

REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-13)  
Delivery Reform  
(Reference Committee A)

EXECUTIVE SUMMARY

Physicians, federal and state governments, health plans and other health care stakeholders are engaging in unprecedented efforts to transform how health care is delivered in this country. One of the core areas of focus of the American Medical Association's (AMA) five-year strategic plan is shaping payment and delivery reform models in ways that enhance physician satisfaction and practice sustainability.

The Council reviewed the body of AMA policy pertaining to the following key issues of delivery reform:

- care coordination and transitions;
- data and health information technology infrastructure; and
- quality and performance assessment and improvement.

In its review, the Council identified several policy gaps and ways to update existing policies to guide AMA advocacy in the evolving health care delivery environment. The report concludes by making seven recommendations that include additions, modifications and rescissions to AMA policy in order to strengthen AMA policy related to delivery reform.

# REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-13

Subject: Delivery Reform

Presented by: Donna E. Sweet, MD, Chair

Referred to: Reference Committee A  
(Jerry L. Halverson, MD, Chair)

---

1 Innovations in health care delivery and payment with the goals of improving care coordination and  
2 quality while reducing the rate of growth in health care spending are now occurring in both the  
3 private sector as well as within the government programs of Medicare and Medicaid. States,  
4 physicians, health plans and other health care stakeholders are engaging in efforts to transform how  
5 health care is delivered in this country. One of the core areas of focus of the American Medical  
6 Association's (AMA) five-year strategic plan is enhancing physician satisfaction and practice  
7 sustainability by shaping payment and delivery reform models. The Council has reviewed the body  
8 of AMA policy pertaining to delivery reform and believes it is important to remove inconsistencies  
9 and close gaps in AMA policy, which guides AMA advocacy efforts.

10  
11 Consistent with the focus on delivery reform, this report provides background on delivery reform,  
12 and highlights key issues for physicians and patients in delivery reform: care coordination and  
13 transitions, data and health information technology infrastructure, and quality and performance  
14 assessment and improvement. This report also outlines and analyzes relevant AMA policy, and  
15 presents policy recommendations.

## 16 17 BACKGROUND

18  
19 The health care delivery system is undergoing changes to be more effective and efficient, provide  
20 better health outcomes and population health, improve quality and patient safety, and slow the  
21 growth in health care spending. The integration of physicians and health care delivery systems and  
22 the transformation of physician practices into patient-centered medical homes are examples. It has  
23 also become more common for physicians to enter into employment relationships with hospitals,  
24 group practices, and other health care organizations and delivery systems. The federal government  
25 began moving in this direction through demonstration projects authorized in a variety of bipartisan  
26 pieces of legislation, beginning in 2000 with the Medicare, Medicaid, and SCHIP Benefits  
27 Improvement and Protection Act, which authorized the Physician Group Practice Demonstration;  
28 the Medicare Modernization Act of 2003, which authorized the Acute Care Episode Bundled  
29 Payment Demonstration; and the Deficit Reduction Act of 2005, which authorized a gainsharing  
30 demonstration. Building on those efforts, two major federal laws—the American Recovery and  
31 Reinvestment Act (ARRA) of 2009 and the Patient Protection and Affordable Care Act (ACA) of  
32 2010—made significant investments in health care delivery reform, and offer new opportunities for  
33 physicians to take part in new delivery models.

34  
35 The ARRA provided significant financial incentives for physicians and other health care providers  
36 to adopt health information technology (HIT). Specifically, the ARRA provided approximately \$19  
37 billion for HIT, \$17 billion of which is for Medicare and Medicaid incentive programs. The ARRA

1 also charged the Office of the National Coordinator for Health Information Technology within the  
2 US Department of Health and Human Services (HHS) to promote the development of a nationwide  
3 interoperable HIT infrastructure. The ARRA provided \$2 billion to help advance the creation and  
4 expansion of health information exchange (HIE) infrastructure and services. The ARRA also  
5 contained provisions for financial incentives through the Medicare program to encourage eligible  
6 physicians and hospitals to adopt and use certified electronic health records (EHRs) in a  
7 meaningful way. Similar incentives were provided for in the ARRA under the Medicaid program  
8 for physicians, hospitals and other providers. Physicians cannot take advantage of the incentive  
9 payment programs under both the Medicare and Medicaid programs. Physicians who do not  
10 meaningfully use a certified HIT system face reductions in their Medicare fee schedule starting in  
11 2015. The AMA has repeatedly raised the concerns of physicians regarding the imposition of  
12 penalties associated with the Medicare meaningful use EHR program and has offered  
13 recommendations for improving the program.

14  
15 The ACA included a variety of provisions to test, implement and support voluntary health care  
16 delivery reforms as a complement to its provisions to expand health insurance coverage and  
17 improve access to care. Notably, the ACA authorized \$10 billion over 10 years to develop and  
18 implement both delivery system and payment reforms through the Center for Medicare & Medicaid  
19 Innovation (CMMI), which is housed within the Centers for Medicare & Medicaid Services.  
20 Additional provisions of the ACA that relate to delivery reform include:

- 21
- 22 • Implementing Accountable Care Organizations (ACOs);
- 23 • Developing primary care practices into medical homes;
- 24 • Identifying, updating, and expanding quality measures as well as the development of the  
25 National Strategy for Health Care Quality;
- 26 • Testing models for improving care transitions from the hospital to other settings;
- 27 • Patient-centered outcomes research (comparative effectiveness research); and
- 28 • Grants to support community-based collaborative care networks, which are consortia of  
29 health care providers with a joint governance structure that provides comprehensive  
30 coordinated and integrated health care services for low-income populations.
- 31

32 Innovative delivery and payment reforms are also currently underway in the private sector and  
33 within state Medicaid programs. State Medicaid programs have been and will continue to be  
34 laboratories for innovation and will continue to play a key role in establishing innovative delivery  
35 and payment models across the country. For example, in Arkansas, the Payment Improvement  
36 Initiative was established, which is a multi-payer, system-wide initiative aimed at improving the  
37 quality of care provided to patients while reducing overall costs. For the state's Medicaid program,  
38 the initiative includes an episode-based care payment model as well as care coordination through  
39 medical homes and health homes.<sup>1</sup> Massachusetts is also tackling Medicaid delivery and payment  
40 reform, including having its Office of Medicaid develop alternative payment methodologies,  
41 including, but not limited to, bundled payments, global payments and shared savings.<sup>2</sup> In Oregon,  
42 legislation was enacted to create Coordinated Care Organizations (CCOs) within Oregon's Health  
43 Plan (OHP). As outlined in the law, CCOs are local health care partnerships that govern and  
44 administer the care provided to OHP members, including dual eligibles, within their community.  
45 Each CCO has its own budget that grows at a fixed rate and each CCO is accountable for the health  
46 outcomes of the members it serves, including physical and mental health.<sup>3</sup>

47  
48 In the private sector, CareFirst BlueCross Blue Shield (MD, VA, DC) launched a patient-centered  
49 medical home program in 2011. The program provides additional fee-based compensation to  
50 primary care physicians who volunteer to carry out the program objectives. The program requires

1 that the primary care physicians only have internet access and does not have any special systems or  
 2 operating requirements that involve hardware, software, or staff upgrade costs.<sup>4</sup> Also, under the  
 3 DIAMOND Initiative organized by the Institute for Clinical Systems Improvement in Minnesota in  
 4 2008, psychiatrists agree to be paid for consulting with primary care practices on the best way to  
 5 manage patients with depression, which has resulted in dramatic improvements in patient  
 6 outcomes. The program uses care managers and health care teams to assess condition severity,  
 7 monitor care through a computerized registry, provide relapse and exacerbation prevention,  
 8 intensify or change treatment as warranted, and transition beneficiaries to self-management.<sup>5</sup>  
 9

10 KEY ISSUES IN DELIVERY REFORM

11  
 12 As delivery reforms continue to be tested and implemented, several issues will be critical to  
 13 physicians and their patients. All health care stakeholders have been involved and have key roles in  
 14 testing and implementing delivery system reforms and innovations, including federal, state, and  
 15 local governments; public and private insurers; health care delivery organizations; health insurance  
 16 exchanges; physicians and other health care professionals; employers and patients.  
 17

18 *Care Coordination and Transitions*

19  
 20 One of the main aims of delivery reform is to deliver the right care in the right place at the right  
 21 time. Part of this aim has been to refocus the delivery system toward preventive and primary care,  
 22 and prioritizing the management of chronic disease. However, these efforts cannot occur without  
 23 advances in care coordination and transitions, without which care can be fragmented, leading to  
 24 patients possibly receiving care too late or care that is duplicative or unnecessary. With the  
 25 development and implementation of new payment and delivery models, many of which have  
 26 received funding from CMMI, there has been increased incentive to coordinate care across an  
 27 episode of care, or groups of episodes of care, in addition to coordinating care around defined  
 28 conditions. The term “episode of care” refers to a defined period of care during which a patient’s  
 29 illness or condition is present and is being managed, including the diagnosis and treatment stages.  
 30 For an acute condition, the episode of care includes all services a patient receives for the condition  
 31 from the time at which the patient is first evaluated to the completion of care for the condition.  
 32 Episodes of care for chronic conditions are typically either a calendar year or the fiscal year of the  
 33 respective patient’s health plan, as these conditions do not have a finite end.<sup>6</sup>  
 34

35 In addition, there are improvements to be made in patient transitions between care settings for  
 36 patients who receive care from multiple physicians and other health professionals practicing in  
 37 different care settings. Ineffective care transition processes can jeopardize patient safety, as well as  
 38 lead to poorer health outcomes. Poor care transition processes have contributed to medication  
 39 errors, duplicative or unnecessary care, higher rates of hospital readmissions, and other healthcare-  
 40 associated conditions.<sup>7</sup> While a primary focus on improving care transitions has been on the  
 41 experience following hospital discharge, challenges in transitions of care to less traditional health  
 42 care settings have been cited, including those involving long-term care, mental health and  
 43 substance abuse care facilities.  
 44

45 Improving care coordination and transitions has focused on how to structure delivery systems to  
 46 accommodate new payment models, encourage provider-provider communication, maximize  
 47 practice efficiency and effectiveness, and support the patient-physician relationship. Organizational  
 48 structures will need to vary based on practice sizes and specialties, geographic location, and patient  
 49 characteristics. Health care stakeholders have several options to consider in structuring health care  
 50 delivery systems to improve care coordination and transitions, as well as health outcomes,  
 51 including:

- 1 • Integrated physician-led groups, with an employed staff;
- 2 • Independent physician associations and physician networks;
- 3 • Physician-hospital organizations;
- 4 • Accountable Care Organizations; and
- 5 • Patient-centered medical homes that include virtually integrated small practices.

6  
7 Analysis of Relevant AMA Policies

8  
9 AMA Policy H-425.997 encourages the development of policies and mechanisms to assure the  
10 continuity, coordination and continuous availability of patient care. AMA policy also recognizes  
11 the need to improve transitions of care (Policies D-160.944, H-160.942 and D-160.945). There are  
12 also numerous policies addressing the need to manage chronic disease (e.g., Policies H-285.944,  
13 H-160.938, D-155.995, D-450.968, D-285.976 and H-425.972). Policy H-160.943 supports care  
14 being coordinated around defined conditions, diseases and organ systems.

15  
16 Defining physician roles in coordinating care, Policy H-160.951 states that a patient's access to  
17 primary and principal care services provided by a physician is not limited by the specialty or  
18 subspecialty designation of the physician, but should be determined by the training, competence,  
19 and experience of the physician to provide primary or principal care services. Policy H-160.952  
20 encourages primary care and other medical specialty organizations to collaborate in developing  
21 guidelines to delineate the clinical circumstances under which treatment by primary care  
22 physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other  
23 specialists are appropriate, timely and cost-effective. Several AMA policies address scope of  
24 practice issues, which delineate the AMA's strong support of the physician-led team approach to  
25 patient care, with each member of the team playing a clearly defined role in patient care, as  
26 determined by his or her education and training (e.g., Policies D-35.985 and H-160.912).

27  
28 AMA policy addresses the various options for structuring health care delivery systems and how  
29 such structures must support various physician payment reforms. To support the operation of health  
30 care delivery systems, and ensure care coordination and transitions, Policy H-285.954 outlines  
31 physician responsibilities for decision-making in health care systems. Other policies provide  
32 principles for specific organizational structures such as ACOs (Policy H-160.915), patient-centered  
33 medical homes (Policy H-160.919); physician involvement in health plans and integrated delivery  
34 systems (Policy H-285.931), and physician employment (Policy H-225.950). Several policies  
35 support antitrust reform, which would allow certain organizational structures to more effectively  
36 operate (Policies H-383.992, H-383.990, H-380.987, H-385.976, H-385.973, H-165.833 and  
37 H-160.915). A more overarching policy outlining principles for Medicare physician payment  
38 reforms, Policy H-390.849, includes a set of 11 principles to guide the development, adoption and  
39 implementation of physician payment reforms. While initially drafted for the Medicare program,  
40 these principles have provided the AMA with a sound foundation on which to base its advocacy  
41 efforts directed at both private and public payer payment reforms. The Council believes that simple  
42 amendments to the policy can ensure that it is more directly applicable to private health plans, as  
43 well as other public health plans including Medicaid, and can be used in the assessment of any  
44 innovative payment reform moving forward.

45  
46 *Data and Health Information Technology Infrastructure*

47  
48 The success of health care delivery reforms is contingent upon a strong data and HIT infrastructure,  
49 which entails the full continuum from developing a strong clinical evidence base to delivering  
50 clinical research results at the point of care, to using relevant clinical data for quality assessment  
51 and performance improvement activities. A strong clinical evidence base requires not only the

1 collection and analysis of de-identified patient data, but also investment in comparative  
 2 effectiveness research.

3  
 4 Clinical and financial data can be used to improve outcomes and population health, the health care  
 5 delivery system and quality of care. At the practice level, clinical data can be used by physicians to  
 6 monitor and manage care, analyze their patient populations and identify areas for improvement.  
 7 The analysis of clinical data may point to ways in which care may be delivered more efficiently  
 8 and effectively. Clinical data, along with research findings and practice guidelines, can be  
 9 aggregated and organized in several ways, including their incorporation into clinical and  
 10 administrative databases, usable clinical registries, and health information exchanges. The Council  
 11 notes that once organized, data should be interconnected through technology tools, such as  
 12 interoperable EHRs or cloud-based data sharing systems that foster computerized physician order  
 13 entry (CPOE) and other decision support capabilities.

14  
 15 HIT interoperability is essential to deliver coordinated care, impact care delivery and improve care  
 16 transitions. Individuals and systems must have the capacity to communicate with each other, share  
 17 clinically relevant data and information, and report risk-stratified outcomes and resource  
 18 utilization. The Congressional Budget Office estimates that as a result of the ARRA, roughly 90  
 19 percent of physicians and 70 percent of hospitals will adopt HIT by 2019.<sup>8</sup> As of the drafting of this  
 20 report, roughly 40 percent of physicians and 44 percent of hospitals are using at least a “basic”  
 21 EHR.<sup>9,10</sup> While physicians and hospitals are increasingly adopting HIT resulting from the ARRA  
 22 incentives, HIT interoperability remains in the nascent stages. In fact, many HIT systems being  
 23 adopted are not interoperable, and many physicians and other health care providers have cited  
 24 usability concerns. Efforts to enable HIT interoperability are ongoing, including in the areas of  
 25 identity authorization, consent management, data validation, and privacy and security issues. In  
 26 addition, improvements need to be made to HIT, including EHRs, to ensure patient safety and  
 27 minimize medical errors resulting from EHR design and software flaws.

28  
 29 In order to promote the interoperability of the HIT infrastructure, there is increasing support for the  
 30 creation and development of health insurance exchanges (HIEs), which “bring together health care  
 31 stakeholders within a defined geographic area and govern HIEs among them for the purpose of  
 32 improving health and care in that community; the entity that provides services enabling the  
 33 electronic sharing of health information.”<sup>11</sup> HIEs can be either private or public organizations that  
 34 connect physicians and other participating providers and facilitate the transmission and exchange  
 35 of electronic clinical information from EHRs.

36  
 37 Analysis of Relevant AMA Policies

38  
 39 Policy H-450.938 states that physicians should have easy access to and consider the best available  
 40 evidence at the point of decision-making, to ensure that the chosen intervention is maximally  
 41 effective in reducing morbidity and mortality. To do so, the policy states that physicians should  
 42 seek opportunities to improve their HIT infrastructures to include new and innovative technologies  
 43 to facilitate increased access to needed and useable evidence and information at the point of  
 44 decision-making. Several policies address the need to implement an interoperable HIT  
 45 infrastructure, including H-478.992 and D-478.996. Policy D-478.996 also supports the  
 46 development, adoption and implementation of HIT standards, overlapping the primary focus area  
 47 of Policy H-478.995. However, Policy H-478.995 also stipulates that the development, adoption  
 48 and implementation of HIT standards should be consistent with “current efforts to set health  
 49 information technology standards for use by the federal government.” As the policy was drafted  
 50 before the enactment of ARRA, as well as the development of the stages and requirements for  
 51 meaningful use of EHRs, the Council believes that it is a strong candidate for rescission.

1 Policies H-480.971, H-315.973 and H-478.981 address the privacy, security and appropriate use of  
2 information within EHRs, as well as the secure exchange of data between EHR and other HIT  
3 systems. As also outlined in Board of Trustees Report 17, Data Ownership and Access to Clinical  
4 Data in Health Information Exchanges, being considered at this meeting, there is a considerable  
5 body of AMA policy that addresses the access and use of clinical data—key issues in ensuring the  
6 protection of data from any potential source, including HIEs (Policies H-315.973, H-315.974,  
7 H-315.983, H-406.991). At this early stage of HIE development and implementation, with HIEs  
8 varying widely in terms of structures, capabilities and services, the Council believes there is a need  
9 for additional AMA policy addressing the basic and foundational priorities of physicians  
10 concerning HIE establishment, including governance, cost, and mandatory versus voluntary  
11 participation.  
12

13 Concerning clinical decision support systems and CPOE, Policy D-478.995 advocates for  
14 continued research and physician education on CPOE user interface design, and on CPOE and  
15 clinical decision support systems and vendor accountability for the efficacy, effectiveness, and  
16 safety of these systems. Policy H-435.944 supports legislation that would create a “safe harbor” for  
17 physicians who use a consensus-based drug-drug interaction list in their clinical decision support  
18 software package. Policy H-450.935 states that any practice guidelines, parameters, best practices  
19 models, or similar set of principles or clinical recommendations, including those that result from  
20 any CER, do not establish standard of care or create specific requirements for physicians that  
21 restrict the exercise of their clinical judgment.  
22

### 23 *Quality and Performance Assessment and Improvement*

24

25 A key focus of delivery system reform has been to incorporate quality and performance assessment  
26 and improvement. In particular, a variety of delivery reform efforts attempt to coordinate care  
27 around defined conditions, episodes of care, or groups of episodes of care and have therefore  
28 sought to refocus quality assessment and performance improvement efforts on these models.  
29

30 There are currently several sources of measures to use in the evolving quality assessment and  
31 performance improvement infrastructure, including:  
32

- 33 • The AMA-convened Physician Consortium for Performance Improvement (PCPI);
- 34 • The National Quality Forum;
- 35 • Specialty societies that own and/or operate clinical registries;
- 36 • The National Committee for Quality Assurance, which owns the Healthcare Effectiveness  
37 Data and Information Set (HEDIS);
- 38 • The Joint Commission; and
- 39 • Several Medicare initiatives including the EHR incentive program and the Physician  
40 Quality Reporting System (PQRS).  
41

42 Defined outcomes and composite measures targeted for episodes of care or team-based care will be  
43 needed as delivery reform evolves. The Council notes that the timely development of defined  
44 outcomes and composite measures requires committed public and private sector funding. These  
45 measures must involve physician experts, and include the development of appropriate risk-  
46 adjustment and attribution methodologies. Performance benchmarks will also need to have the  
47 capacity to be applied across providers and settings.  
48

49 The Council believes that a key challenge in measuring performance for coordinating care will be  
50 how to attribute performance and outcomes, particularly when a team of health care professionals

1 is involved in delivering care. Therefore, new delivery system organizational structures will need to  
2 have the capacity to reliably assign and measure the accountability of care among providers and  
3 specify clear lines of attribution.

4  
5 Analysis of Relevant AMA Policies

6  
7 Policy H-450.975 defines quality of care as the degree to which care services influence the  
8 probability of optimal patient outcomes. Many policies state that the AMA will be actively  
9 involved in private and public sector efforts to evaluate and enhance quality of care (H-450.946,  
10 H-450.941, H-450.939 and D-450.978). Specifically, Policies H-450.939, D-450.978 and  
11 D-450.983 support the role of the PCPI as the measure developer for physician-level performance  
12 improvement.

13  
14 Policy H-410.960 encourages all physicians to be open to the development and broader utilization  
15 of evidence-based quality improvement guidelines and indicators for measurement of quality  
16 practice. Policy D-450.988 outlines continued AMA support for the appropriate use of evidence-  
17 based clinical performance measures. Policy H-450.966 advocates principles to be used to guide  
18 the development and evaluation of quality and performance standards and measures under federal  
19 and state health system reform efforts, but does not reflect the current lack of outcomes and  
20 composite measures available for episodes of care, as well as team-based care. In addition, the  
21 policy does not reflect the need to establish performance benchmarks across settings and providers,  
22 to ensure that performance measures have valid comparators, and that performance scores are  
23 objective.

24  
25 Regarding attribution, Policy H.390.849 states that Medicare physician payment reforms should  
26 have attribution processes that emphasize voluntary agreements between patients and physicians,  
27 minimize the use of algorithms or formulas, provide attribution information to physicians in a  
28 timely manner, and include formal mechanisms to allow physicians to verify and correct attribution  
29 data as necessary. Policy H-160.915 supports the inclusion of an appropriate attribution  
30 methodology as part of an ACO quality reporting program. Policy H-406.991 states that the data  
31 and methodologies used in profiling physicians, including the use of representative and statistically  
32 valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid  
33 attribution rules produce verifiably accurate results that reflect the quality and cost of care provided  
34 by the physicians. However, full implementation of policies calling for the use of accurate and  
35 valid risk adjustment methodologies, including H-406.991 and H-390.849, cannot occur without  
36 additional financial resources being directed toward the validation of statistical models used for  
37 risk adjustment.

38  
39 **AMA ACTIVITY**

40  
41 The AMA has been actively engaged with the Administration, Congress, state governments, and  
42 other key stakeholders, such as private payers, patient organizations, business coalitions, hospitals  
43 and multi-stakeholder collaboratives, in advocating delivery reforms and has developed resources  
44 for its membership. As outlined in the appendix to this report, resources developed for AMA  
45 members include issue briefs, model state legislation, and documents providing answers to  
46 frequently asked questions. Concerning the implementation of provisions of the ACA related to  
47 delivery reform, the AMA submitted comments on a range of issues, including ACOs,  
48 administrative simplification, HIT and EHR incentives and penalties, comparative effectiveness  
49 research, and the National Health Care Quality Strategy and Plan. Additional examples of AMA  
50 activities related to delivery reform are outlined in the appendix of this report.



1 In addition, in 2011, the AMA, partnered with a small group of state and specialty medical  
2 societies to form the Innovators Committee, an advisory group of physicians with hands-on  
3 experience in the development and management of innovative delivery and payment models. The  
4 Innovators Committee has begun to develop a series of resources offering practical guidance to  
5 physicians on how to implement delivery reforms, which are outlined in the appendix in more  
6 detail.

7  
8 Ongoing AMA activities on delivery reform support one of the core areas of focus of the AMA  
9 five-year strategic plan: enhancing physician satisfaction and practice sustainability by shaping  
10 delivery and payment models. With respect to delivery reform specifically, a main objective is to  
11 develop best practices for delivery that improve outcomes and health, increase productivity,  
12 improve patient safety and achieve cost savings. As a first step, the AMA, in collaboration with the  
13 RAND Corporation, is conducting in-depth field research, sampling approximately 30 physician  
14 practices in the coming months. Also, the AMA will carry out quantitative research with a diverse  
15 group of physician practices. As of the drafting of this report, initial findings from this effort were  
16 expected to be published in the summer or fall of 2013, which could be used as part of AMA  
17 advocacy efforts to make key changes in the regulatory process.

## 18 19 DISCUSSION

20  
21 Within the body of AMA policy pertaining to the key issues in delivery reform—care coordination  
22 and transitions, data and health information technology infrastructure, and quality and performance  
23 assessment and improvement—the Council has identified several policy gaps and ways to update  
24 existing policies to guide AMA advocacy in the evolving health care delivery environment.  
25 Carrying out the intent of Policy G-600.111, which recommends rescinding outmoded or  
26 duplicative policies, combining policies that relate to the same topic, or modifying policy to update  
27 it, the Council believes that the following additions, modifications and rescissions to AMA policy  
28 would strengthen AMA policy related to delivery reform.

- 29  
30 1. Policy H-390.849 should be modified to ensure it is applicable to the payment reforms of  
31 all payers, rather than solely Medicare. Originally drafted to guide the development,  
32 adoption and implementation of Medicare physician payment reforms, the principles  
33 outlined in H-390.849 have provided the AMA with a sound foundation on which to base  
34 its advocacy efforts directed at both private and public payer payment reforms. As such,  
35 the proposed amendment makes the policy directly applicable to and useful in evaluating  
36 payment reforms of all payers.  
37
- 38 2. Policy H-478.995, which advocates for the development, adoption and implementation of  
39 HIT standards consistent with current efforts to set health information technology  
40 standards for use by the federal government, should be rescinded. The basic premise of the  
41 Policy H-478.995, to advocate for the development, adoption and implementation of HIT  
42 standards, is also addressed as a main focus area of Policy D-478.996. In addition, the  
43 language of the policy stating that the AMA advocates for the development of HIT  
44 standards consistent with “current efforts to set health information technology standards for  
45 use by the federal government,” can be read to implicitly endorse any “current” effort to set  
46 health information technology standards for use by the federal government, including the  
47 stages and requirements proposed by the federal government for meaningful use.  
48
- 49 3. There is a need for new policy to support physician and patient representation on HIE  
50 governance structures, to ensure that their interests are embodied in HIE decision-making  
51 processes.

- 1 4. There is a need for policy that indicates that physician participation in HIEs should be  
2 voluntary and not mandatory as efforts move forward by states, localities, health plans and  
3 other entities to establish HIEs.  
4
- 5 5. There is a need for new policy addressing the cost of physician participation in HIEs, so as  
6 not to discourage their participation or jeopardize the economic viability of their practices.  
7 Direct costs of HIE participation vary, and participation fees can be charged per  
8 transaction, monthly, annually, or a combination of transaction and subscription fees. In  
9 addition, physicians may need to upgrade their HIT systems in order to meet the system  
10 requirements of HIEs, as well as alter their workflow processes during the implementation  
11 stage.  
12
- 13 6. Policy H-450.966 should be amended to reflect the need to develop outcomes and  
14 composite measures for episodes of care, as well as team-based care. The policy also  
15 should reflect the current need to establish performance benchmarks across providers and  
16 settings. AMA policy does not currently reflect the current lack of outcomes and composite  
17 measures available for episodes of care, as well as team-based care. These measures are  
18 essential to measure the success of many delivery and payment reform efforts. In addition,  
19 policy does not reflect the need to establish performance benchmarks across settings and  
20 providers, to ensure that performance measures have valid comparators, and that  
21 performance scores are objective.  
22
- 23 7. There is a need for new policy supporting the establishment of a public-private partnership  
24 to validate statistical models used for risk adjustment. Full implementation of policies  
25 calling for the use of accurate and valid risk adjustment methodologies, including Policies  
26 H-406.991 and H-390.849, cannot occur without additional financial resources being  
27 directed toward the validation of statistical models used for risk adjustment. The  
28 establishment of a public-private partnership using existing ACA funding appropriated for  
29 risk adjustment, in addition to other congressional appropriations or private sector  
30 resources, is an essential step in ensuring that risk adjustment methodologies are verifiable,  
31 accurate, and based on current data.  
32

### 33 RECOMMENDATIONS

34  
35 The Council on Medical Service recommends that the following be adopted and the remainder of  
36 the report be filed:  
37

- 38 1. That our American Medical Association (AMA) amend Policy H-390.849[1] and its title by  
39 deletion to read as follows: “~~Medicare~~-Physician Payment Reform (1) Our AMA will advocate  
40 for the development and adoption of ~~Medicare~~-physician payment reforms that adhere to the  
41 following principles: ...” (Modify Current HOD Policy)  
42
- 43 2. That our AMA rescind Policy H-478.995. (Rescind HOD Policy)  
44
- 45 3. That our AMA support the inclusion of actively practicing physicians and patients in health  
46 information exchange governing structures. (New HOD Policy)  
47
- 48 4. That our AMA advocate that physician participation in health information exchanges should be  
49 voluntary, to support and protect physician freedom of practice. (New HOD Policy)  
50

- 1 5. That our AMA advocate that the direct and indirect costs of participating in health information  
2 exchanges should not discourage physician participation or undermine the economic viability  
3 of physician practices. (New HOD Policy)  
4
- 5 6. That our AMA amend Policy H-450.966[6] by addition and deletion to read as follows: “The  
6 AMA ... (6) advocates that the following principles be used to guide the development and  
7 evaluation of quality and performance standards and measures under federal and state health  
8 system reform efforts: (a) Standards and measures shall have demonstrated validity and  
9 reliability. (b) Standards and measures shall reflect current professional knowledge and  
10 available medical technologies. (c) Standards and measures shall be linked to health outcomes  
11 and/or access to care. (d) Standards and measures shall be representative of the range of health  
12 care services commonly provided by those being measured. (e) Standards and measures shall  
13 be representative of episodes of care, as well as team-based care. (f) Standards and measures  
14 shall account for the range of settings and practitioners involved in health care delivery. (eg)  
15 Standards and measures shall recognize the informational needs of patients and physicians. (fh)  
16 Standards and measures shall recognize variations in the local and regional health care needs of  
17 different patient populations. (gi) Standards and measures shall recognize the importance and  
18 implications of patient choice and preference. (hj) Standards and measures shall recognize and  
19 adjust for factors that are not within the direct control of those being measured. (ik) Data  
20 collection needs related to standards and measures shall not result in undue administrative  
21 burden for those being measured.” (Modify Current HOD Policy)  
22
- 23 7. That our AMA support the development of a public-private partnership for the purpose of  
24 validating statistical models used for risk adjustment. (New HOD Policy)

Fiscal Note: Less than \$500.

## References

- <sup>1</sup> Arkansas Health Care Payment Improvement Initiative Overview FAQs. Arkansas Health Care Payment Improvement Initiative. Available at: <http://www.paymentinitiative.org/referenceMaterials/Documents/FAQs%202012.09.10%20ACHPII%20OVERVIEW.pdf>.
- <sup>2</sup> Mechanic, RE, Altman, SH, McDonough, JE. The New Era of Payment Reform, Spending Targets, and Cost Containment in Massachusetts: Early Lessons for the Nation. Health Affairs. 2012; 31(10): 2334-2342. Available at: <http://content.healthaffairs.org/content/early/2012/09/17/hlthaff.2012.0338.full>.
- <sup>3</sup> Coordinated Care Organizations. Oregon Health Policy Board. Available at: <http://www.oregon.gov/oha/ohpb/pages/health-reform/ccos.aspx>.
- <sup>4</sup> Patient-Centered Medical Home Program: Program Description and Guidelines. CareFirst BlueCross BlueShield. Available at: <https://provider.carefirst.com/wcmwps/wcm/connect/52a3c780456e3cdfa7d6afed9a4bbc9e/BOK5423.pdf?MOD=AJPERES&CACHEID=52a3c780456e3cdfa7d6afed9a4bbc9e>.
- <sup>5</sup> DIAMOND for Depression. Institute for Clinical Systems Improvement. Available at: [https://www.icsi.org/health\\_initiatives/diamond\\_for\\_depression/](https://www.icsi.org/health_initiatives/diamond_for_depression/).
- <sup>6</sup> Evaluating and Negotiating Emerging Payment Options. American Medical Association Practice Management Center. Available at: <http://www.ama-assn.org/resources/doc/psa/payment-options.pdf>.
- <sup>7</sup> Report to the Congress: Medicare and the Health Care Delivery System. Medicare Payment Advisory Commission. June 2012. Available at: [http://www.medpac.gov/documents/Jun12\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun12_EntireReport.pdf).
- <sup>8</sup> Health Information Technology for Economic and Clinical Health Act: Estimate of direct spending and revenue effects for the legislation as posted on the Web site of the Committee on Ways and Means on January 16, 2009. Congressional Budget Office. Available at: <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9966/hitechrangelltr.pdf>.
- <sup>9</sup> Hsiao, C and Hing, E. Use and Characteristics of Electronic Health Record Systems Among Office-Based Physician Practices: United States, 2001–2012. National Center for Health Statistics. NCHS Data Brief No. 111, December 2012. Available at: <http://www.cdc.gov/nchs/data/databriefs/DB111.pdf>.
- <sup>10</sup> Charles, D, King, J, Patel, V, Furukawa, MF. Adoption of Electronic Health Record Systems among U.S. Non-federal Acute Care Hospitals: 2008-2012. Office of the National Coordinator for Health Information Technology. ONC Data Brief, no 9, March 2013. Available at: <http://www.healthit.gov/sites/default/files/oncdatabrief9final.pdf>.
- <sup>11</sup> Health Information Exchange (HIE) in the Era of Meaningful Use. HIMSS. Available at: [http://www.himss.org/content/files/12\\_21\\_2010\\_HIE%20OverView%20in%20HITECH.pdf](http://www.himss.org/content/files/12_21_2010_HIE%20OverView%20in%20HITECH.pdf).

Appendix  
Examples of AMA Activities and Resources Related to Delivery Reform

Overarching Activities on Delivery Reform

- In August 2011, the Innovators Committee released “Guiding Principles on Health Care Delivery and Payment Reform,” which can be found online at <http://www.ama-assn.org/resources/doc/washington/delivery-and-payment-reform-guiding-principles.pdf>. As part of this document, there are guiding principles specifically geared toward delivery reform:
  1. Coordination of care must be clearly demonstrable in the delivery of health care.
  2. Care must be centered on the patient.
  3. Quality Assessment and Performance Improvement processes must become an integral component of both delivery and coordination of care.
  4. Accountability for delivery of care for both acute and chronic conditions must be clearly defined, yet flexible enough to accommodate innovations and local differences in care delivery.
  5. The delivery system should measure, and strive to create, not only quality but also value.
  6. Function must trump form/structure.
  7. Supporting infrastructure and technology must underpin all aspects of care delivery.
  8. Delivery systems should work to eliminate disparities and to address the needs of underserved populations.
  
- In May 2012, the AMA released the whitepaper titled “The Case for Delivery Reform: Implementing Innovative Strategies in Your Practice,” which can be found online at <http://www.ama-assn.org/resources/doc/washington/delivery-reform-white-paper.pdf>. The purpose of the whitepaper was to offer practical guidance to practicing physicians to enact delivery reforms. Specifically, the whitepaper addresses improving care coordination and transitions; assessing where physicians can have the most impact; defining conditions to measure and episodes of care; performance targets and thresholds; and outreach and advocacy.
  
- In the ongoing effort to repeal the Medicare Sustainable Growth Rate (SGR) formula, the AMA and 110 specialty organizations and state medical societies have agreed to “Principles and Core Elements for Transitioning from the SGR to a High Performing Medicare Program.” These principles have been shared widely with Congress, the Administration and other key federal policymakers to inform and shape the ongoing effort to repeal the SGR. These principles state that eliminating the SGR formula is essential to developing a high performing Medicare program. In conjunction with SGR repeal, the following driving principles can provide a foundation for a transition plan that organized medicine can support:
  - Successful delivery reform is an essential foundation for transitioning to a high performing Medicare program that provides patient choice and meets the health care needs of a diverse patient population;
  - The Medicare program must invest and support physician infrastructure that provides the platform for delivery and payment reform; and
  - Medicare payment updates should reflect costs of providing services as well as efforts and progress on quality improvements and managing costs.

### Care Coordination and Transitions

- AMA advocacy resulted in a Medicare Accountable Care Organization (ACO) final rule, including Stark law waivers and antitrust guidance, which is very favorable to the formation of physician-led ACOs. As of January 2013, the Centers for Medicare & Medicaid Services (CMS) has announced a total of 220 Shared Savings Program ACOs (including 20 Advanced Payment ACOs), approximately half of which Medicare classifies as physician-led.
- AMA advocacy directly resulted in the Center for Medicare & Medicaid Innovation (CMMI) introducing the Advanced Payment ACO Initiative, designed to provide smaller ACOs with upfront capital to make infrastructure upgrades. Qualifying groups are: 1) physician-led ACOs that do not include any inpatient facilities and that have less than \$50 million in total annual revenue or 2) ACOs in rural areas that have less than \$80 million in total revenue. CMMI will recoup the advance payments through the ACO's earned shared savings in year two. There are a total of 35 Advanced Payment ACOs with April 2012, July 2012, and January 2013 start dates.
- The AMA's Advocacy Resource Center (ARC) drafted an issue brief on Medicaid delivery and payment reforms (<http://www.ama-assn.org/resources/doc/arc/medicaid-payment-delivery-models-issue-brief.pdf>) and has provided guiding principles on innovative Medicaid delivery system and payment models (<http://www.ama-assn.org/resources/doc/arc/guiding-principles-medicaid-delivery-system.pdf>).
- The ARC developed the model bill "Enabling Coordinated Care Organizations with Medical Integrity" Act that addresses coordinated care organizations as well as ACOs (<http://www.ama-assn.org/resources/doc/arc/x-ama/coordinate-care-organizations-act.pdf>).
- The ARC developed model state legislation titled "Transparent Payment to Ensure Access to Care Act," which establishes standards for ensuring transparency in payment for health care services (<http://www.ama-assn.org/resources/doc/arc/x-ama/transparent-payment-ensure-access-care-model-bill.pdf>).
- The Chronic Care Coordination Workgroup of the AMA proposed that the CPT Editorial Panel develop new codes to describe Transitional Care Management and Complex Chronic Care Coordination services to be reported for care coordination provided over a 30-day period. After development of these codes in May 2012, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) reviewed the physician work and practice costs associated with the provision of these services and submitted its recommendations to CMS in October. Effective January 1, 2013, Medicare will implement the RUC recommendations and begin payment for CPT codes 99495 and 99496 for the care of transitioning patients from a hospital or skilled nursing facility to the home.
- In February 2013, the AMA Center for Patient Safety released "There And Home Again, Safely," a report that lists and discusses five responsibilities of ambulatory practices in transitions of care, which can be found online at <http://www.ama-assn.org/resources/doc/patient-safety/ambulatory-practices.pdf>. Responsibilities of outpatient physicians recommended by the AMA's Expert Panel on Ambulatory Roles and Responsibilities in Safe Care in the report include assessing the patient's health; goal-setting to determine desired outcomes; supporting self-management to ensure access to resources the

patient may need; medication management to oversee needed prescriptions; and care coordination to bring together all members of the health care team.

#### Data and Health Information Technology Infrastructure

- With respect to health information technology, including the meaningful use electronic health record program, the AMA has developed resources for its members on how the American Recovery and Reinvestment Act (ARRA) and subsequent regulations impact their practices, found online at <http://www.ama-assn.org/ama/pub/advocacy/topics/health-information-technology.page>.
- AMA's Practice Management Center has developed resources on the benefits and risks of participating in a health information exchange, found online at <http://www.ama-assn.org/go/hie>.

#### Quality and Performance Assessment and Improvement

- Improving health outcomes is one of the core areas of focus of AMA's five-year strategic plan. Toward these goals, the AMA will first identify a focused set of outcomes that would potentially have great impact on the U.S. population, then set a course of innovation and action to develop, enhance, and implement strategies aimed at reducing the disease and cost burden associated with these conditions.
- The AMA has continued to serve as a leader in quality measurement and improvement, through the AMA-convened Physician Consortium for Performance Improvement (PCPI).
- The AMA serves as a member organization in the National Quality Forum (NQF).
- The AMA convened on behalf of the US Department of Health and Human Services (HHS) a stakeholder meeting with physician organizations and officials in HHS on the topic of clinical registries and their role in transforming health care delivery, and the AMA conducted additional meetings with the Federation to garner additional input into this topic.
- As part of its 2009 work plan, the AMA-convened PCPI developed a set of Care Transition measures. Jointly developed with the American College of Physicians, the Society of Hospital Medicine and the ABIM Foundation, these performance measures focus on the key process components of the transition of care for patients discharged from an inpatient facility or an emergency department. NQF endorsed several of these measures, and the AMA continues to promote the use of these measures in both public and private pay for performance programs.