Maximizing value in the health care system

In recent years the public dialogue about spending on health care services has largely shifted from one focused on health care costs to one focused on improving the value of health care through the Triple Aim of better population health and better outcomes at lower cost. The concept of value encompasses both the clinical benefits gained from a particular service or treatment and the cost of that treatment. Although the growth in health care spending has slowed in recent years, policymakers and the public remain concerned about the high cost of health care services and whether the level of spending reflects the best use of our nation's health care resources.

The American Medical Association knows that access to timely, appropriate, high-quality health care is heavily dependent on whether or not that care is affordable—for individuals and society. The overall value of health care cannot be improved by making changes in only one part of the health care system. The AMA has identified several objectives that it believes must be accomplished in order to bring health care costs and quality into proper alignment.

Empower physicians to deliver high-quality and efficient care by supporting streamlined quality improvement programs that can help guide physicians in their clinical decision-making.

The AMA believes that well-designed performance measurement and quality improvement programs have the potential to provide physicians with the information and tools they need to provide high-quality, cost-effective care to patients. Effective quality improvement programs should ensure that physicians are actively involved in the development of quality measures, and that data reporting requirements are flexible enough to accommodate a wide range of specialties, practice settings, and patient case mixes. The AMA-convened Physician Consortium for Performance Improvement® (PCPI) is a national, physician-led initiative to enhance quality of care and patient safety by taking the lead in the development, testing, and maintenance of evidence-based clinical performance measures and measurement resources for physicians.

Develop and implement better methods of generating and disseminating information to physicians about comparative practice patterns to enable them to improve efficiencies.

Quality measurement and performance data must be translated into practical information that helps physicians evaluate and make adjustments in their practices. Research suggests that physicians who have access to timely, meaningful data about their practice patterns and resource use consistently improve the quality of their practices and are able to achieve cost savings. The AMA convened a multi-stakeholder data transparency workgroup to develop standards for the collection and reporting of meaningful physician practice data that will increase the quality and usability of the information collected.

Expand the functionality of health information technology and better leverage the power of electronic health records to enhance patient care, improve productivity, and reduce administrative costs.

Widespread adoption and use of health information technology (HIT) can help improve the efficiency of health care delivery and the quality of health care decision-making. The AMA has identified several priorities that should be the focus of electronic health record development efforts, such as:

- Enhancing physicians’ ability to provide high-quality patient care
- Promoting care coordination
- Offering product modularity and configurability
- Reducing cognitive workload
- Expediting user input into product design and post-implementation feedback

Reduce the burden of preventable disease by supporting efforts to encourage the adoption of healthy patient lifestyles and behaviors.

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Significant levels of health care spending are attributable to modifiable behaviors such as unhealthy nutrition, physical inactivity, smoking, excessive alcohol use, motor vehicle collisions and violence. Increased efforts are necessary to promote and encourage the adoption of healthy behaviors and effective chronic disease management strategies. In particular insurers should support routine lifestyle evaluation and counseling by providing coverage for services related to educating and supporting patients in ways that help maintain good health, and by providing adequate payment to physicians for providing these services.

Notably, type 2 diabetes and cardiovascular disease cost the nation more than $500 billion annually. With proper intervention the effects of these conditions can be dramatically reduced. The AMA is committed to bringing physicians together with communities and public and private sector organizations to prevent the onset of these diseases, and to better manage patients already suffering from these conditions.

**Develop and support health insurance benefit design structures that encourage patients to seek necessary and appropriate care while also providing incentives to control costs.**

Health plan benefit designs and network development strategies increasingly require patients to assume greater financial responsibility for their care choices. Increasing the amount enrollees are required to pay out-of-pocket for each covered service has the potential to curb utilization, spending, and premium growth, but excessive cost-sharing requirements risk creating financial barriers to care that could compromise patient health and result in higher health care costs over the long term. Health insurance benefit designs should promote the most efficient and effective use of health care services, which will result in better health outcomes in return for the dollars spent. Value-based insurance designs that determine coverage and cost-sharing rules based on the clinical value of individual health care treatments or services give patients an incentive to be responsible health care consumers while also providing a structure to guide them toward clinically valuable services.

Many health insurers use tiered and narrow provider networks as a way to reduce costs. Although plans with narrow networks may have lower premiums and cost-sharing requirements, some narrow networks may end up being inadequate to provide meaningful access to timely, convenient and quality care. The AMA supports several strategies to ensure network adequacy, including supporting state regulators as the primary enforcer of network adequacy standards, and additional financial protections for patients who are forced to seek out-of-network care.

**Reduce non-clinical health system costs that do not add value to patient care, such as improving and promoting electronic transactions, simplifying billing processes, and standardizing the claims and review processes.**

There is an opportunity to reduce system-wide health care costs by simplifying administrative processes. Administrative inefficiencies associated with claims processing, payment and reconciliation consume 10–14 percent of practice revenue. Insurers must increase transparency of payment policies and procedures, and enable automated, real-time health plan transactions throughout the physician’s claims management revenue cycle.

**Support physician payment and delivery models that enable physicians to pursue practice innovations that promote improved patient access to high-quality, cost-effective care.**

There is widespread agreement that payment reforms are needed to make health care less fragmented, achieve better health outcomes and reduce the rate of growth in health care costs. The AMA supports the development of patient-centered, physician-led health care payment and delivery systems that promote improved patient access to high-quality, cost-effective care and flexibility for physician practices. Physicians should be supported in efforts to explore and experiment with physician-led health care team models, accountable care organizations, medical homes, bundled payments and other innovative ways of providing better, more coordinated care to their patients.