant role in both CER findings and diagnostic/treatment planning in the clinical setting. As a result, sufficient information should be made available on the limitations and exceptions of CER studies so that physicians who are making individualized treatment plans will be able to differentiate patients to whom the study findings apply from those for whom the study is not representative (Policy H-460.909 [K]).

As CER is implemented on a federal level, the AMA will continue to monitor its progress, advocate that aspects of the AMA principles are included in CER efforts, and support effective methods of translating research findings relating to quality of care into clinical practice (Policy D-390.961[1]).

STRATEGIES TO PROTECT THE PATIENT-PHYSICIAN RELATIONSHIP

In addition to the AMA's positions on protecting the patient-physician relationship in the context of bundled payment methodologies, physician profiling and CER, the AMA has a solid foundation of policy that supports protecting the patient-physician relationship in general (Policies H-450.941[3], H-285.954[1,p], H-120.988, H-275.937[2], and H-5.989).

The Council believes that the closer patients and physicians are to health care transactions and collaborations regarding the patient's well-being, the better the relationship and resulting health care outcomes. The AMA supports the physician's duty of patient advocate as a fundamental element of the patient-physician relationship that should not be altered by the system of health care delivery. Physicians must continue to place the interests of their patients first (Opinion E-8.13 [1]). The AMA advocates for the right of physicians and patients to privately contract for health care services, supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.) and supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance coverage arrangements between the patient and the insurers (Policies H-383.991 and H-385.926). The AMA has adopted principles of patient-centered

medical homes, which may enhance the patient-physician relationship by allowing physicians to have more continuous contact with patients, to coordinate care better across the entire health system and to use more evidence-based medicine in clinical decision-making (Policy H-160.919).

In addition, the Council highlights the importance of patients and physicians collaborating on the patient's well-being, such as by using shared decision-making tools as outlined in Council on Medical Service Report 7-A-10, "Shared Decision-Making," which is being considered at this meeting and value-based decision-making tools (Policies H-450.938 and D-155.994). These tools serve different and complementary functions in the decision-making process. Shared decision-making tools provide patients with background information to ensure that they have enough information necessary to make health care decisions in conjunction with their physician that best reflect their personal values and preferences in cases where the best choice of treatment option is not clinically evident. Value-based decision-making tools, on the other hand, assist patients and physicians in the consideration of costs and benefits of a specific treatment option using evidence-based information when the best choice of treatment option is clinically evident.

The Council believes payment arrangements that encourage patients to be more responsible for the resources used for health care and that foster transparency enhance the patient-physician relationship. The AMA supports the use of consumer-directed health care, such as health savings accounts (HSAs) and health reimbursement arrangements (HRAs), which empower patients to take responsibility for their health care decision-making and to spend resources wisely (Policies H-165.852 and H-165.854). AMA policy outlines concerns with financial incentives used in the management of medical care by insurance companies and encourages physicians to be aware of such practices and the resulting potential for some types of plans to create conflicts of interest (Policy H-285.951[2]). The relationship between a physician and a patient is fundamental and should not be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship (H-275.937[2]).

Furthermore, while financial transparency can be achieved through cost-sharing arrangements such as the use of coinsurance, the Council studied the benefits of coinsurance versus copayment for pharmaceuticals in Council on Medical Service Report 1-I-07, "Cost-Sharing Arrangements for Prescription Drugs," and concluded that cost-sharing arrangements should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients. For example, 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 (H-110.990).

DISCUSSION

The political urgency of health system reform throughout 2009 and in 2010 stimulated the consideration of techniques to address health care spending, with a possible threat to the patient-physician relationship. The AMA successfully advocated on behalf of patients and physicians using a foundation of policies aimed at protecting this key relationship, and will continue to do so as implementing regulations are developed. AMA policy emphasizes protecting the patient-physician relationship in the context of physician profiling and CER (Policies H-406.991[2,3] and H-460.909[K]). Additional AMA policy outlines specific strategies to further protect the patient-physician relationship.

At critical junctures in the health system reform debate, the AMA sent letters to the Administration and Congress encouraging continued efforts to enact meaningful health system reform this year.

The communications outlined essential elements of health system reform, based on long-standing AMA policy, including assuring that health care decisions are made by patients and their physicians and allowing them to privately contract without penalty (Policies H-165.838 [1,c] and H-385.926). The AMA will continue to monitor relevant legislation, related regulatory activity, and advocate for the protection of the patient-physician relationship.

The increased focus on restraining costs and improving quality through payment reform, while presenting some challenges, also provides opportunities for physicians to develop innovative practice models that appear to be the wave of the future. Practice groups that have embraced these difficult changes, whether it be accepting pay-for-performance, bundled payment methods or realigning to establish an accountable care organization, have started to report their experiences, including positive outcomes. The Council is aware of the challenges involved in such changes, but remains cautiously optimistic regarding these emerging trends.

This report accomplishes the request to prepare a report on the health of the patient-physician relationship addressing the impact of new methods of health care financing, third party judgments of physician quality, and third party directed use of comparative clinical effectiveness research data on the patient-physician relationship. In addition, specific strategies to protect the patient-physician relationship have been recommended. Accordingly, the Council recommends that Policy D-165.944 be rescinded.

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 (AMA) support protecting the patient-physician relationship by continuing to advocate for: the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision-making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements. (New HOD Policy)

2. That our AMA continue to advocate protecting the patient-physician relationship in the context of bundled payment methodologies, comparative effectiveness research and physician profiling. (New HOD Policy)

3. That our AMA rescind Policy D-165.944. (Rescind HOD Policy)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

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