REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-13)
Payment Mechanisms for Physician-Led Team-Based Health Care
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2012 Interim Meeting, the House of Delegates adopted as amended the joint report of the Council on Medical Education (CME) and the Council on Medical Service (CMS), Report I-12, "The Structure and Function of Inter-professional Health Care Teams." This report is in response to an amendment of the I-12 joint report of the Councils requesting that the American Medical Association (AMA) study innovative payment mechanisms that appropriately compensate the physician and/or team for team-based health care.

Team-based health care and related payment models are increasingly being established by some health insurance companies, provided by large integrated health care systems, and implemented by small and large physician practices. Team-based models are also being used for specific diseases and medical specialties. This report highlights case studies of various team-based models and their respective payment systems in order to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for physician practices working to improve patient care and lower costs.

While a review of the literature predicts that fee-for-service payments will not be replaced entirely in the near future, payment models are deliberately moving away from volume-based payment structures toward ones based on value. Value-based payment structures that are being used in team-based delivery models include episode-based bundled payments, global bundled payment systems, pay-for-performance programs, care management models, shared savings arrangements, various combinations of incentives coupled with base salaries, and evolving patient-centered medical home payment mechanisms.

This report provides background on evolving team-based care payment mechanisms, reviews key challenges for team-based payment, presents case studies of various team-based payment models, outlines AMA advocacy and relevant policy, discusses avenues for AMA advocacy and policy development, and provides recommendations.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-13

Subject: Payment Mechanisms for Physician-Led Team-Based Health Care

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee J
(Dolleen M. Licciardi, MD, Chair)

At the 2012 Interim Meeting, the House of Delegates adopted as amended the joint report of the Council on Medical Education (CME) and the Council on Medical Service (CMS), Report I-12, "The Structure and Function of Inter-professional Health Care Teams." The report was amended to ask that the American Medical Association (AMA) "study innovative payment mechanisms that appropriately compensate the physician and/or team for team-based health care with a report back to the House" (Policy D-160.936). The Board of Trustees referred the requested study to the Council on Medical Service for a report back to the House at the 2013 Interim Meeting.

This report provides background on evolving team-based care payment mechanisms, reviews key challenges for team-based payment, presents case studies of various team-based payment models, outlines AMA advocacy and relevant policy, discusses avenues for AMA advocacy and policy development, and provides recommendations.

BACKGROUND

AMA Policy H-160.912[1], established by the I-12 joint report of CME and CMS (the Councils), defines "team-based health care" as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other, the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care. A premise of the joint report was that such teams will likely be an important component of addressing anticipated coverage gains under the Patient Protection and Affordable Care Act.

New delivery models, such as team-based health care, are evolving along with new payment mechanisms, including episode-based bundled payments, global bundled payment systems, pay-for-performance programs, care management models, shared savings arrangements, various combinations of incentives coupled with base salaries, and evolving patient-centered medical home payment mechanisms. While a review of the literature predicts that fee-for-service payments will not be replaced entirely in the near future, payment models are deliberately moving away from volume-based payment structures toward ones based on value.

Established by the I-12 joint report of the Councils, Policy H-160.912[6] advocates that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members. Furthermore, innovative payment mechanisms should appropriately compensate the team and all team members for team-based health care.

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KEY CHALLENGES FOR TEAM-BASED PAYMENT

Various factors must be taken into consideration when developing a payment structure for health care practitioners working in a team-based environment. How to attribute performance and outcomes to each practitioner on a team can be complicated. In some situations attribution may be shared between several practitioners due to the interdependence of their duties. With an increasing focus on value, the care provided should be verifiable so that assessments about a practitioner's performance are accurate. Therefore, to the extent possible, new team-based delivery and payment models will need to have the capacity to reliably assign and measure the accountability of care provided by each practitioner and specify clear lines of attribution.

Defined and reliable outcome measures targeted for team-based care are lacking. The timely development of outcome measures will require committed public and private sector funding, must involve physician experts, and must include the development of appropriate risk-adjustment and attribution methodologies. Outcome measures will need performance benchmarks to be applied across providers and settings.

National measures for rating practitioners' performance and patient outcomes serve as a critical and necessary starting point. However, the problems of one locale may not exist in another or the treatment protocol may be different due to any number of variables, such as patient population, level of practice integration and market demographics. Therefore, as the transition toward value-based payments continues, all healthcare stakeholders will need to balance the use of nationally recognized and standardized measures with a more flexible approach that enables local providers to identify measures and targets as well as payment mechanisms that take into account their unique circumstances.

Some health care systems that provide team-based care use team-based incentives, performance measures, and evaluations that factor into a practitioner's compensation. Other systems combine a percentage of the team-based performance with a percentage of the individual's performance to determine compensation. Still other health care systems compensate team-based physicians entirely with a base salary or by providing a base salary in combination with a percentage of their compensation that fluctuates according to the team's overall performance. A combination of one or more of these payment methods along with fee-for-service is expected to be common during the transition from providing volume-based to value-based health care.

CASE STUDIES OF TEAM-BASED PAYMENT MODELS

Team-based health care and related payment models are increasingly being established by some health insurance companies, provided by large integrated health care systems, and implemented by small and large physician practices. Team-based models are also being used for specific diseases and medical specialties. Following are the case studies:

Health Insurance Company: Highmark Inc.

Highmark Inc. is a health and wellness company based in Pittsburgh that operates health insurance plans in Pennsylvania, Delaware and West Virginia serving approximately 5.3 million members. The company is focused on transitioning from fee-for-service payments to incentivizing physician payments in order to promote efficiency, affordability and quality care. A key move in this direction occurred in 2011 when Highmark conducted a pilot study of patient-centered medical homes (PCMH). Results of the pilot study demonstrated an increase in quality and outcomes, a

decrease in hospital admissions and readmissions, and cost savings.[1] In response to the success of this pilot, Highmark has expanded its PCMH initiative in both Pennsylvania and West Virginia.

In July 2013, Highmark announced the formation of the "Accountable Care Alliance," which is a network of physicians and hospitals working together to provide coordinated care, similar to an accountable care organization (ACO) that relies on bonuses to reward performance. Highmark assists physician practices in transitioning to this delivery and payment model by providing services to achieve quality care. This assistance helps transform physician practices so that payment depends on the value of care rather than the volume of care provided.[2] For example, according to M. Piasio, Medical Director, Quality & Medical Performance Management, Highmark (email and telephone communication, August 2013) physician practices are given resources, such as practice transformation support, care coordinators, population management software tools, and cost and utilization data to help implement, manage, and sustain a successful practice model based on providing value. Initially, payment will be made in the form of capitation and unit compensation for services. In the future, the company plans to alter the payment structure to include potential combinations of incentives, risk-sharing and capitated payments.

Integrated Health Care System: Mayo Clinic

The Mayo Clinic is the oldest and largest integrated, multispecialty group medical practice in the US.[3] The fundamental structure of the Mayo Clinic involves a physician-directed team-based approach to providing health care and relies heavily on an integrated electronic health record system. Physicians at the Mayo Clinic receive a fixed salary so that compensation is not based on quantity or the number of patients seen. Allowing physicians to spend the time they deem necessary to provide quality patient care is believed to foster team-oriented patient care and peer accountability. The implementation of salary-based compensation and shared system resources are intended to remove barriers to teamwork that tend to exist in other reimbursement models. Centrally held discussions and decisions about resources are viewed as helping to reduce competition or disagreements among departments or disciplines. The pressure of peer review, rather than productivity incentives, is used to create group expectations for physicians to see the appropriate number of patients.[4]

Integrated Health Care System: Geisinger Health System

Geisinger is one of several large health care systems in the US. It is a physician-led team-based health care system that employs a mixture of health care professionals to create inter-professional teams focused on patient-centered care. Physicians who are employed by Geisinger are given a base salary that comprises 80 percent of their income and is calculated according to work load such as teaching, research activities and administrative duties, as well as the physician's experience and specialty market rates. The base salary for physicians fluctuates according to the work that is performed outside of expected ranges. The remaining 20 percent of total physician compensation also varies depending upon annual individual and group performance related to improvements in quality, efficiency and growth in clinical volume. However, for most clinicians employed by Geisinger, the work load is measured primarily by "work relative value units," a fee-for-service metric based upon the time, skill, training and intensity needed to deliver different services.[5]

Specific Disease: Diabetes

Team-based care for individuals with a chronic disease, such as diabetes, is a delivery model that has been used for at least the past two decades.[6] Even though this is not a new delivery model for

diabetes, better payment mechanisms are needed to support team-based care for diabetes management. Payment frequently does not cover every practitioner on the team. Primary care physicians (PCP) are the common leaders of diabetes care teams, which can also include nurse practitioners, social workers, medical specialists, clinical pharmacists and diabetes educators. Fair payment to each member of a diabetes care team is exemplified in the practice of a family physician from San Antonio who uses a one-page template to document the medical appointment for billing purposes. Each member of the team completes the relevant section of the template with the PCP filling out the final portion, reviewing each team members' documentation and submitting it to the health insurer by using the usual CPT codes for primary care visits (99213 or 99214).[7] Revenue generated by the physician-led practice allows the physician leader to pay each team member according to a predetermined salary based on geographic norms.

Specialty: Surgery

Team-based leadership and care is of utmost importance in the surgical setting. Medicare has established a national definition of a global surgical package to ensure payment consistency across Medicare contractors. Each global surgery package includes all necessary services normally provided by a surgeon at all stages of the surgical procedure. Physicians in the same group practice who are in the same specialty are required to bill and be paid as though they were a single physician. [8] As outlined by CMS, when such group physicians are providing care that is unique to their individual medical specialty and managing at least one of the patient's critical illness(es) or critical injury(ies) then the initial critical care service may be payable to each physician. CMS has outlined in great detail the specifics of payment for a global surgical package.[9] Payment is dispersed to surgeons or practitioners who provided services in accordance with a plan established by each practice.

Physician Practices

In 2012, an American Medical Association survey found that 20 percent of practicing physicians worked in solo practices, 20 percent worked in small practices of two to four physicians, and 19 percent worked in practices of five to nine physicians.[10] While there has been a trend toward physician employment by hospitals and large integrated systems, the survey found that 60 percent of physicians worked in practices that were owned by physicians.

The overall shift from volume-based payment structures toward ones based on value, are impacting the way physicians practice medicine. Small practices are increasingly pressured to use sophisticated health information technology systems and to demonstrate care management efficiencies that increase quality of care and decrease health care costs. Many small practices may not have the resources to make these investments.

According to P. Gaziano, Chairman and CEO of Accountable Care Associates (ACA) (telephone communication, August 2013), small physician practices do not need to independently change their practice models in radical ways to provide high quality care. Instead, 15 years ago Dr. Gaziano developed ACA in order to assist practices, including smaller ones, in achieving the high performance that integrated health care systems accomplish. ACA is an innovative health care management services organization, and developer and vendor of health information technology, data and infrastructure for health care providers.

ACA is an accountable care organization that uses a global capitation payment model. The organization contracts with established independent practice associations (IPAs), accountable care

organizations (ACOs) and independent physician practices to assist in increasing practice efficiencies. ACA provides the following supports to contracted physician practices: consultation and administrative services; web-based data sharing and reporting tools (Care Screen™), coding and compliance tools; care management and clinical services; and provider education and training. If a physician practice decides to contract with ACA, the practice can determine their needed services. The selected services are free as long as the practice uses them for a certain amount of time each day. ACA is a "one-sided" or "upside" only shared savings model so there are no performance risks to physicians even if they have higher costs or do not achieve quality performance goals; ACA accepts financial risk for patient care. The savings help pay for the services provided to physician practices. A physician practice receives payments according to how much they use the provided services and the resulting efficiencies.

AMA ADVOCACY

AMA Strategic Plan

The 2013 AMA strategic plan includes a focus on shaping payment and delivery models to enhance physician satisfaction. As a first step in this endeavor, the AMA collaborated with RAND Corporation to conduct in-depth field research on delivery and payment models. Thirty physician practices across six states were surveyed to provide quantitative analysis on a diverse group of physician practices. The research is aimed at better understanding which payment models promote satisfaction and sustainability in different practice settings, and to identify critical factors of success. Findings from this effort were released in October 2013 and can be found online at www.rand.org/pubs/research_reports/RR439.html.

AMA Innovators Committee

In June 2011, the AMA formed the Innovators Committee, an advisory group of physicians with hands-on experience in the development and management of innovative delivery and payment models. The committee members' experience guides the development of AMA resources to help physicians enact innovations that improve patient care and increase their professional satisfaction and success. The committee is charged with developing resources and guidance that will help local physicians from various specialties assume leadership roles in the development and diffusion of new delivery and payment models.

In July 2012, the Innovators Committee released a whitepaper entitled "Physician Payment Reform: Early Innovators Share What They Have Learned." The whitepaper highlights new payment models that are focused on incentivizing the provision of team-based care and how to ensure that payments are appropriate. The whitepaper includes a discussion of episode-based bundles and global payment bundles. The main message from the whitepaper is that accurate episode definitions with well-defined start and end points that clearly delineate each clinician's role will be critical to ensure appropriate payment. Developing such models will require physician leadership and partnerships with other stakeholders, including providers and payers, in the design and periodic maintenance of these models.

In November 2012, the Innovators Committee launched a series of free educational webinars to provide practical information to AMA member physicians on specific aspects of new delivery and payment models. The archived webinars that focus on new payment models include "Here it comes … Delivery reform, payment reform and everything in between," "Delivery reform implemented? Payment models that reward your performance" and "Building new payment models and getting

paid." The culminating webinar in the series is "The final piece of the puzzle: Customizing the payment model to fit your practice." This final webinar explains how to move from delivering value to building the infrastructure and establishing the partnerships that will enable physician practices to design and implement a sustainable payment model. To access these webinars, visit http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/shaping-delivery-and-payment-models/payment-model-resources/payment-and-delivery-reform-webinars.page

RELEVANT AMA POLICY

Our AMA will 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. Our AMA will also continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives (D-385.963[4, 5]). In addition, our AMA advocates that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members (H-160.912[6]). In adopting principles to guide physician leaders of health care teams, our AMA advocates that the physician team leader facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation (H-160.912 [4, j]). Importantly, our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers (Policy H-160.912 [5]).

DISCUSSION

Policy D-160.936, established by the joint Council on Medical Education and Council on Medical Service Report from the 2012 Interim Meeting, "The Structure and Function of Interprofessional Health Care Teams," asked the AMA to study innovative payment mechanisms that appropriately compensate the physician and/or team for team-based health care. In developing this report, the literature repeatedly stated that new payment models need to be developed for team-based care. However, the Council notes that innovative payment mechanisms can be found in various practice settings and replicated in a team-based physician practice of any size. The Council is encouraged that health plans may be seeking physician innovation to develop meaningful physician-led team-based models in all types of practices. In such innovative models, physician leaders will have the responsibility and opportunity to design payment models that best promote the goals of the team.

It is important that as the physician team leader of a practice, the physician holds the authority to administer the revenue generated by services provided to patients. The Council believes that team-based physician leaders should receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster team-based care.

For physician-led practices, the Council believes that it is up to the physician leader to decide how to distribute the payment from the health insurer among team members for the services provided. One method is to pay each professional team member according to an agreed upon salary reflective of geographic norms. Alternatively, physician practices can be innovative in developing an evaluation process and payment model that works best for their practices. For example, the Council suggests that evaluations could include team members' contributions, such as the volume and intensity of services provided, the profession of the team member, the training and experience of the physician team member, and the quality of care provided. In this situation, the physician leader

of the practice should be responsible for reviewing each team member's performance regarding the agreed upon elements and can then distribute payments received accordingly.

The Council strongly believes that the payment models for team-based care should be determined by individual physician practices working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. Physician practices that are considered team-based innovators should be able to design and build hybrid payment models that include the right mix of bundles, care management fees and/or fee-for-service. The Council suggests that an effective payment system for team-based care should: reflect the value provided by the team and that any savings accrued by this value should be shared by the team; reflect the time, effort and intellectual capital provided by individual team members; be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and be sufficient to sustain the team over the time frame that it is needed.

Finally, the Council recommends rescinding Policy D-160.936, which asked the AMA to study innovative payment mechanisms that appropriately compensate the physician and/or team for team-based health care. This report accomplishes the request for study.

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 advocate that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care. (New HOD Policy)

2. That our AMA advocate that physicians make decisions about payment disbursement in consideration of team member contributions, including but not limited to:
   a. Volume of services provided;
   b. Intensity of services provided;
   c. Profession of the team member;
   d. Training and experience of the team member; and
   e. Quality of care provided. (New HOD Policy)

3. That our AMA advocate that an effective payment system for physician-led team-based care should:
   a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team;
   b. Reflect the time, effort and intellectual capital provided by individual team members;
   c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and
   d. Be sufficient to sustain the team over the time frame that it is needed. (New HOD Policy)

4. That our AMA rescind Policy D-160.936, which asked the AMA to study innovative payment mechanisms that appropriately compensate the physician and/or team for team-based health care with a report back to the House of Delegates. (Rescind HOD Policy)

5. That our AMA advocate that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. (New HOD Policy)

6. That our AMA develop educational programs to assist members wishing to develop and implement physician-led team-based care payment methodologies at the individual team, practice, accountable care organization, hospital and health system levels. (Directive to Take Action)

7. That our AMA report back to the House on issues, developments and AMA activity on "Payment Mechanisms for Physician-Led Team-Based Care" by the I-15 meeting.

Fiscal Note: Less than $500 to implement.

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