REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-11

Subject: Implementing Alternative Health Care Delivery and Physician Payment Models (Resolution 814-I-10)

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee A
(Joseph W. Zebley, III, MD, Chair)

At the 2010 Interim Meeting, the House of Delegates referred Resolution 814, which was introduced by the South Carolina Delegation and asked that the American Medical Association (AMA) "study and provide a detailed AMA report by the 2011 Annual Meeting that describes how a single, global, or 'bundled' payment would be divided among primary care physicians, specialists, ambulatory care centers and hospitals describing in detail what percentage of each 'healthcare dollar' goes to each participant." The Board of Trustees referred Resolution 814-I-10 to the Council on Medical Service for study.

In testimony at the Reference Committee hearing and in a follow-up letter to the Council, the sponsor of Resolution 814-I-10 clarified that the intent of the resolution was to learn how the "health care dollar" is currently distributed to various players in the health care system. The resolution author indicated that he believed this information would be useful as the AMA moves forward in its policy development and advocacy efforts related to new physician payment models.

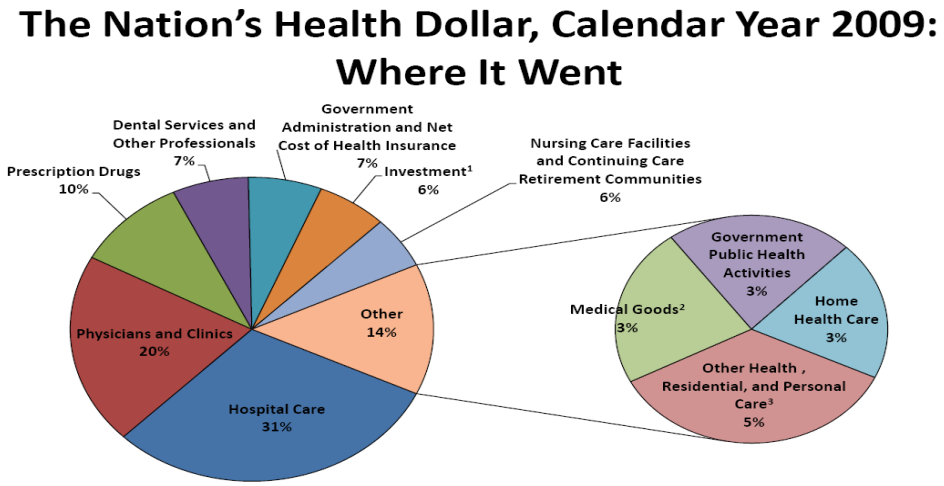
This report describes how the health care dollar is distributed, according to data available from the Centers for Medicare and Medicaid Services (CMS). It also describes examples of physician groups around the country that are using innovative physician payment and health care delivery systems successfully in their practices. The report recommends that our AMA continue to develop resources to help members connect with local practices and physician leaders who can share examples of best practices in designing and implementing practice models that benefit physicians and patients.

SPENDING ACROSS THE US HEALTH CARE SYSTEM

The most commonly cited source of health care financing and spending patterns is the National Health Expenditure (NHE) data produced by the CMS Office of the Actuary, National Health Statistics Group. NHE data includes information about sources of health care funding (e.g., public and private insurance, out-of-pocket spending) and health spending by type of service or product. The data is used to identify trends in health care financing and spending, including system-wide growth patterns and historical shifts in the spending across individual sectors.

Figure A summarizes how health care spending was distributed across broad segments of the health care system in 2009. Analysis of 2009 spending by CMS showed that overall health care spending grew four percent from 2008 levels, which was the lowest spending increase in fifty years (Martin et al., Health Affairs, January 2011). Distribution across the categories identified in Figure A remained relatively stable between 2008 and 2009.

Figure A



[1] Includes Research (2%) and Structures and Equipment (4%).
[2] Includes Durable (1%) and Non-durable (2%) goods.
[3] Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The aggregate nature of the NHE data limits its usefulness as a tool to help develop a framework for bundled payment distribution. NHE data reflect how many services are provided in each service category, without capturing the clinical circumstances of the care, or addressing whether the distribution of services is appropriate. Furthermore, although NHE data are available for state-level spending, numerous studies (e.g., the Dartmouth Atlas) have shown that health care spending and service delivery patterns vary across local communities due in part to unique cultural and demographic factors. The AMA continues to advocate that policymakers support local innovation to identify physician payment and health care delivery reforms that best fit local needs (Policy D-390.961, AMA Policy Database).

Other than NHE statistics, there are limited publicly-available data about how health care spending is distributed across various players in the health care system. Even if such data were available (for example, if insurance companies were willing to share their claims data), it is unlikely to provide meaningful or relevant information that could help policymakers design a bundled payment structure. Payment mechanisms that are based on delivery of a coordinated set of services – rather than individual services – will require a new way of calculating prices and payment levels. Harold Miller, Director of the Center for Health Care Quality and Payment Reform, notes that "one cannot directly determine the appropriate levels for…new payment [methodologies] from the current payment levels" (Miller, June 2010).

PAYMENT PATHWAYS AND PHYSICIAN SUCCESS STORIES

The physician payment and health care delivery reforms outlined in the Patient Protection and Affordable Care Act (ACA, PL 111.148), such as accountable care organizations (ACOs), shared savings programs, and the use of payment modifiers based on resource use (see Council on Medical Service Report 4-A-11, "Pay for Value," also before the House at this meeting), represent a significant departure from traditional fee-for-service care delivery systems. For many physicians, it is difficult to conceptualize the practical effects of incorporating these reforms into their practices. There is concern and uncertainty about whether implementing these reforms will

jeopardize patient care and physician autonomy, and whether they will result in further erosion of physician payments.

Although there is a temptation to focus advocacy efforts on defining specific policies or rules that will preserve physician autonomy and the patient-physician relationship, many policy analysts agree that a "one size fits all" approach cannot be successfully applied to health care delivery reforms. AMA advocacy efforts have emphasized physician leadership of reform initiatives, and call for policies and regulations that enable rather than restrict practice innovations that best serve the needs of patients and enhance the value of health care delivery. AMA believes that the ACA offers physicians new opportunities to explore models that will help improve the quality and lower the cost of health care, while at the same time strengthening and restoring physician control over the practice of medicine.

As part of its educational outreach efforts, the AMA has developed and sponsored a regional seminar series entitled, "AMA Pathways to Success: What physicians need to know about ACOs and the coming revolution in payment practices." These seminars, moderated by Harold Miller, feature local physicians from each region discussing the challenges and opportunities they face in developing their own innovative programs around clinical integration, bundling, and the patient-centered medical home. Four seminars were held in 2010, and six seminars are planned for 2011. The goal of these seminars is to create a forum where physicians can learn from peers who have been "early adopters" of innovative health care delivery models, and share ideas about how to design and implement practice changes that reflect the unique needs of communities of physicians and their patients. Miller also highlights several examples of how physicians can participate in payment reforms in the AMA-commissioned white paper, "Pathways for Physician Success Under Health Care Payment and Delivery Reforms." While not an exhaustive survey, the following examples provide a snapshot of the types of structures and innovations that physicians are currently exploring.

Mesa County Physicians IPA, Grand Junction, CO

Grand Junction has been identified as "one of the lowest-cost markets in the country," where physicians and the hospital system had "adopted measures to blunt harmful financial incentives and taken collective responsibility for improving the sum total of patient care" (Gawande, June 9, 2009). Mesa County Physician's Independent Physicians Association (IPA) manages risk contracting for 265 independent physician members – 90 percent of physicians in the county.

Mesa County Physician's IPA serves as the provider network for Rocky Mountain Health Plans (RMHP), the dominant insurer in the region with approximately 40,000 members, and works closely with RMHP to align incentives that promote quality and efficiency. The IPA is a not-for-profit organization funded by a one-half percent administrative tax on RMHP claims, a monthly stipend from RMHP, and a one-time membership fee paid by participating physicians. Physicians remain independent practitioners, but are encouraged to be actively engaged in the IPA through participation on committees that oversee quality and other issues. The IPA emphasizes data sharing and transparency as ways to improve quality and efficiency and provides an infrastructure to collect and distribute this information to IPA members. The Mesa County Physicians IPA established physician performance incentive funds in 1991. The quality program is data driven, with physician members receiving regular reports on how measures of their patients' health compare with the rest of their practice and with the IPA as a whole.

Baptist Health System, San Antonio, TX

Orthopaedic and cardiac specialists joined with Baptist Health System in San Antonio to participate in the Medicare Acute Care Episode Demonstration Project, which authorized payment of a single, bundled payment to a physician-hospital organization for specific cardiovascular and orthopaedic procedures. The purpose of the demonstration is to create incentives for physicians and hospitals to work together to identify cost savings in providing the designated procedures. Under the rules of the project, a portion of these savings is returned to the patients, the surgeons may receive up to a 25 percent increase in their Medicare payments per procedure, a portion goes to the Medicare program, and a portion goes to the hospital.

At Baptist, the gainsharing project has been extremely successful because the surgeons were able to negotiate deep discounts with vendors, and they have been able to meet the targets they set for quality metrics. Patient satisfaction improved, and over 90 percent of physicians met the gainsharing criteria. David Fox, MD, an orthopaedic surgeon who described the Baptist experience to a "Pathways" audience, noted that his surgical colleagues were initially very skeptical of the demonstration project. However, once financial rewards and measurable quality improvements became evident, support for continuing and even expanding the program increased.

Geisinger Health System, Danville, PA

Geisinger Health System is often cited as a leader in innovative care delivery process. Geisinger's ProvenCare program allows patients to pay a single fee for a 90-day period of care related to one of eight conditions or treatments currently offered through the program (including cardiac bypass surgery [CABG], cardiac stents, cataract surgery, total hip replacement, bariatric surgery, perinatal care, low back pain and treatment of chronic kidney disease). ProvenCare is described as giving patients a "warranty," since the fee covers all care for any related complications or readmissions, in addition to related pre-admission and post-acute follow up care. Geisinger's ProvenCare process is guided by core elements, including patient-centricity, emphasis on evidence/consensus-based best practices, explicit accountabilities, and performance-based reimbursement. The connection between payment incentives and process improvements has resulted in better outcomes and lower costs. Clinical outcomes for ProvenCare CABG patients improved in ten areas, including a 21 percent reduction in patients with any post-treatment complications, and a 44 percent reductions in readmissions within 30 days (http://www.geisinger.org/provencare).

PHYSICIAN PAYMENT AND DELIVERY REFORM LEADERSHIP GROUP

As the previous section illustrates, some physicians in Colorado, Texas and Pennsylvania have successfully experimented with process and payment redesign. Each group of physicians pursued different strategies to achieve the same goals of improved patient care at lower cost. Common elements among the initiatives are active and creative engagement by the participating physicians, including their ability to identify and define payment arrangements that fairly and effectively reflect the shared accountability for patient care.

The AMA recognizes the importance of providing physicians with relevant information that will help them assess which delivery and payment reform strategies might be appropriate for their patients and their practices. Accordingly, the AMA is collaborating with state medical associations and national medical specialty societies to establish a Physician Payment and Delivery Reform Leadership Group that will enable organizations representing physicians to share expertise and resources so that physicians can lead system reform. The group will develop resources based on experiences from early innovators, who can share information about the steps involved in

establishing new payment and health care delivery models, what challenges they encountered, how solutions were identified, and the impact of the reforms on patient care and on the practice. Nominations for the group's Committee on Innovation were solicited in March 2011, and at the time this report was written the nominations were being reviewed by a selection committee including representatives of the AMA, the American College of Physicians, and the American College of Surgeons.

RELEVANT AMA POLICY

Policy H-390.849, adopted at the 2009 Annual Meeting, established a set of broad principles to guide the development, adoption, and implementation of physician payment reforms. The principles include ensuring that reforms promote improved patient access to high-quality, cost-effective care; be designed with input from the physician community; give physicians appropriate decision-making authority over bonus or shared-savings distributions; and include participation options for varying practice sizes, patient mixes, specialties, and locales.

In addition to the broad guidelines established in Policy H-390.849, Policy H-160.915, "Accountable Care Organization (ACO) Principles," adopted at the 2010 Interim Meeting, provides additional detailed guidance related specifically to the design and implementation of ACOs. H-160.915[10] states that ACOs should be allowed to use different payment models, depending on the needs of the participating members and patient community.

Policy D-390.961 identifies several advocacy initiatives to support appropriate payment and delivery reform efforts, including improved data collection and dissemination methods to enhance clinical decision-making, and changes in antitrust laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery. Policy D-390.961[6] calls on the AMA to work with public and private entities to ensure that bundled payment do not lead to hospital-controlled payments to physicians. Policy D-390.961 also urges state medical associations and national medical specialty societies to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, and supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.

Council on Medical Service Report 1-A-11, "Physician Payment Reform Update," also before the House at this meeting, describes AMA education and advocacy efforts to support and enable a wide variety of physician efforts to provide the best quality care to their patients in the most efficient and effective manner.

DISCUSSION

Resolution 814-I-10 asks our AMA to provide the House with background information to help physicians anticipate how a global or bundled payment might be distributed under new payment reform models. NHE data available through CMS are too broad to offer insight into how payments might be distributed locally, or among physicians and other providers for the care of a single patient. Claims data from insurance companies are proprietary, and would be unlikely to yield information that could build a meaningful bridge between fee-for-service payments made to multiple physicians and providers and bundled payments paid to a single entity.

The Council is concerned that efforts to define acceptable or desirable payment methodologies could have the unintended consequence of restricting creativity and true innovation on the part of

physician practices. Polices H-390.849, H-160. 915, and D-390.961, which emphasize the importance of physician leadership and active involvement in decision making help ensure that physicians will be able to retain control over their payment arrangements, without limiting the characteristics of those payment arrangements.

The Council is aware of physician groups that are modifying and adapting some of the specific initiatives highlighted in this report to meet the needs of their practices and communities. Such examples of physician-led initiatives are the best models for physicians interested in conceptualizing how new payment reforms might work in their practices. The Council is optimistic that the efforts of the new Physician Payment and Delivery Reform Leadership Group will yield valuable insight into how physicians met implementation challenges, and secured trust and participation by all players. The Council believes that the methodologies used to allocate bundled payments among physicians and other providers should be determined by the individuals participating in the arrangement, depending on the priorities and program goals identified by the affected stakeholders.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 814-I-10, and that the remainder of the report be filed:

That our American Medical Association continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs (Directive to Take Action).

Fiscal Note: Staff cost estimated to be $4,580 to implement.

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