REPORT 9 OF THE COUNCIL ON MEDICAL SERVICE (A-16)
Physician-Focused Alternative Payment Models
(Reference Committee A)

EXECUTIVE SUMMARY

The Council initiated this report to provide an overview of the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and to provide needed discussion of MACRA's opportunities for physicians to participate in Alternative Payment Models (APMs) and Physician-Focused Payment Models (PFPMs). MACRA built on the Affordable Care Act of 2010 (ACA) and created new opportunities to create better physician-led payment systems. MACRA ends the constant threat of pay cuts to which physicians were subject under the Sustainable Growth Rate and creates new incentives designed to accelerate payment reform progress. Specifically, MACRA creates incentives for physicians to participate in APMs and provides opportunities for them to participate in the development and implementation of PFPMs.

The focus on APMs is grounded in the notion that coordinated, integrated, and technically supported care will result in better health outcomes at a lower cost than volume-based fee-for-service. No single approach to payment reform will yield the best outcome for every physician or every specialty. Opportunities to improve care will differ in every community, and both providers and payers will differ in their capabilities to manage and implement payment system changes. PFPMs provide a chance to create APMs that enable successful participation by all physicians in all specialties and practice settings. If properly structured, PFPMs create an opportunity for physicians to improve patient care in ways that are feasible in their unique practice environments.

With growing pressures to control costs and emphasize value-based care, the Council believes there is a need for a set of guidelines in American Medical Association policy to support the appropriate shift to and implementation of APMs. Accordingly, the Council recommends recognizing that the physician is best suited to lead the transition to APMs and proposes a set of goals for APMs to that end.

Because physician practices will need support implementing APMs, the Council recommends encouraging the Centers for Medicare & Medicaid Services and private payers to support various types of technical assistance. Further, the Council recommends a set of guidelines to help medical societies and other physician organizations develop feasible APMs for their members and reiterates the importance of these organizations continuing to be involved in the development of APMs and serving in an educational role.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-16

Subject: Physician-Focused Alternative Payment Models

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee A
(A. Patrice Burgess, MD, Chair)

During the past six years, the nation has seen adoption of significant public policies aimed at moving physicians to a payment system that can help them lower spending growth and improve the quality of patient care. The 2010 Affordable Care Act (ACA) included a variety of reforms intended to lay the groundwork for a shift in how the US pays for health care with an emphasis on improving quality and reducing cost in addition to expanding coverage. In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) eliminated the Sustainable Growth Rate (SGR) and created new opportunities to create better physician-led payment systems. MACRA ends the uncertainty and the constant threat of double-digit pay cuts to which physicians were subject under the SGR and creates new incentives designed to accelerate payment reform progress.[1] Specifically, the new law creates incentives for physicians to participate in Alternative Payments Models (APMs) and provides opportunities for them to participate in the development and implementation of Physician-Focused Payment Models (PFPMs).[2]

Meeting the demands of a shifting health care payment paradigm requires physician leadership guiding the direction of APMs. This report, initiated by the Council, provides an overview of MACRA provisions relevant to physician-focused APMs; explains what physician-focused APMs are and provides examples; summarizes relevant policy; and presents policy recommendations.

BACKGROUND

Driven by the ACA and MACRA, the Centers for Medicare & Medicaid Services (CMS) has developed and implemented a number of initiatives to test APMs. In January 2015, the Department of Health and Human Services (HHS) Secretary Sylvia Burwell announced national goals for transitioning to value-based payment and APMs.[3] The shift in focus to APMs is grounded in the notion that coordinated, integrated, and technically supported care will result in better health outcomes at a lower cost.[4]

The MACRA legislation provides incentive payments to physicians who reach threshold levels of APM participation for each year from 2019 through 2024.[5] APMs that are recognized by MACRA include Medicare Shared Savings Program accountable care organizations (ACOs) and models established by the CMS Center for Medicare & Medicaid Innovation (CMMI), such as the Bundled Payments for Care Initiative, and medical home models that are expanded by the CMMI, which may potentially include a future expansion of the Comprehensive Primary Care Initiative. However, the APMs currently being implemented by CMS do not represent the full range of potential APMs authorized by MACRA. In addition, MACRA specifically encourages the development of PFPMs by creating a permanent advisory committee to review proposals from

physicians and other stakeholders and make recommendations to HHS and CMS as to which models to implement.

MACRA allocates funding to enable the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review physician-focused payment model proposals and to provide comments and recommendations to HHS as to which such payment models should be implemented.[6] Additionally, the law allocates $100 million over five years for HHS to support technical assistance to help small practices and practices in health professional shortages areas to participate in payment reform efforts.[7]

BARRIERS IN THE CURRENT PAYMENT SYSTEM

There are significant barriers to changing the way health care services are delivered in order to improve patient health and reduce spending because current payments are tied to utilization of services. Under the current fee-for-service (FFS) system, practices lose revenue if physicians perform fewer or lower-cost services even though their practice costs often remain the same.[8] Additionally, providers may be financially penalized for providing higher quality services. For example, if a practice reduces errors and complications resulting in the need for fewer services, the practice's operating margins can decline and threaten its financial viability.[9]

Moreover, Medicare and most health plans do not pay for beneficial services like patient education and care coordination activities that can help reduce avoidable spending.[10] For example, there is generally inadequate or no payment for providing proactive telephone outreach to high-risk patients to ensure they receive preventive care.[11] Outreach could prevent serious health problems and avoid more expensive services like hospital admissions.

A number of the current APMs, such as ACOs, are subject to regulatory policies that favor large practices, multi-specialty practices, and health systems, not small physician practices, and, as a result, they can make it difficult for independent physicians who wish to participate in the APMs to remain independent.[12] Current APMs also have not been designed to include many specialists or their patients. Many physicians participating in these APMs have expressed concern that they impose significant administrative burdens.[13] Many of these APMs were not structured in a physician-driven manner with the needed flexibility. For example, nearly all of the CMS APMs that have been implemented to date are based on a shared savings model which can reward denying needed care as well as reducing unnecessary care, and which does not remove the barriers in the underlying payment system. Further, these APMs require the participating physicians to take accountability for total spending on the APM's patients instead of limiting accountability to the components of care delivery that the physicians can reasonably influence. As a result, the current APMs may increase financial risks for physicians without giving them the appropriate resources and flexibility to manage that risk. What some policymakers perceive as unwillingness by physicians to move away from FFS payment may be more a reflection of physicians' legitimate concerns about the way APMs have been structured to date by CMS and private health plans.

OPPORTUNITIES UNDER MACRA

No single approach to payment reform will yield the best outcome for every physician or every specialty. Opportunities to improve care will differ in every community, and both providers and payers will differ in their capabilities to manage and implement payment system changes.[14] PFPMs provide a chance to create a family of APMs that enable successful participation by all physicians in all specialties and practice settings. If properly structured, PFPMs create an opportunity for physicians to improve patient care in ways that are feasible in their unique practice

environments. Specialty-specific and condition-based models allow physicians to redesign care for the specific types of patients for whom the physicians deliver care.

The goal of PFPMs should be to break down the barriers in the current payment system that prevent physicians from taking advantage of opportunities to improve patient care that can also help control growth in spending. For example, if better management of a patient's chronic disease can prevent the patient from being hospitalized, the patient receives better care while spending is reduced. Yet currently there is no payment for training patients to manage their conditions at home and provide feedback by phone, or for physicians taking time to consult with other specialists about how to successfully manage a patient's condition. PFPMs could provide an opportunity to be paid for such valuable services that support improved patient health. If better surgical care helps patients avoid infections and other complications, then the patients have better outcomes and spending is reduced. Patients are heterogeneous, and different interventions are required for different patients. Physicians are best poised to balance the goal of reducing health care costs while delivering high quality care. Accordingly, physicians should have a leadership role in steering the models.

With strong leadership, physicians can provide the ethical foundation needed to design models that help to reduce costs appropriately and improve patient care. Because some value-based payment designs can lead to reductions in necessary care, not just inappropriate services, properly risk adjusted PFPMs that pay physicians for high-value services that they may already be providing is a way to mitigate these concerns. APMs should be physician-driven to ensure an understanding of proper health care delivery and quality patient care.

MACRA is designed to increase physician accountability, and the development of PFPMs allows accountability to be focused on what each physician can influence in practice and to provide the resources and flexibility physicians need to accept that accountability. The Council has previously expressed concern that the established CMS APMs could force physicians to join large health systems or ACOs in order to participate in an APM. Properly constructed PFPMs could be flexible and allow physicians across practice size, setting, and specialty to participate in APMs. Developing physician-focused APMs gives physicians the resources and flexibility needed to implement their own solutions for improving care for their patients rather than having CMS dictate the way care should be delivered.

EXAMPLES OF ALTERNATIVE PAYMENT MODELS

American Society of Clinical Oncology (ASCO)

ASCO has developed the Patient-Centered Oncology Payment (PCOP) model for a potential oncology APM. The PCOP model addresses the serious barriers in FFS faced by oncologists: lack of payment in the current FFS structure for an array of services critical to supporting patients with cancer and managing complex illness.[15] The PCOP offers three payment approaches for oncology practices, recognizing that oncology practices across the US have different capacities and face different marketplace and practice environment challenges.[16] The PCOP allows oncologists to direct more resources to activities such as spending time with patients in shared decision making about alternative treatments, developing care plans, and providing triage and in-office treatment in order to avoid emergency visits and hospital admissions. The model identified opportunities to reduce spending during an episode of chemotherapy such as reduced emergency department visits and hospital admissions for chemotherapy-related complications, unnecessary or duplicative testing, and unnecessary drugs. Additionally, the model supports team-based care by providing funding for the use of educators, social workers, and triage nurses with the recognition that the whole team manages a

patient. ASCO estimates that oncology practices would receive a significant increase in payments for patient services compared to the current FFS payments, yet overall spending on cancer care would decrease by avoiding expensive hospitalizations and unnecessary tests and treatments.[17]

American Society for Radiation Oncology (ASTRO)

ASTRO has created two "bundled payment" models that could serve as APMs: one focused on palliative care for bone metastases and the other on treatment of breast cancer. Both models are designed to provide flexibility to radiation oncologists in choosing the most appropriate treatment modality for patients without financially harming the practice when it uses lower-cost treatments. ASTRO arrived at these two models by analyzing Medicare data to identify areas of potential savings. The ASTRO model provides a clear definition of services in specified treatment categories and rewards maintaining and improving performance on quality measures and disease specific measures. To ensure adequacy of payment, a base payment rate using the weighted average of the FFS payments is developed for all clinically appropriate radiation therapy services, and a bonus is applied for compliance with care pathways and care coordination. The ASTRO models help reduce overutilization of existing services without harming radiation oncology practices financially.

American College of Cardiology (ACC)

The ACC has created the SMARTCare model to improve the appropriate use of diagnostic testing and interventions for patients with stable ischemic heart disease.[18] SMARTCare assists physician and patient decision-making, incorporating practice guidance required for guideline-based optimization of care, and, based on evidence-based standards, avoiding care that is unlikely to help in many clinical situations. SMARTCare uses data collection and numerous tools at the point of care that are integrated into the physician's workflow. These tools include an ACC tool embedded in the electronic health record that guides physicians through the collection of patient data on appropriate use to identify performance gaps and ultimately implement a quality improvement plan for the practice. Additionally, SMARTCare uses a tool that helps physicians assess the risk of heart attacks for patients. The ACC believes that these tools will bring more evidence-based clinical information to the point of care and ultimately reduce usage of unnecessary services. Further, SMARTCare works to re-establish the strength of the physician-patient relationship through patient-specific consent and education. The SMARTCare model is being piloted for three years across 10 sites and is expected to save $42.2 million over the course of those three years.[19]

American Society of Anesthesiologists (ASA)

The ASA developed a learning collaborative to implement the Perioperative Surgical Home (PSH).[20] The PSH is a physician-led, patient-centered, team-based model to coordinated care that guides patients through the surgical experience from the decision to undergo surgery to discharge and medical and social supports.[21] The PSH model aims to reduce variability in perioperative care because variability increases the likelihood of errors and complications.[22] The model assures continuity of care and treats the entire perioperative episode as one continuum of care.[23] The PSH model has been implemented in a variety of settings including medical centers, community health systems, and independent group practices. Because the PSH is primarily a method of organizing and delivering care, PSH payment systems may be flexible.[24] For example, PSH may use shared savings arrangements, bonus payments, and bundled payments among others.[25] The PSH has demonstrated success as both a financially sustainable model and a beneficial model of care for patients.[26] The model has been shown to result in increased patient satisfaction, improved postoperative outcomes, reduced length of stay, and reduced risk of hospital-acquired infections.[27]

Individual Physician-Led Model

Many individual physician leaders are developing provider-specific models that work for their practices, including the Minnesota Birth Center model. Consistent with American Medical Association (AMA) policy recognizing certified freestanding birth centers as a suitable setting for labor, delivery, and immediate post-partum care, the Minnesota Birth Center is a physician-led freestanding birth center (Policy H-245.971). The center employs team-based care to offer a bundled payment and care delivery model that includes pre-natal, intra-partum, and post-partum care. The goal of the center is to lower the cost of childbirth by providing care in a birth center setting for those women who are classified as low risk and who continue as low risk through delivery. Mothers who need care in the hospital during the delivery process are transferred there to complete the delivery. The Minnesota Birth Center provides a way to improve outcomes and reduce costs in normal childbirths and also to provide greater predictability about costs for new parents and health insurance plans.

AMA ACTIVITY

The AMA is actively engaged in the development and implementation of better health care payment systems. The AMA has convened regular meetings with CMS on APMs and has hosted MACRA and APM workgroup meetings with representatives from state and specialty societies to build on physician experiences and offer best practices. These workgroups are identifying common themes and potential strategies to overcome the challenges of transitioning to APMs. Additionally, the workgroups participated in developing robust comments on APM aspects of the CMS Request for Information and continue to advocate with CMS and be actively involved with MACRA implementation. Further, in April 2016, CMS released the MACRA notice of proposed rulemaking, and the AMA is working with the Federation to analyze and respond to the MACRA proposed rule, including criteria for PFPMs and proposals from the PTAC for how it will review and develop recommendations on stakeholder APM proposals.

Moreover, the AMA has been working for many years to encourage the development and implementation of successful and sustainable payment systems that achieve the following goals:

- Give physicians more resources and flexibility to deliver care;
- Improve financial viability in physician practices;
- Minimize administrative burdens that weigh physicians down;
- Enable physicians to control aspects of spending that they can influence; and
- Avoid transferring inappropriate financial risk to physicians.

Additionally, the AMA's Physician Satisfaction and Practice Sustainability strategic focus area has developed multiple tools to help physicians thrive in practice and adopt sustainable new models of care delivery and payment. STEPS Forward, launched in 2015, intends to drive physician internal practice improvement with a focus on small practice. STEPS Forward will be enhanced with the recent award of a CMS Transforming Clinical Practices Initiative grant to provide practice transformation resources for physicians. New modules are being identified and were released, in April 2016, including a module on implementing new payment models in practice. Additional tools include:

- Leadership training for physicians focused on episodic leadership training for practicing physicians in area of professional development, personal development, and health systems;
- Commercial payer contracting resources on new payment models of pay-for-performance and bundled payments;

- AMA and American Hospital Association joint principles on physician-hospital integrated leadership; and
- Development of an interactive online education assessment tool for individual physicians to evaluate the financial and patient care delivery impacts of new payment models under MACRA and provide physicians with tools and resources to assist them in practice transformation and sustainable payment model adoption.

RELEVANT AMA POLICY

Policy D-390.953 directs the AMA to advocate with CMS and Congress for alternative payment models developed in concert with specialty and state medical organizations.

The AMA has extensive policy related to physician-led payment reform models. AMA policy is committed to promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs (Policy D-385.963). Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients. In transitioning from the SGR, the AMA advocates for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions (Policy H-390.844).

Policy H-390.849 directs the AMA to advocate for the adoption of physician payment reforms that promote improved patient access to high-quality and cost-effective care and that such reforms be designed with input from the physician community. The policy also states that reformed payment rates must be sufficient to maintain a sustainable medical practice and that payment reform implementation should be undertaken within a reasonable timeframe and with adequate assistance.

Policy H-450.931 recognizes that physicians will need assistance transitioning to alternative payment models. To that end, the AMA is committed to helping physician practices optimize the quality and content of physician work under APMs and addressing physician concerns. The policy also recognizes that physician practices will need data and resources for data management and analysis to participate in an APM.

The AMA has significant policy on avoiding financial incentives that could potentially conflict with the best interests of their patients or influence their judgment related to quality of care. Ethics Opinion E-8.0501 provides guidelines for physician leaders to ensure that practices for the financing and delivery of care are ethical, and the policy further directs physicians to address potential conflicts of interest in payment models and financial incentives. Ethics Opinion E-8.0501 states that physicians are free to enter into a wide range of contractual agreements and should be mindful of and negotiate the removal of terms that are known to compromise professional judgment or integrity, particularly when compensation varies according to performance. Further, Policy H-140.978 states that physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward or the avoidance of financial penalties.

DISCUSSION

In response to the growing pressures to control costs and the increasing emphasis on value-based payment, MACRA has prompted payers to begin moving away from traditional FFS payment and toward experimentation with APMs.[28] The ACA and MACRA codified this shift to new innovative payment models, marking a significant shift in policy. As payment reform surges forward, it is important for physicians to take a leadership role in order to ensure that future changes fulfill the promise of delivering better care for patients as well as lower costs for payers in

ways that are financially viable for physician practices. Physicians must have the freedom to choose their mode of practice and method of earning a living. Accordingly, physicians should be driving this change. Physicians should determine what infrastructure is needed to deliver good care for patients in a workable environment for physicians, patients, and practice sustainability. The AMA is in the unique position to help physicians shape payment reform appropriately through its advocacy efforts. Current AMA policy is silent on the intended goals of APMs and how physicians may be active in developing and piloting new payment models tailored to their practices and patient populations, and physicians have an opportunity to shape advocacy efforts moving forward.

Value-based health care should be the goal of any health reform initiative. However, even with the repeal of the SGR, there are major challenges to achieving the goal of value-based care, including the lack of an agreed-upon patient-centered definition of value; shortage of streamlined, meaningful performance metrics; a deficiency of health information technology to support the type of information-gathering and data analysis necessary to transition to new systems; and a lack of physician-focused APMs.[29]

The implementation of MACRA means that the shift toward better value will accelerate. Therefore, it is imperative that physicians are aware of and become involved in the shifting payment reform structure in order to ensure its success and mitigate possible administrative burdens on physician practices.

The Council strongly encourages physicians to be at the forefront of this payment reform shift. Using flexible PFPMs provides a way for providers and payers to support improved care in the most efficient and effective fashion. For example, in many cases, there is no need to create complex bundled payment models; a provider and payer may need only agree to create new fees for currently uncompensated services along with feasible targets for avoidable utilization and spending that the physician works to achieve and maintain.[30] Physicians must lead payment reform initiatives to ensure new payment initiatives are approached with caution and that changes work for them and their patients. They must organize themselves to advocate for a transitional approach to models and push for an adequate transition period.

Small and solo practitioners are likely to need additional support to transition to value-based payment. Payment reform activities must recognize that these practices may have additional obstacles to participation for which solutions need to be identified. For example, the calculated cost per patient may be much higher with a small patient panel, and small and solo practices will experience greater swings in revenues and costs from low probability events. Approaches to ensure these problems do not inappropriately penalize small practices include measuring performance over multiple years, measurement for all patients regardless of payer, and defining composite measures of utilization or spending that can be directly controlled by the physician. All practices should receive adequate support to enable them to make the transition to new payment models. Models and practice supports should be physician-driven and developed with the support of the AMA working jointly with specialty societies.

It is important to note that APM participation will not be appropriate for every patient or every service. There may not be an APM for every patient, and most models will exclude certain patients. For example, some highly complex patients may require customized services that are best supported by FFS payment, not an APM. Additionally, there are services for which FFS remains appropriate. Routine services associated with fewer complications may be best addressed by FFS. These considerations must be built into proposed payment reform models.

Physicians and payers must be cognizant of the potential ethical implications of entering into an APM. While one goal of moving to value-based payment is to help reduce unnecessary services, APMs must also work to avoid underuse of necessary services. Ethical scrutiny around financial incentives is important to achieve appropriate use of services in APM designs while avoiding unintended consequences such as underuse. To mitigate these concerns, the Council recommends physicians remain actively involved in the development of APMs in order to lead improvement in patient care while avoiding ethical conflicts that can arise from conflicting duties to their patients and their contractual obligations. There are ethical challenges ahead in the transition to value-based payment, and physicians should lead this evolution to ensure the focus remains on appropriate care and improved patient outcomes.

Though the transition to value-based payment will no doubt be difficult, the Council believes, with a united physician voice and strong leadership, that payment reform will allow physicians to provide higher quality care to patients and better sustain their physician practices. In this report, the Council recommends establishing a set of APM goals consistent with AMA policy and advocacy. The Council recognizes that minimal resources exist to help physicians identify and develop viable APMs for their practices. As such, the Council recommends guidelines to help physicians identify feasible models for their practices. An additional recommendation offers principles to both educate physicians and help physicians reach the goals of APMs. Physicians need tools to move from delivering care under the current FFS payment rules to building the infrastructure and establishing the partnerships that will enable them to implement sustainable APMs. Physicians must be equipped to shape payment reforms appropriately and to resist imposition of inappropriate models by payers. The Council is hopeful that its recommendations will help physicians as they transition to value-based payment reform.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-385.926 supporting physician choice of practice and the freedom of physicians to choose their method of earning a living. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-385.963 promoting physician-led payment reform and Policy H-390.844 emphasizing the importance of physician leadership and providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions. (Reaffirm HOD Policy)

3. That our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs). (New HOD Policy)

4. That our AMA support that the following goals be pursued as part of an APM:
    a. Be designed by physicians or with significant input and involvement by physicians;
    b. Provide flexibility to physicians to deliver the care their patients need;
    c. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
    d. Reduce burdens of health information technology (HIT) usage in medical practice;
    e. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the

amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
f. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
g. Avoid placing physician practices at substantial financial risk;
h. Minimize administrative burdens on physician practices; and
i. Be feasible for physicians in every specialty and for practices of every size to participate in. (New HOD Policy)

5. That our AMA support the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
a. Identify leading health conditions or procedures in a practice;
b. Identify barriers in the current payment system;
c. Identify potential solutions to reduce spending through improved care;
d. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
e. Define services to be covered under an APM;
f. Identify measures of the aspects of utilization and spending that physicians can control;
g. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
h. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
i. Identify mechanisms for ensuring adequacy of payment; and
j. Seek support from other physicians, physician groups, and patients. (New HOD Policy)

6. That our AMA encourage CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
a. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
b. Assistance in obtaining the data and analysis needed to monitor and improve performance;
c. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
d. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
e. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties. (New HOD Policy)

7. That our AMA continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. (New HOD Policy)

Fiscal Note: Less than $500.

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