REPORT OF THE ORGANIZED MEDICAL STAFF SECTION
GOVERNING COUNCIL

OMSS GC Report B
(I-24)

Subject: Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure
(OMSS Resolution 10-A-23)

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Referred to: OMSS Reference Committee
(, MD, Chair)

INTRODUCTION

At its 2023 Annual Meeting, the OMSS Assembly referred Resolution 10-A-23, Managing Conflict of Interest Inherent in New Payment Models—Patient Disclosure, for report. The resolution asked the AMA to:

> Seek legislation requiring complete disclosure of potential conflicts of interest by:
> a. All insurance plans: Medicare (Medicare Advantage), Medicaid, and commercial insurers;
> b. Employers of physicians (for example, accountable care organizations in the Medicare Shared Savings Program);
> c. Pharmacy benefit managers;
>
> Advocate that disclosure of potential conflicts of interest are to be written in plain language and detail the following:
> a. The type of physician incentive arrangement, whether withhold, bonus, or capitation;
> b. The percentage of the withhold or bonus as the intensity of the incentives clearly effect the extent of the physician's conflict of interest;
> c. The amount and type of stop-loss protection;
> d. A breakdown of capitation payments by the percentages for primary care, specialty care, hospital care, or other services;
> e. Whether physicians are at significant risk for services not personally provided by them;
> f. The possibility of a reduction in care that has a positive expected benefit but is not deemed cost-effective;
> g. Disclosure of "shared" savings that may be earned by the individual physician from limiting patient options, access to specialist referrals, diagnostic tests and treatment;

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DISCUSSION

Resolution 10-A-23 seeks to expand and codify specific conditions around physician payment or reimbursement that should be automatically disclosed to patients. The resolution argues that exacting and specific disclosures are a key component of the social compact between physicians and society at large, such that patients can have some assurances that the care they are being prescribed are not unduly influenced by physicians' financial obligations or contractual arrangements. The resolution posits that this concern is particularly relevant given the rise of value-based care payment systems, which task physicians not only with being care providers, but also with being cost managers.

Anecdotal evidence provides for this argument. Physicians who were interviewed or otherwise contacted for this report recounted having been pushed out of value-based contracts when their practices account for greater spending while lower-spending physicians did not seem to have the same risks. They questioned if they were being disincentivized from treating sicker patients or having a riskier patient mix. A structure that financially rewards physicians who "cost" less could easily create a disincentive for expensive, but required, treatment. Likewise, a physician who sees a greater number of costly patients could find herself losing out on reimbursements.

Physicians we spoke to also recounted firsthand experiences of pressure to cut medication costs even to the extent of changing patient prescriptions or treatment options. The threat of outcome scores having a negative impact on physicians' ratings was specifically cited. In these cases, physicians admitted to altering treatment plans or making other changes without necessarily fully informing patients of the financial risks to the physicians' own practices.

Given these anecdotal data and the lack of objective data due to the subject matter, it is reasonable to conclude that performance measurements based on narrow quantitative criteria alone and without a qualitative component have had unintended consequences, such as "measure fixation," "tunnel vision," and "physician myopia," to name a few. Applying the same quality standards to all patients may lead to under or overtreatment, as not all patients have the same needs.

A key barrier to addressing these concerns is that greater exposure to incentive and disincentive structures may fail to cure the problem. Sunshine laws and other regulations that require disclosure are a patchwork, making compliance potentially time-consuming and difficult as well as creating different standards of disclosure throughout the country. The federal Physicians Payment Sunshine Act, for example, dates to 2010 but pertains mostly to financial relationships between physicians and life sciences companies, excluding relationships that do not directly involve the use or prescribing of those companies' products. Individual states have additional reporting requirements, which can make compliance tricky for larger health systems or for practices that may have operations across state lines.

Another key problem is that transparency's effects are limited. Limited studies have not shown that exposing patients to greater transparency about their healthcare costs has had a significant effect on lowering those costs. The Congressional Budget Office estimated that adopting price transparency strategies alone was only associated with a minimal reduction of prices, between 0.1 percent and 1 percent of price. Transparency can also have unintended consequences; the rise of vaccine skepticism demonstrates how greater access to information without understanding context can backfire and compound problems.

It is not enough, however, to say that greater transparency efforts simply don't work and abandon efforts to ensure equity is achieved. Even if patients are not themselves particularly inclined to pay

attention to the incentives of their physician's practice, physicians' ethical code of conduct should still require that physicians make certain disclosures as they are tasked with acting in the best interests of their patients.

CONCLUSION

Physicians and hospitals have always been tasked with managing the tension between delivering the highest standard of care to patients and the costs associated with that care. While patient health and safety are rightfully given the greatest weight in such calculations, physicians ideally are to be mindful of cost while not being boxed in by it.

Likewise, detailed but understandable descriptions of the incentives and disincentives placed on physicians and their possible effects on treatment should be readily available to patients so that patients can make informed decisions, but also so they can better understand why physicians may opt for some care decisions over others.

As such, the key question is not whether such disclosures should be available, it is who should be responsible for maintaining and disseminating them. Given that such incentives and disclosures are administrative actions, your Governing Council believes the best solution is to make them readily available and place the responsibility for producing them on the payors and facilities that utilize them.

RECOMMENDATION

The OMSS Governing Council recommends that the following be adopted in lieu of Resolution 10-A-23, and that the remainder of this report be filed:

1. That the AMA advocate for legislation at the state and federal level requiring complete disclosure of potential conflicts of interest, including financial incentives and disincentives, by insurers, facilities that employ physicians, and pharmacy benefit managers.

2. That the AMA update its Code of Medical Ethics to include guidance on disclosure of conflicts of interest related to financial incentives and disincentives in treatment to be borne by healthcare facilities, employers, and payors. Disclosures should be written in plain language and include the following details:
    a. The type of physician incentive arrangement, whether withhold, bonus, or capitation;
    b. The percentage of the withhold or bonus as the intensity of the incentives clearly effect the extent of the physician's conflict of interest;
    c. The amount and type of stop-loss protection;
    d. A breakdown of capitation payments by the percentages for primary care, specialty care, hospital care, or other services;
    e. Whether physicians are at significant risk for services not personally provided by them;
    f. The possibility of a reduction in care that has a positive expected benefit but is not deemed cost-effective;
    g. Disclosure of "shared" savings that may be earned by the individual physician from limiting patient options, access to specialist referrals, diagnostic tests and treatment;