REPORT 1 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (A-11)
Physician Payment Reform Update
(Resolutions 818-I-10, 832-I-10, and 833-I-10)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2010 Annual Meeting, the House of Delegates adopted Policy D-385.963 (AMA Policy Database), which asks the American Medical Association (AMA) to (1) work with the Centers for Medicare and Medicaid Services and other payers to identify viable options for any evolving health care delivery programs; (2) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (3) make information available to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; (4) work with Congress and the appropriate governmental agencies to change existing laws and regulations to facilitate the participation of physicians in new delivery models; and (5) update the House of Delegates on these issues at the 2011 Annual Meeting.

At the 2010 Interim Meeting, the House of Delegates referred a series of resolutions related to accountable care organizations (ACOs) that the Board of Trustees referred to the Council on Medical Service for study. These resolutions, 818-I-10, 832-I-10 and 833-I-10, are closely related to the issues raised in Policy D-385.963.

Per Policy D-385.963, this report provides a status update of AMA advocacy and educational activities related to physician payment and health care delivery reforms and proposes amendments to current AMA policy that will help strengthen the effectiveness and relevance of the policy, while also maintaining its flexibility. The Council believes that this information and the recommended policy modifications address referred Resolutions 818, 832 and 833 from the 2010 Interim Meeting. This report also responds to a request of the Indiana State Medical Association that was submitted to the AMA Board of Trustees and transferred to the Council, which asks the AMA to consider establishing policy that would require that at least 50 percent of ACO board members be physicians in private, independent practice.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-11

Subject: Physician Payment Reform Update
(Resolutions 818-I-10, 832-I-10, and 833-I-10)

Presented by: William E. Kobler, MD, Chair

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

At the 2010 Annual Meeting, the House of Delegates adopted Policy D-385.963 (AMA Policy Database) as follows:

> Our AMA will:
>
> (1) work with the Centers for Medicare and Medicaid Services (CMS) and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs;
> (2) develop guidelines for health care delivery payment systems that protect the patient-physician relationship;
> (3) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems;
> (4) work with Congress and the appropriate governmental agencies to change existing laws and regulations (e.g., antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians; and
> (5) update the House of Delegates on these issues at the 2011 Annual Meeting.

Following the 2010 Interim Meeting, the Board of Trustees assigned several referred resolutions to the Council on Medical Service for study. These resolutions are closely related to the issues raised in Policy D-385.963.

Resolution 818-I-10, introduced by the California Delegation, asked our American Medical Association (AMA) to "continue to evaluate Accountable Care Organizations (ACOs) and medical foundations and their compliance with existing law, and their impact on the ability of physicians to practice appropriate and quality patient care," and "continue to make available to physician members and local county medical societies existing resources (webinars, issue briefs, noteworthy articles etc.) related to ACOs and medical foundations."

Resolution 832-I-10, introduced by the Organized Medical Staff Section, asked our AMA to "continuously monitor health care laws and regulations to develop and make available to AMA members model organizational information for all physicians, including independent and/or small

groups as well as medical staffs, so that the AMA can communicate, organize and participate in care processes for high quality and efficient service delivery of health care that will permit independent physician practitioners and/or small groups to clinically integrate and provide accountable care." Resolution 832-I-10 also asks our AMA to "make available to AMA members no later than the 2011 Annual Meeting, by electronic means as well as on the AMA web site, and in hard copy on request, specific model organizational information to provide accountable care."

Resolution 833-I-10, also introduced by the Organized Medical Staff Section, asked "that our AMA develop and propose specific AMA principles concerning ACOs and the provision of accountable care," "that these principles place the patient's best interests before all other considerations, and ensure no intrusion into the patient-physician relationship," and "that our AMA make available to AMA members no later than the 2011 Annual Meeting, by electronic means as well as on the AMA web site, and in hard copy on request, specific AMA principles concerning ACOs and the provision of accountable care."

Per Policy D-385.963, this report provides a status update of AMA advocacy and educational activities related to physician payment and health care delivery reforms and proposes amendments to current AMA policy that will help strengthen the effectiveness and relevance of the policy, while also maintaining its flexibility. The Council believes that this information and the policy modifications recommended address referred Resolutions 818, 832 and 833 from the 2010 Interim Meeting. This report also responds to a request of the Indiana State Medical Association that was submitted to the AMA Board of Trustees and transferred to the Council, which asks the AMA to consider establishing policy that would require that at least 50 percent of ACO board members be physicians in private, independent practice.

RELEVANT AMA POLICY

Policy H-390.849, adopted at the 2009 Annual Meeting, established the following set of broad principles to guide the development, adoption, and implementation of physician payment reforms:

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; and
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization.

Policy H-160.915, adopted at the 2010 Interim Meeting, provides detailed guidance specifically related to the design and implementation of ACOs. The Council believes that Policy H-160.915

accomplishes the intent of Resolution 833-I-10, which calls for the development of ACO principles and was referred by the House.

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 anti-trust 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 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 8-A-11, "Implementing Alternative Health Care Delivery and Physician Payment Models," also before the House at this meeting, includes several examples of physician groups that are experimenting with innovative payment and delivery designs.

RELEVANT AMA ADVOCACY

Policy D-385.963[1] and [4] ask the AMA to work with CMS, Congress, and appropriate governmental agencies to identify "viable" options for payment and delivery reforms, and to secure legal and regulatory changes that would facilitate physician participation in these new systems.

On March 31, 2011, the Obama Administration released four proposed regulations and statements to implement the ACO program: 1) The Centers for Medicare and Medicaid Services (CMS) issued a proposed regulation on the governance, quality and payment structure of the ACO program; 2) CMS and the Office of the Inspector General (OIG) issued a joint solicitation of comments on proposed waivers for Medicare ACOs from the self-referral, anti-kickback, and civil monetary penalties statutes; 3) The Department of Justice and the Federal Trade Commission issued a proposed policy statement on antitrust enforcement and ACOs; and 4) The Internal Revenue Service issued a proposal on the tax treatment of ACOs. Each of the agencies provided a 60-day public comment period on the proposed rules. At the time this report was being developed the AMA was working closely with the Federation to collect feedback to incorporate into its comments.

The AMA has been actively engaged with the Administration and others regarding ways to increase the likelihood of success for proposed payment and delivery reforms. In addition to AMA comments on the proposed ACO implementation rules, AMA federal advocacy efforts to date include:

1. Provided written comments on March 1, 2010 urging the OIG of the Department of Health and Human Services to consider, develop and adopt a number of new safe harbors to the Anti-Kickback Statute that would remove regulatory and legal barriers that impeded innovations in the health care delivery system.

2. Provided comments for June 24, 2010 CMS Open Door Forum on Accountable Care Organizations. The AMA comments emphasized the importance of:
    - Ensuring opportunities for participation by solo practitioners or physicians in small practices;
    - Securing exceptions to anti-kickback and antitrust laws for ACO participants;
    - Developing adequate risk adjusters and efficiency measures; and

- Providing adequate technical support to physicians to facilitate implementation and participation

3. Wrote a letter to CMS on August 12, 2010 outlining the AMA's recommendations for the structure of ACOs.

4. Submitted written and oral comments for October 5, 2010 Federal Trade Commission, CMS and OIG joint workshop to examine the intersection of ACOs and antitrust, physician self-referral, anti-kickback, and civil monetary penalty laws. AMA President Cecil B. Wilson participated as a panelist at this workshop, and emphasized AMA support for the establishment of a full range of waivers, safe harbors, and exceptions that will enable independent physicians to effectively participate in ACOs.

5. On November 15, 2010, AMA President Cecil B. Wilson and AMA Board of Trustees Chair Ardis D. Hoven participated in a summit meeting convened by the Administration to discuss reforms, such as bundled payments, medical homes and ACOs.

6. On December 2, 2010, the AMA prepared a detailed response to a Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program. The intent of the request was to provide CMS with information related to ACOs in anticipation of CMS' initial rulemaking for the Shared Savings Program. The AMA's detailed response to this request (available online at http://www.ama-assn.org/ama1/pub/upload/mm/399/cms-aco-comment-letter-2dec2010.pdf) reflects several of the principles outlined in Policy H-160.915, as well as the broader guidelines for physician payment reform articulated in Policy H-390.849.

RELEVANT AMA EDUCATIONAL EFFORTS

Policy D-385.963[3] asks the AMA to make resources available to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems. Referred Resolutions 812-A-10 and 832-I-10 also address the need to ensure that resources are available to help physicians understand payment and delivery reform proposals and options. Since enactment of the ACA in March 2010, the AMA has undertaken the following education efforts for physicians on the payment and delivery reform provisions:

1. Produced and distributed "Pathways for Physician Success under Health Care Payment and Delivery Reforms," by Harold Miller of the Center for Healthcare Quality and Payment Reform.

2. Created a "Pathways" homepage on the AMA Web site (www.ama-assn.org/go/paymentpathways) that provides up-to-data resources for physicians on payment and delivery reforms.

3. Held a "Pathways" webinar with Harold Miller in June 2010.

4. Developed and sponsored regional "Pathways" seminars for physicians. These seminars feature Harold Miller as the lead speaker, with local physicians from each region discussing the challenges and opportunities they face in developing their own innovative programs incorporating clinical integration, bundling, and the patient-centered medical home. Four seminars were held in 2010, and six seminars are planned for 2011. Continuing medical education credits are available for these seminars.

5. In December 2010, released *ACOs, CO-OPs and Other Options: A "How-To" Manual for Physicians Navigating a Post-Health Reform World* (www.ama-assn.org/go/ACO). This resource is specifically designed to help physicians maximize the likelihood of success, while minimizing the risk of failure. Topics include an overview of ACOs and issues to consider such as governance, partnerships with hospitals or health insurers, and managing antitrust risks. The resource also discusses opportunities for consumer operated and oriented plans (CO-OPs) and provides guidance on earning incentive payments for electronic health records.

6. In March 2011, the AMA issued a call for nominations for the organizing committee of a new AMA Physician Payment and Delivery Reform Leadership Group. The ultimate goal of the Leadership Group is to share resources across states and specialties so that physicians can assume the lead in the development and diffusion of new payment and health care delivery models. It is intended to produce data, analysis, and other resources that physician organizations need to inform their own policy development.

REFINING AMA POLICY ON PHYSICIAN PAYMENT REFORM

Policy D-385.963[2] asks the AMA to develop guidelines for health care delivery payment systems that protect the patient-physician relationship. The recommendations in Council on Medical Service Report 6-I-09 established the set of 11 principles to guide the development, adoption, and implementation of payment reforms that were previously cited in the "Relevant AMA Policy" section of this report (Policy H-390.849).

These principles were designed to provide AMA leadership with a strong framework on which to base its advocacy efforts, while also permitting enough flexibility 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. As noted, Council on Medical Service Report 8-A-11, also being considered at this meeting, includes examples of ways in which physicians and groups are implementing changes in their practices that are helping them treat patients more efficiently and effectively.

In November 2010, the Council on Medical Service met with the Council on Legislation to discuss ways in which AMA policy related to physician payment and health care delivery reform might be strengthened. The Councils agreed that existing principles expressed in Policies H-390.849, H-160.951 and D-390.961 remain relevant to AMA advocacy efforts and effectively represent our AMA's broad position on payment and delivery reform. In their review of policy, the Councils noted that AMA policy could be enhanced by explicitly considering two additional elements of the payment and delivery reform process: patient attribution and defining and measuring the "success" of reform initiatives.

Patient Attribution Process

The overarching goals of new payment and delivery reforms are to yield improvements in patient care and spending levels. These improvements arise within the context of the individual patient-physician relationship, and the appropriate attribution of patients to physicians is critical to any system-wide effort to measure and reward improvements in care delivery.

In an ACO model, quality of care and spending levels for the patients assigned to the ACO are measured against established benchmarks, and performance in these areas will determine whether bonus payments are awarded. Furthermore, performance data feedback and the distribution of bonus payments among physicians and other providers are dependent upon the ability to accurately

link individual physicians to individual patients. The integrity of the ACO model and shared savings program depends on a reliable attribution process.

Under the ACA, Medicare beneficiaries are not required to enroll in an ACO, and physicians are not required to identify their patients. Instead, an algorithm would be used to assign patients to an ACO based on patterns of service use. For example, an ACO would be responsible for a patient if the patient received most of his or her care from a physician participating in the ACO. The attribution could be prospective based on service use in prior years, so that ACOs are aware who their beneficiaries are at the beginning of the performance period. Alternatively, attribution could be retrospective, with beneficiaries assigned to an ACO at the end of the performance period based on the services they received from the ACO during the prior year.

CMS has acknowledged that the design of the process of attributing beneficiaries to an ACO is important to ensuring that expenditures are appropriately reported and that quality performance is accurately measured. The CMS Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program specifically asked for comments regarding the process of attribution. Consistent with the general body of AMA policy (e.g., H-373.998, H-165.888, E-9.06), the AMA response to this complex issue was to emphasize the primacy of the voluntary patient-physician relationship. The AMA also expressed concern about attribution methodologies that use a formula to assign individual patients to individual physicians for the purposes of calculating overall ACO performance. In particular, the AMA noted that, "retrospective attribution is particularly problematic, since neither the patient nor the physician knows that CMS is assigning accountability to the physician…until after the care has been delivered." The AMA also expressed concern that retrospective attribution could create an incentive for ACOs to avoid providing primary care services to new Medicare patients, since a single visit could result in all of the beneficiary's health care costs being attributed to the ACO. The AMA urged CMS to minimize the use of attribution algorithms or formulas, and encouraged that ACOs be accountable only for those patients who voluntarily choose its physicians to provide or manage their care.

To the extent that patient attribution is used to produce individual physician performance reports, there is widespread concern that physicians may be held accountable for care that they did not provide and could not have controlled. Regardless of the attribution process used, physicians should have the opportunity to verify all data used to measure ACO or individual physician performance.

Evaluating the Effectiveness of Reform Initiatives

As the country moves closer to implementing health care delivery and physician payment reforms on a broad scale, it is important to consider the original intent of such reforms. The delivery and payment reform proposals outlined in the ACA were specifically intended to improve the quality of care for Medicare beneficiaries and to improve the value of health care delivery. Transitioning to ACOs and shared savings models will be a significant change for many in the health care community, and policymakers and other stakeholders should be consistently aware of whether the reforms are yielding the intended benefits. The goal of the newly established Center for Medicare and Medicaid Innovation is to "produce better experiences of care and better health outcomes for all Americans and at lower costs through improvements" (www.innovations.cms.gov). To this end, it is important the payment and delivery reform designs include ongoing evaluation processes to monitor the success of the reforms in achieving the goals they were intended to achieve.

Policy Proposal by the Indiana State Medical Association

In December 2010, the AMA Board of Trustees received a letter from the Indiana State Medical Association (ISMA) suggesting that the AMA "support legislation that mandates that boards of directors of each accountable care organization consists of at least 50 percent physicians who own their own practice, and not physicians who are employed either directly or indirectly by any hospital system." ISMA's letter stated that the ISMA Board of Trustees had decided to contact the AMA Board of Trustees directly because the Council on Medical Service was already in the process of preparing a report on ACOs. The Board of Trustees transferred ISMA's letter to the Council for review.

The Council appreciates the opportunity to consider ISMA's proposal in the context of its ongoing work, and shares ISMA's concern that independent physicians and physicians in small practices have the opportunity to participate in ACOs without being dominated by hospital interests. Our AMA has vigorously advocated for physician leadership of ACOs, and continues to urge policymakers to address barriers to ACO participation by independent physicians. The ACO principles adopted at the 2010 Interim Meeting (Policy H-160.915) explicitly address these concerns. Policy H-160.915[2] outlines detailed principles for ACO governance, and emphasizes physician leadership of ACOs. In addition, Policy H-160.915[6] promotes the availability of start-up funding to help facilitate the creation of ACOs, especially among solo or small group independent practice physicians. Similarly, Policy H-390.849(g) urges that physician payment reforms make participation options available for varying practice sizes, patient mixes, specialties and locales.

The Council believes that is important that AMA policy on ACOs remain flexible in order to support a variety of ACOs structures, depending on the needs and dynamics of local communities. Federally imposed mandates that dictate ACO board composition could ultimately conflict with or undermine local efforts to pursue ACO systems that could yield benefits for patients and physicians. For this reason, the Council believes that the intent of the proposal by ISMA is best achieved by continuing to advocate for physician leadership in ACO development and implementation and for expanding opportunities for involvement by physicians of varying practice sizes and styles.

DISCUSSION

The principles outlined in Policy H-390.849, along with the ACO principles adopted at the 2010 Interim Meeting (Policy H-160.915) have provided a strong basis for AMA advocacy efforts. The AMA continues to advocate strongly that payment and delivery reforms – and specifically the development of ACOs – be physician-led, and that physicians and other key stakeholders be given broad latitude to implement changes in their practices and communities that are consistent with the goals of improving patient care and increasing the overall value of health care delivery.

The issue of patient attribution has become more visible as efforts to define and implement the ACO concept become more advanced. The Council believes that core AMA policy related to physician payment reform could be strengthened by emphasizing that attribution methods should be based on voluntary agreements between physicians and patients, and that processes should be in place to allow physicians to verify and appeal attribution reporting.

The Council also believes that, in order to maintain the integrity of the goals of payment and delivery reform efforts, particular attention should be paid to the development of ongoing

evaluation processes to monitor the success of the reforms in achieving the goals of improving the quality of patient care and reducing unnecessary or wasteful spending.

The resolutions from the 2010 Interim Meeting that were referred by the House of Delegates are closely related to the policies and activities highlighted in this report. The Council will continue to update the House of Delegates on AMA advocacy efforts related to physician payment and health care delivery reform, and believes that this report, previously established policy, and the following recommendations accomplish the intent of Resolutions 818, 832 and 833 from the 2010 Interim Meeting.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolutions 818-I-10, 832-I-10 and 833-I-10, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-390.849 by addition to read:

   Our AMA will advocate for the development and adoption of Medicare physician payment reforms that adhere to the following principles: 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. (Modify HOD Policy)

2. That our AMA amend Policy H-390.849 by addition to read:

   Our AMA will advocate for the development and adoption of Medicare physician payment reforms that adhere to the following principles: 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. (Modify HOD Policy)

3. That our AMA continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives. (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.