Integrated Physician Practice Section

2018 Interim Meeting
Gaylord National Resort & Convention Center (National Harbor, MD)
November 9

Meeting agenda

Meeting app and hotel map

IPPS Governing Council

Special Governing Council election

Programs and briefings

- Direct contracting with large employers: Is your organization an appealing partner?
  - Speaker bios: Savageau, Muma
  - Slides
  - Claim your credit
- RAND/AMA study: Effects of payment models on U.S. physician practices: Is the U.S. making progress in value-based care models?
  - Slides
- 2019 Medicare payment policy: Everything you need to know
  - Speaker bios: MacHarris, Levy
  - Slides

IPPS policy discussion

Looking ahead

- Future IPPS meetings
- 2019 Governing Council elections

AMA Integrated Physician Practice Section

2018 Interim Meeting
Gaylord National Convention Center
National Harbor, MD
November 9

Thursday, Nov. 8		**Location**
6:00 – 7:00 p.m.	IPPS Welcome Reception	Potomac Foyer (Ballroom Level)
Friday, Nov. 9		
8:00 – 8:30 a.m.	Continental breakfast	Potomac 1 & 2 (Ballroom Level)
8:30 – 8:45 a.m.	IPPS opening session - IPPS special elections	"
8:45 – 10:45 a.m.	**Direct contracting with large employers: Is your organization an appealing partner?** 8:45 – 9:45 a.m. Bruce Muma, MD, Henry Ford Health System, and Sheila Savageau, General Motors 9:45 – 10:45 a.m. Roundtable discussions	"
10:45 a.m. – noon	**RAND/AMA study: Effects of payment models on U.S. physician practices: Is the U.S. making progress in value-based care models?** 10:45 – 11:05 a.m. Kathleen Blake, MD, AMA 11:05 – 11:30 a.m. Reaction panel 11:30 a.m. – noon Q&A	"
12:00 – 1:00 p.m.	Networking lunch	"

1:00 – 2:20 p.m.	**2019 Medicare payment policy: Everything you need to know** 1:00 – 1:20 p.m. Molly MacHarris, CMS 1:20 - 1:40 p.m. Q&A 1:40 – 2:00 p.m. Barbara Levy, MD, Co-Chair AMA CPT/RUC Work Group 2:00 – 2:20 p.m. Q&A	Potomac 1 & 2 (Ballroom Level)
2:20 – 2:45 p.m.	Break	"
2:45 – 3:15 p.m.	IPPS Policy discussions	"
3:30 p.m.	Meeting adjourned	"

Downloading the App

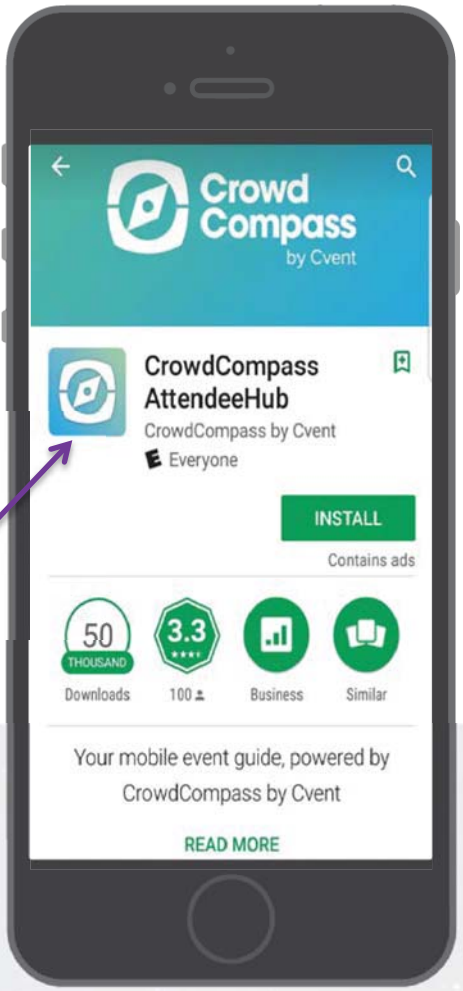
Get the app

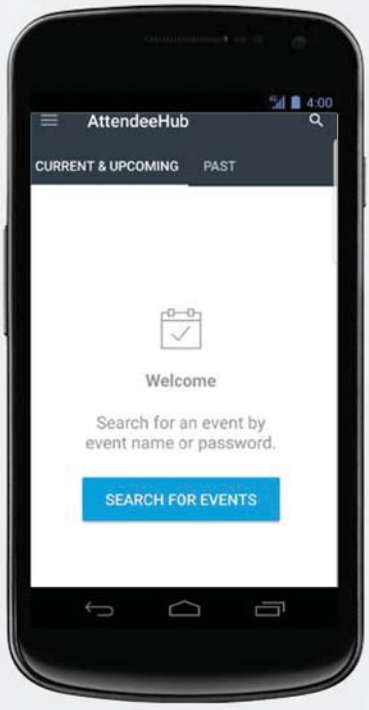
1. Go to the right store. Access the App Store on iOS devices and the Play Store on Android.

If you're using a Blackberry or Windows phone, skip these steps. **You'll need to use the web version of the app found here: https://event.crowdcompass.com/ama2018interim**

2. Install the app. Search for CrowdCompass AttendeeHub Once you've found the app, tap either **Download** or **Install**.

After installing, a new icon will appear on the home screen.





Find your event

1. Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter AMA 2018 Interim Meeting

2. Open your event. Tap the name of your event to open it.

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The "CrowdCompassAttendeeHub" Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

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AttendeeHub

If you're using a Blackberry or Windows phone, skip these steps. You'll need to use the web version of the app found here https://event.crowdcompass.com/ama2018interim

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2018 Interim Meeting

The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees

Where can I get my log-in information?

The log-in process is largely self-managed. Just follow the steps below to log in from your device:

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

I've requested log-in information, but I never received an email.

If you haven't received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email. The sender may be listed as CrowdCompass.

I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?

To have a verification email resent to you, start by accessing the sign-in page.

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

How can I export my schedule to my device's calendar?

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.

3. **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device's calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event's app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event's App.** Scroll down and tap App notifications. Find your event's app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private…

1. **Access your profile settings.** If you'd rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

…Or Hide Your Profile Entirely

1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then **My Messages**.

How do I block a person from chatting with me?

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

I want to network with other attendees. How do I share my contact info with them?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

I want to schedule an appointment with other attendees. How do I do that?

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.

2. **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts...

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.

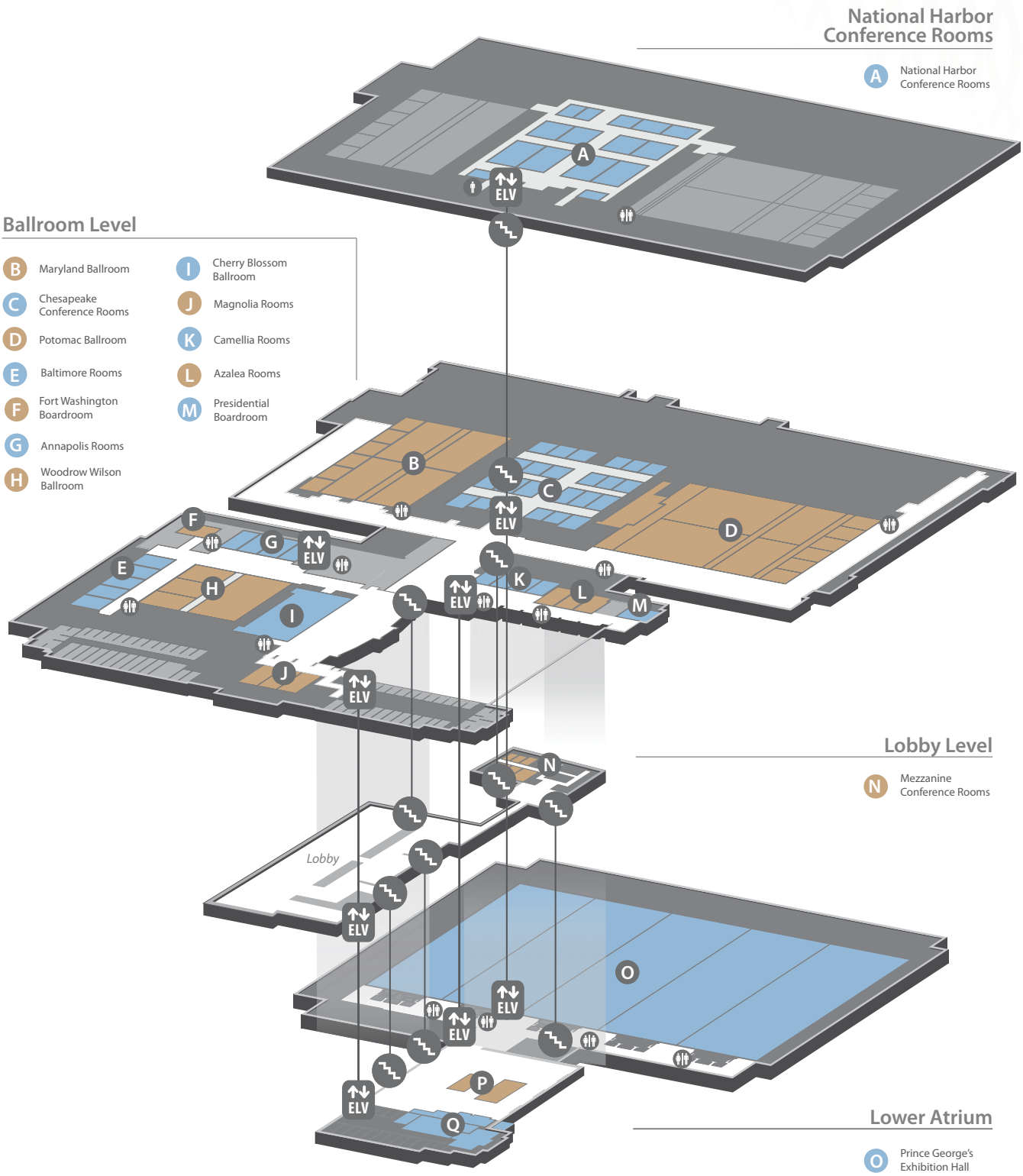
2. **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you've finished.

…Then Export Them

1. **Navigate to My Notes.** Tap the hamburger icon in the top right, then My Notes. Here you'll find all the notes you've taken organized by session.

2. **Choose where to send your notes.** Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.

Meeting Space Map



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Overview Map

★ Dining ★

- Old Hickory Steakhouse & Lounge (Upper Atrium)
- Moon Bay Coastal Cuisine and Bar (Lower Atrium)
- National Pastime Bar & Grill (Lower Atrium)
- Pienza Italian Market and Bar (Lower Atrium)

★ Cafés ★

- Java Coast (Lower Atrium)

★ Bars / Lounges ★

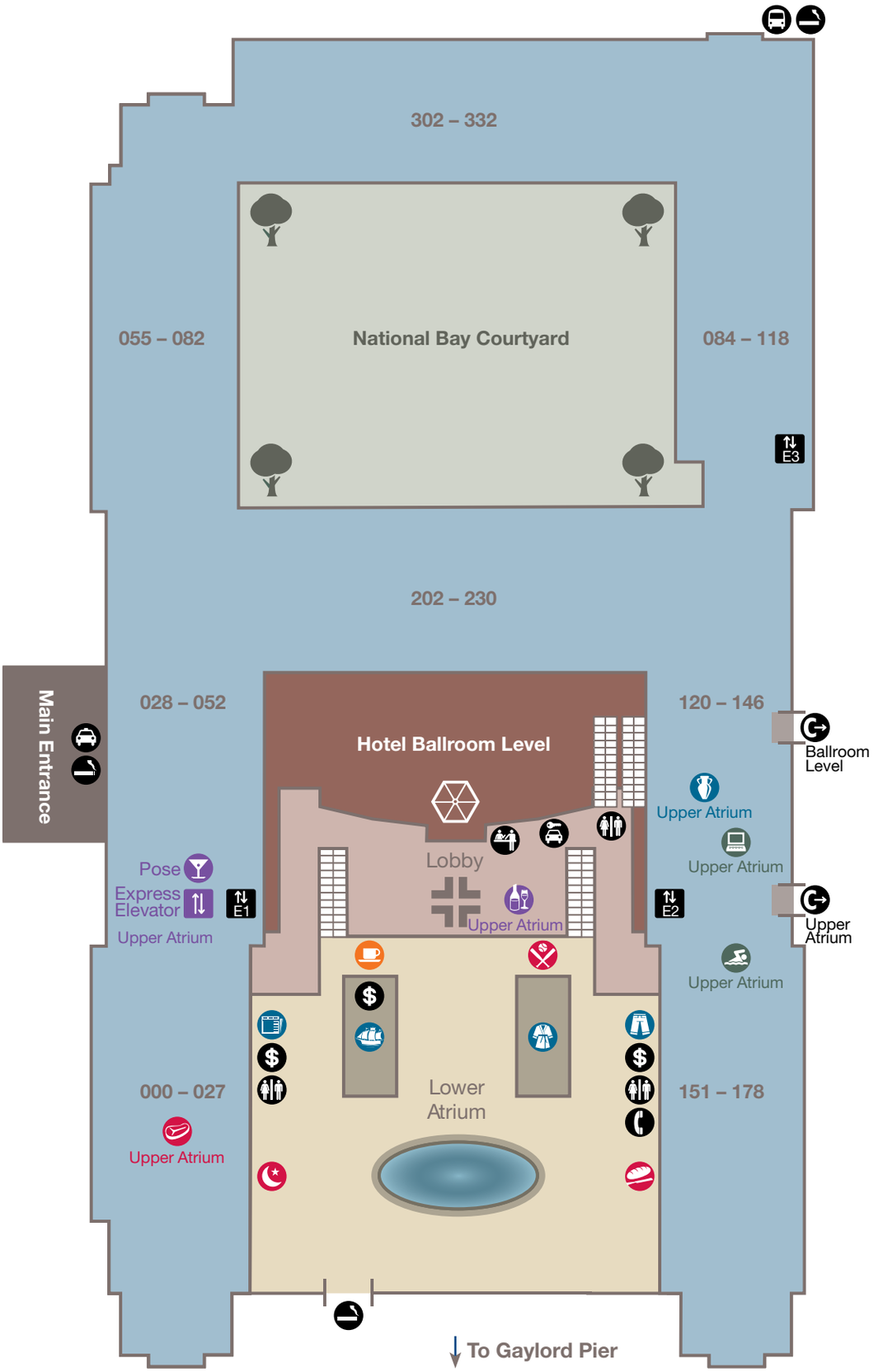
- Belvedere Lobby Bar (Upper Atrium)
- Pose, Ultra Lounge (18th Floor)

★ Retail ★

- The Williamsburg Shop (Lower Atrium)
- Pajama Party (Lower Atrium)
- Urban Chic (Lower Atrium)
- Strictly First Glass (Upper Atrium)
- Key Provisions News*Sundries*Gifts (Lower Atrium)

★ Miscellaneous ★

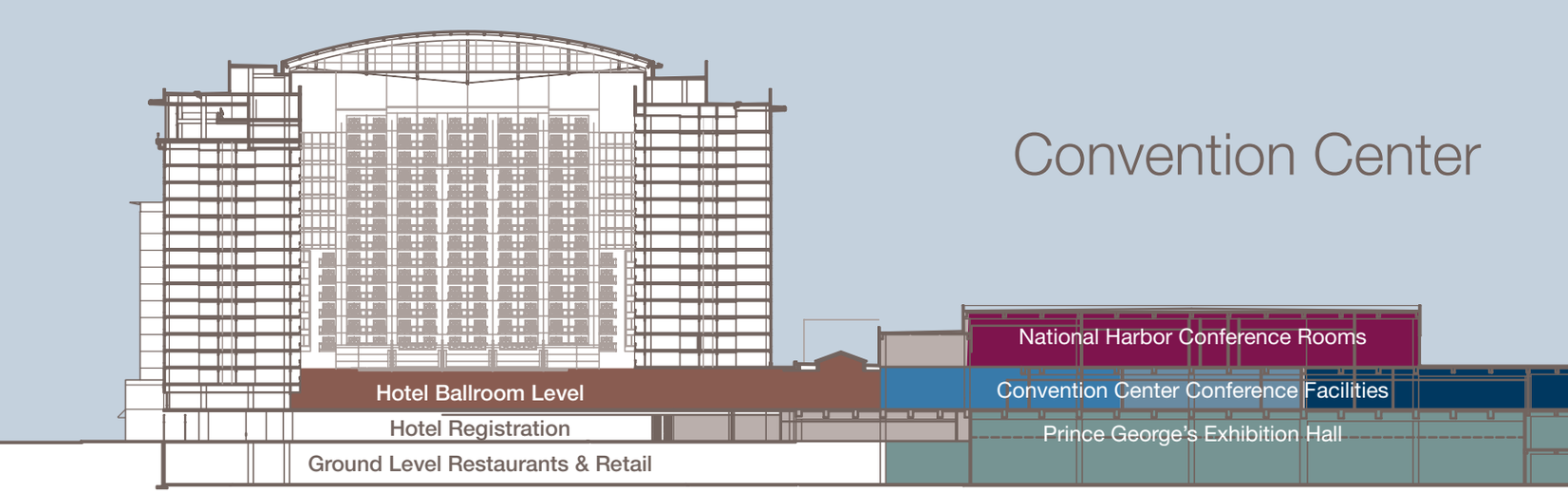
- Business Center (Upper Atrium)
- Relâche Spa / Entrance to Fitness Center and Pool (Upper Atrium)

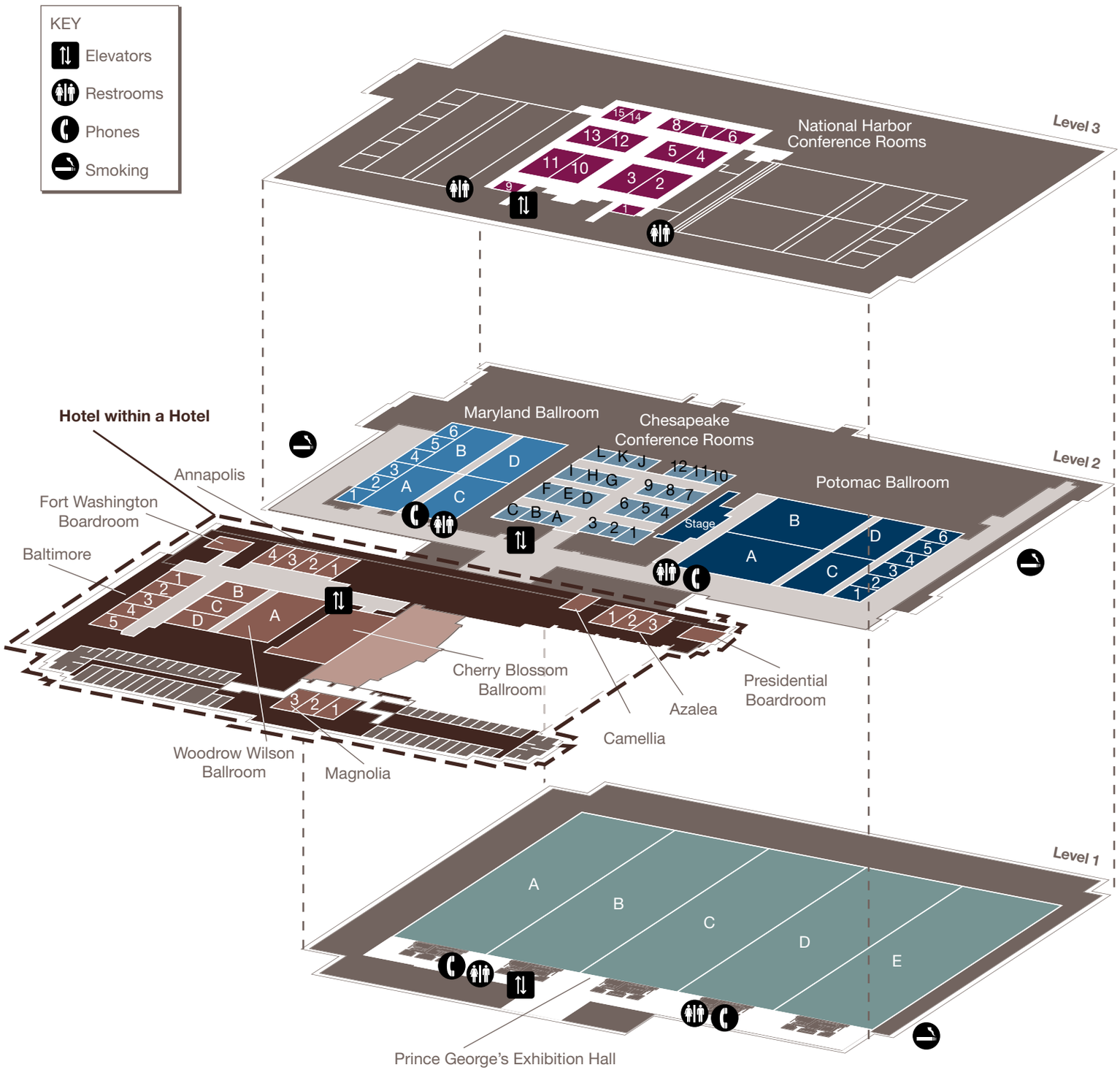


Key

- Elevators
- Restrooms
- ATM
- Phones
- Convention Center
- Concierge
- Car Rental
- Bus Pickup
- Taxi Pickup
- Smoking

Convention Center





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IPPS Governing Council

Peter Rutherford, MD
Chair
Chief Executive Officer
Confluence Health, WA

Susan Pike, MD
Member at-Large
Director, Division of Plastic and Reconstructive Surgery, Baylor/Scott & White, TX

Michael Glenn, MD
Vice-Chair
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Virginia Mason Medical Center, WA

Barbara Spivak, MD
Member at-Large
President and Board Chair
Mount Auburn Cambridge IPA, MA

Russell Libby, MD
Delegate
Founder and President,
HealthConnect IPA, VA

Large group slotted seat
Vacant

Devdutta Sangvai, MD
Alternate Delegate
Executive Director, Duke Connected Care, Duke Health, NC

Randall Gibb, MD
Small/Medium group slotted seat
CEO, Billings Clinic, MT

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IPPS Governing Council Elections
Interim Meeting 2018

Due to an unexpected vacancy on the IPPS Governing Council, the IPPS will hold a special election at the Interim Meeting. The current nominee is listed below.

Large group slotted seat

- Narayana Murali, MD
  EVP of Care Delivery and Chief Clinical Strategy Officer,
  Marshfield Clinic Health System
  Executive Director, Marshfield Clinic
  Marshfield, WI
  Specialty: Nephrology

Candidate's leadership experience in physician-led, integrated health care organizations:

- Executive Vice President of Care Delivery and Chief Clinical Strategy Officer of the Marshfield Clinic Health System, an integrated health system with an Operating Revenue of $2.4 Billion.
- In 2015, elected Marshfield Clinic's Physician Executive Director (ED), a permanent position until retirement.

Currently oversees:

- 1250 clinicians and its clinical operations
- Recently expanded to 5.5 Hospitals (soon to be 6.5). The 0.5 is a JV Critical Access Hospital
- 4 Ambulatory Surgical Centers, 7 urgent cares, 17 pharmacies
- 60 clinical locations, 86 specialties
- 3 Skilled Nursing Facilities & CARES
- 33 Human &Veterinary Laboratories
- ACO 29,000 members, top 5% of MSSP and tied for the first place in MACRA
- Marshfield Clinic Research institute, the largest private medical research institute in Wisconsin, founded in 1959. Extramural funding in 2017 - $17 Million
- Personalized Recovery Care - JV - our Hospital@Home Program
- Division of Education, which trains 77 Medical residents annually in addition to other training programs & partnerships – Nursing School, Pharmacy fellowship, Radiology etc.
- Family Health Center with 10 Dental Clinics

Candidate's statement of interest:

Presently serve as a Physician Executive Member, Integrated Care Consortium, AMA. In that capacity I have worked with senior AMA Advocacy Staff, members of the IPPS Governing Council, some of the AMA Board of Trustees. My desire to serve on the IPPS Governing Council is to strengthen the AMA and the IPPS section by supporting them through value added, collaborative, synergistic insight of having been involved in running clinical care delivery, education and research of one of the largest physician led, multi-specialty, not for profit, rural Integrated Health Systems in the nation. Potential areas of value that I could add involve broad range of issues from how physicians are paid, capitation/risk, large employer-based contracting, direct primary care, granular operational elements of clinical care delivery, processes, data driven analytics, guideline development, innovation, leadership, group problem solving, policymaking and educational content development for AMA. I have particular interest in the value equation, engagement, education, physician burnout and leadership development.

AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

Direct contracting with large employers: Is your organization an appealing partner?

8:45 a.m. – 10:45 a.m. | Friday, November 9 | Potomac 1 & 2 | Gaylord National Resort and Convention Center

INTEGRATED PHYSICIAN PRACTICE SECTION

8:45 a.m. – 10:45a.m. **Direct contracting with large employers: Is your organization an appealing partner?**
(2.0 AMA PRA Category 1 Credits™)

Recently, Henry Ford Health System (HFHS) and General Motors (GM) announced a direct contracting partnership in which HFHS provides a wide range of services to 24,000 GM employees. Join senior executives from both organizations to learn more about this venture and more broadly, how you can prepare your system to partner with large employers.

Sheila Savageau

Sheila Savageau is the U.S. Healthcare Leader at General Motors. Sheila has been with General Motors since November 2013 and is responsible for U.S. healthcare benefits plan design strategy and policy for hourly and salaried employees. Sheila has been instrumental in establishing and executing the healthcare benefits strategy for General Motors and managing over $1B in annual expense. Sheila is an advocate for improving experience, engagement and efficiencies across the healthcare industry. Sheila is an active member of other employer coalitions, including National Business Group on Health, the ERISA Industry Committee and American Benefits Council.

Prior to joining General Motors, Sheila spent nine years at Ingersoll Rand leading strategy, design and implementation of new initiatives and managing benefits programs for 60,000 employees globally, Sheila is an accomplished Global Benefits leader. She was instrumental in contributing to Ingersoll Rand's bottom line by effectively finding ways to help meet company productivity goals while maintaining a competitive and robust benefits offering. Sheila led the Benefits Integration team in a merger acquisition, resulting in approximately $60M dollars in benefit program savings over three years, while achieving high employee engagement.

Sheila has over 20 years of experience with manufacturing, retail and insurance industries in the areas of finance, operations, design strategy and vendor management related to global benefit plans.

Bruce K. Muma, M.D., FACP

Bruce K. Muma, M.D., FACP, is the Interim Chief Executive Officer of the Henry Ford Physician Network and the Henry Ford Accountable Care Organization. He also serves as Chief Medical Officer for the Henry Ford Health System's Innovation Institute.

In these roles, Dr. Muma supports clinical integration across a broad platform of more than 2000 physicians within the Henry Ford Physician Network as well as across the newly formed, statewide Affirmant Health Partners network. These integrative efforts include developing metrics and dashboards to improve provider performance, collaborating with clinical leaders to identify opportunities to improve value, as well as promoting clinical policies and programs to create more effective and efficient care delivery models.

Dr. Muma has led numerous improvement initiatives across the health system including creating inpatient care pathways using advanced practice providers, launching an internal IPD admission review service, developing ambulatory chronic disease management programs (Diabetes, Depression, Lipid Management, Anticoagulation), implementing the first electronic prescribing program in Southeast Michigan, establishing electronic visits within an EMR, building advanced access models for primary care, and developing high risk care management programs. Dr. Muma is a student of LEAN methodologies and has served as a Baldrige examiner for the State of Michigan.

Dr. Muma has held various physician leadership positions including serving as the inaugural CMO of Henry Ford West Bloomfield Hospital (2007 – 2013), as Regional Medical Director of the Northern Region of the Henry Ford Medical Group (1997-2006), and as HFMG HAP Network Medical Director (1993 – 1996). Dr. Muma currently serves on the HFMG Board of Governors, HFPN Board of Trustee's and HFHS Government Affairs Board.

Dr. Muma received his medical education at Wayne State University in 1983 and completed a combined residency in Internal Medicine and Pediatrics at Henry Ford Hospital in 1987. He is a fellow in the American College of Physicians.

Claim your credit

Information about how to claim CME credit will be available on site at the meeting. If you have questions following the meeting, please contact carrie.waller@ama-assn.org

General Motors and Henry Ford Health System

Welcome

General Motors

- Sheila Savageau, U.S. Health Care Leader

Henry Ford Health System

- Bruce Muma, MD, CEO, Henry Ford Physician Network

Agenda

- General Motors – Background and problem statement
- What does a good partner look like?
  - Enabling Factors
  - Commitment Factors
- Henry Ford Health System – Background and strategy
  - RFP Response Strategy
  - Existing Capabilities and New Processes

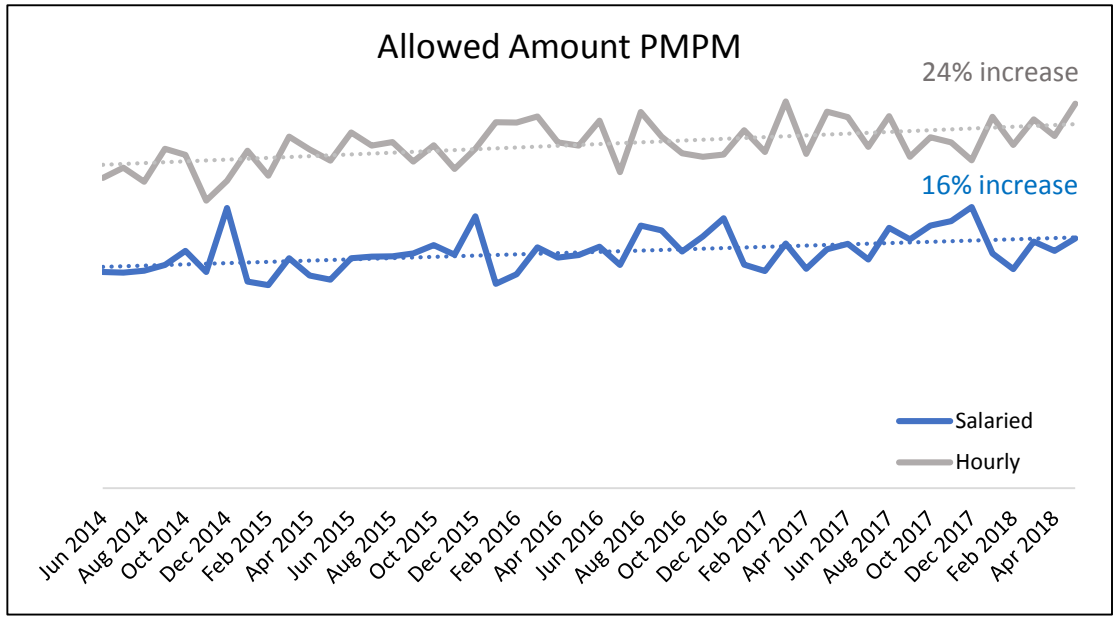
Health Care at General Motors

Three populations with different characteristics and strategies:

Salaried	Hourly / Union	Retirees
• White collar • Design, Engineering, IT and Corporate staffs • Healthier • Value-based solutions - Detroit, Atlanta, Austin, Ft. Wayne, Kansas City, Phoenix • High-deductible plans, transparency, direct communication	• Blue collar • Manufacturing • Less healthy • Collectively bargained, minimal cost share	• Limited coverage • Pre-65 only • Benefit expense is capped, broad PPO options available

The problem

GM and its employees are paying more every year but not receiving improved quality of care and efficiencies from the healthcare system



- **Flint** – 30 spinal fusions ranging in price from $14k - $210k, avg. facility ★ rating 2/5
- **St. Louis** – 50 patients admitted >3 per year, 33% of admit cost
- **Detroit** – 356 patients with >5 ED visits, 2,710 total visits
- Less than half of people know where to go for the best health care value*

Is this the triple aim?

*Aon Hewitt Consumer Health Mindset Study 2016

Why direct contracting?

Incentives are misaligned

GM's triple aim: Improved **Experience** (customer service & quality), Increased **Engagement** (right patient/right program/right plan) and Greater **Efficiencies** (cost and elimination of waste)

Accountability for cost and quality outcomes

What does a good partner look like?

- Enabling Factors
- Commitment Factors

Enabling Factors

Maturity and demonstrated ability to drive change

Does a health system have experience in risk-based arrangements or other organized systems of care?

Examples: Next Gen ACO, Employee plans, other MSSPs

Do you have a demonstrated (and quantifiable) history of driving change through your entire system?

Examples: CMS reported quality measures, Hospital Acquired Conditions reduction, CAHPS providers rates 9/10, percentage of physicians employed?

Enabling Factors

Connectivity

A key to identifying issues/successes and driving change is a supportive IT Infrastructure and robust data analytics strategy

Examples:

- Uniform or interoperable EMR
- Ability to measure individual provider performance
- Physician access to Meaningful Use Stage 2 or greater
- Internal score cards and process improvement plans

Enabling Factors

Access

Can your organization provide all or most health care needs to an acceptable standard?

GM borrowed methodology and criteria from Medicare Advantage. Network concerns go beyond facilities:

Specialists, super-specialists (transplants), pediatric care, children's hospitals, behavioral health, primary care with capacity retail clinics, virtual care

Commitment Factors

Financial risk and payment evolution

A partner must immediately take on risk at a meaningful level

- *Must* be a down-side risk component with a tie to both quality and financials
- Services at risk should stretch beyond service provided (i.e. an ED visit outside your system is *your* responsibility)
- Payments tied to quality *must* trickle down to those providing care, not just headquarters
- We are driving care to you, a discount on fees is required

Commitment Factors

Customer service

Enhanced customer experience is priority #1

Examples: Concierge servicing/patient advocacy, patient real-time access to information (e.g., MyChart), same day appointments, top box CAHPS performance, online appointments, virtual care

Customer experience is a key differentiator and starts before a member enters the healthcare system

Commitment Factors

Governance

As a partner, you must be willing to solve problems together

Joint Operating Committee of executives and program managers meet quarterly

- Shared responsibility in measurement and reporting
- Third-party Administrator is a strategic partner, not a barrier
- Robust operational plans, implementation plans, data-sharing, transparency and commitments to continual improvement

Henry Ford Health System

Background

Henry Ford established an integrated hospital in 1915

>30,000 employees at Henry Ford Health System (HFHS)

Henry Ford Hospital

- 802-bed academic medical center
- 16th largest teaching hospital in the U.S.

Community hospitals

- Macomb – Clinton Township
- Wyandotte
- West Bloomfield
- Allegiance
- Behavioral Health (3 facilities)

Henry Ford Health System

Background

Ambulatory facilities

- Includes medical centers, outpatient surgery, urgent care and emergency services

Community Care Services

- Full pharmacy services: OPD, PBM, Specialty, home infusion
- DME
- Optometry
- Dialysis
- Home Health Services

Provider Based Health Plan: Health Alliance Plan Insurance

Clinically Integrated Network: Henry Ford Physician Network launched in 2010

- 2,200 physicians, employed and independent
- Next Generation ACO

RFP Response and Implementation Strategy

Created a new, multidisciplinary team to be on the “other” side of the RFP process

- Sponsorship and active involvement by HFHS senior leadership
- Core team and sub teams: Population Health, Henry Ford Physician Network, Analytics, Finance and Managed Care Contracting, IT, Legal, Access Service, Care Experience, Quality & Safety, Marketing, Communications, Health Alliance Plan
- For core team, at least weekly meetings throughout implementation process and at least monthly ongoing. For sub teams, meetings as needed

Key Existing Capabilities and New Processes

Existing

- Expertise in risk contracting with 25+ years of experience
- System strategic intent to pursue value based care
- Data infrastructure and advanced analytics
- Longstanding commitment to performance improvement
- Virtual care capabilities

New

- Pulling together experts and decision makers for RFP response
- Provider network agility in responding to geo-access requirements and risk contracting opportunity
- Customer service enhancements, including new resources and appointment access guarantees

Clinically Integrated Network

Experience with upside/downside, value-based risk contracts

Henry Ford Physician Network - 2010

- Commercial ACO (40,000 covered lives) – focused on HFHS employee's and HFHS's health plan (HAP)
- 2,200+ Physicians – 65% employed/35% independent physicians
- Favorable incentive performance – multi-year

CMS Next Generation ACO - 2016

- 80% upside/downside risk - 27,000 beneficiaries
- Subset of Henry Ford Physician Network
  - All PCPs on HFHS version of EPIC
  - 85% employed physicians
- Favorable shared savings incentive in 2016, 2017, YTD 2018 (90.5% quality score in 2017)

Provider Network Management

Process to quickly meet geo access standards

- Restructuring of CIN – shift to PO centric model
- Significant attraction to participate among POs in high profile, direct-to-employer contract
- Identification of gaps and alignment using geo-access mapping

Process to integrate across diverse provider landscape

- Practice profiling for concierge services
- Data integration platform to collect PO based registry/EMR data
- Communication/liaison planning

Process to align financial model and shared savings incentives

- HFHS holds primary contract with HFPN as exclusive provider network.
- Incentive distribution formula patterned after NG ACO model

Network Utilization Management

Network Model

- Prospective attribution to HFPN network based on majority of claims expense during baseline period.
- Self insured PPO model with TPA support
  - Claims-based data provided to EDW to detect trends and educate providers
  - Selected TPA sponsored, prior authorization programs (selected high cost episodes, elective procedures, admissions review)
  - ADT information via State of Michigan HIE (MiHIN)

Population Health Tools

- Leverage EPIC registry tools and alerts within employed practices
- Leverage independent PO capabilities (embedded CM, performance reports, specialist variation reporting, etc.)
- Enrollment in existing, embedded population health programs (case management, emergency department disposition support, comprehensive care centers, virtual chronic care, post-acute care surveillance, external hospitalist agreements)

Data Capabilities

Existing infrastructure and connectivity

- Epic as EMR, Care Everywhere
- Enterprise data warehouse, ability to receive and analyze claims and EMR data
- Michigan Health Information Network (MiHIN) for ADT tracking
- Patient registries embedded in EMR and equipped with alerts
- CCD data exchange with independent EMR's

Existing analytic support

- Dashboards and quality reporting deployed across entire network
- Risk/population stratification capability (OPTUM and home grown models)

Customer Experience

Care and experience is part of System's existing strategic plan and True North framework

New/expanded service offerings implemented for GM

- Concierge team
  - New group within existing contact center focused solely on GM patients who choose ConnectedCare
- 24/7 nurse advice line
  - Opening to all GM patients who choose ConnectedCare
- Appointment access guarantees
  - Primary care within next day, specialty within 10 business days

Virtual care alternatives to enhance customer satisfaction and convenience

System Alignment

HFHS True North framework aligned with triple aim

- GM / HFHS Quality Metrics consist of a balance of quality, cost, utilization and patient experience metrics

HFHS Contracting Strategy

- Shift all contracts to value based model with risk

HFHS “Core Network” Strategy

- Invest in becoming the “highest performing” network in Southeast Michigan

Future Innovation

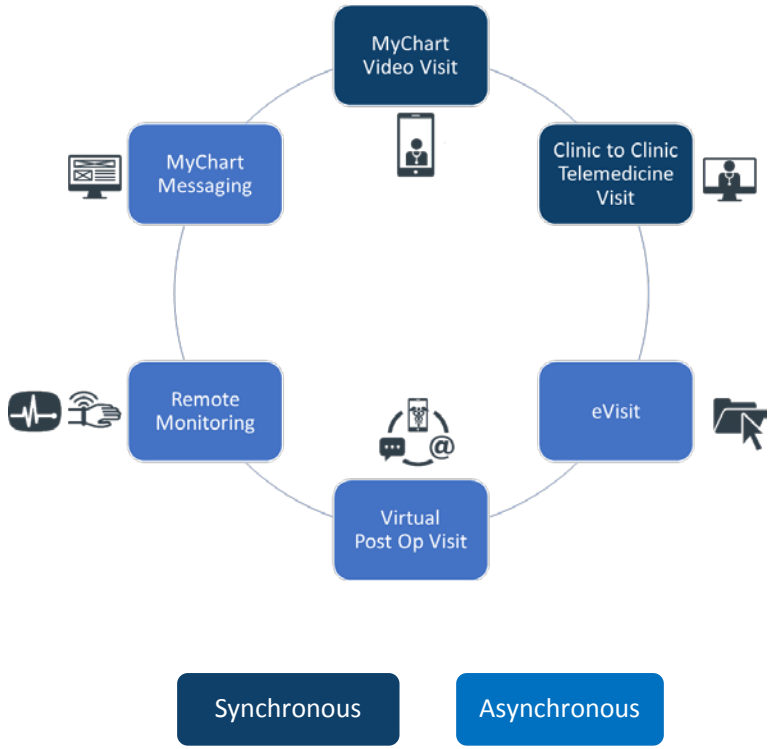
Manufacturing Innovator meets Health Care Innovator

Billing

- Look for opportunities to integrate billing processes to reduce duplication and waste
- Enhance patient experience

Virtual Care

- Revise benefit structure to support development of virtual care services
- Build on existing virtual care options and System's digital strategy



Effects of payment models on U.S. physician practices

Is the U.S. making progress in value-based care models?

November, 2018
Washington, DC

AMA
AMERICAN MEDICAL ASSOCIATION

RAND
CORPORATION

Where to begin…

AMA/Rand Report 2013

Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy

When physicians perceived themselves as providing high quality care, they reported better professional satisfaction

Factors that *lower* professional satisfaction

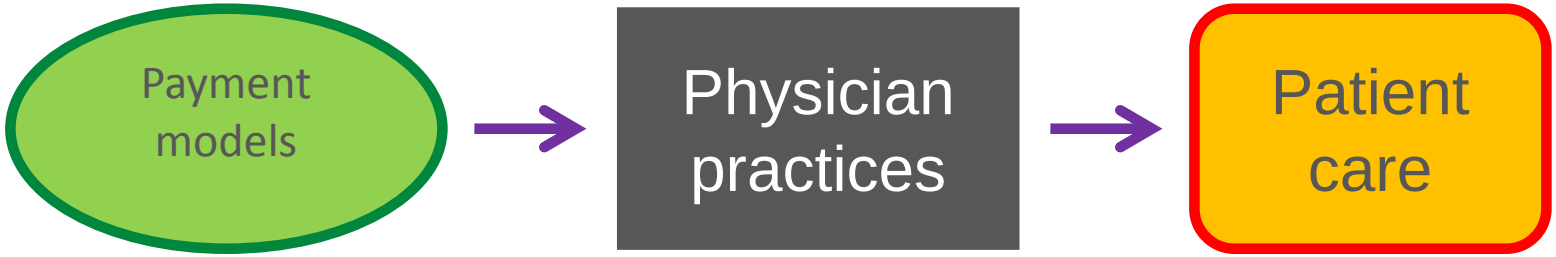
- Perceived barriers to high-quality care
- Electronic health records
- Lack of faith in practice leadership
- Worries about practice sustainability as a business
- Work volume: too little or too much
- Regulatory burden: many small things adding up

Source: Friedberg, et al., *Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy*. Rand Health.

AMA/RAND Report 2014

Effects of New Payment Models on Physician Practice

- Purpose: Describe events within the black box



- How do alternative payment models affect:
  - Physician work experience
  - How practices deliver patient care
  - Practice organizational structure, sustainability, and help needed
- How do payment models interact with regulations and with each other?

Key findings of 2014 study

- At the organizational level, alternative payment models…

  …encouraged practices to merge or become affiliated with hospitals and large provider organizations

  …encouraged practices to develop team approaches to care, new access options for patients, new referral patterns

  …increased the importance of data and data analysis (and data deficiencies and inaccuracies)

  …sometimes conflicted with each other, complicating practices' abilities to respond in a constructive manner

Key findings of 2014 study

- For individual physicians, alternative payment models…

  …were not passed through to individual physicians without significant alteration by practices. No individual physicians in the study faced financial incentives, based on personal performance, to contain costs of care. Instead, practices applied non-financial incentives and interventions to encourage cost containment.

  …generally did not change physicians' core clinical work but increased other activities (e.g., documentation). Physicians in leadership positions were more enthusiastic about these changes than other physicians.

- Features of payment model implementation:

  - Problems with data integrity and timeliness, errors in payment model execution (including inaccurate measure specification and patient attribution), incomprehensible incentives, and concerns about measure validity were reported as limiting the effectiveness of new alternative payment models

Effects of Health Care Payment Models on Physician Practice in the United States: Follow-up Study October 2018

Study Aims

- Describe evolution (or lack thereof) in 2014 findings
  - Stable/progressing payment models
  - New or changing payment models
- Describe changes in physician work content, professional satisfaction
- Describe changes in what help practices need

Friedberg M, Chen P and colleagues. Effects of Health Care Payment Models on Physician Practice in the United States: Follow-up Study October 2018. Available at: https://www.rand.org/content/dam/rand/pubs/research_reports/RR2600/RR2667/RAND_RR2667.pdf

Same six markets as in 2014

→Same practices and interviewees, to extent possible

Data collection primarily via semi-structured interviews

- Market context interviewees: 24 interviews
  - Medical societies, MGMA chapters
  - hospitals & health plans with significant market share
- Physician practice interviewees: 84 interviews in 31 practices (18 in 2014 study)
  - 25 with non-clinician practice leaders
  - 59 with clinicians (some were practice leaders)
- Supplemented by financial questionnaires

Current study: persistent findings since 2014

- General openness to VBP as a concept despite challenges in real-world implementation, such as:
  - Data issues (timeliness, accuracy)
  - Operational errors in payment models
  - Conflicting payment models
- Strategies used by practices:
  - New capabilities & patient care models
  - Investment in data & analysis
  - Incentives modified within practices

Current study: new findings

- Pace of change has increased
  - Overwhelming to some practices
  - Unexpected APM reversals problematic
    - Some APMs reversed due to leadership changes (rather than model performance)
    - Affects practices' ability to invest, morale, willingness to participate, financial position

Current study: new findings

- Complexity of models has increased
  - Understandability a more prominent issue
  - One pathway to success: investing in ability to understand each model
    - Better understanding → new strategies to earn bonuses & avoid penalties
  - MACRA QPP a good example of complexity

Current study: new findings

- Practices expressed more risk aversion
  - Especially when burned by prior experience
  - Avoiding downside risk, in general
    - Transfer of downside risk to partners
    - Shifting risk back to payers, in some categories (e.g., drug spending)
    - Willing to forego some upside bonus potential to reduce downside risk

Persistent challenges

Data issues

- Timeliness and accuracy

We've had three months in this year…[and] they're supposed to give us a list of what we need to do this year for our patients… [but] we still don't know what we're supposed to do on these patients. Are we supposed to get mammograms on them? Because they're supposed to give us a list of who needs what, and it was supposed to be done two days ago, and they said "Oh, it's not going to be done until the next refresh, which is next month." ***So we're going to go a quarter of the year into the program, without really having the data to actually do what we were supposed to do****. So all we can do is guess. …It just would be nice at the beginning of the year, at the very beginning, the first of the year, or let's say in December of the previous year, if they just said, "This is what we're measuring. So as you're seeing your patients here, why don't you start working on this?"*

--Physician owner of a small primary care practice participating in PFP programs

Operational errors

- Errors in 2014 had consequences for participation in later APMs

[In 2014] the real issue was …they had incorrect data*. Because to qualify for a bonus, you had to make certain all the patients were on an ACE inhibitor or an angiotensin receptor blocker. And they said we were hitting the target like 75 percent of the time, or 50 percent of the time, and then you could also see what the data was for all the other aggregated hospitals and I saw that they were even lower than us …so I was suspicious that something was wrong, and then we audited some of our charts. And that's when we reported to, you know, we brought this to the attention of the state. And they said, "Yeah, we'll get on top of it. We'll correct it." But nothing ever happened. And we would keep getting the reports back, and they'd say the target wasn't met.* ***It was never fixed… I gave up, and I think the hospital leadership gave up.***

*…[Regarding Medicare bundled payments,] I was probably one of the most anxious about that and said, "Guys, you know, we got to get together on this and get going." …****Perhaps because everything fell apart with the state initiative before, I wasn't getting a lot of traction****... They put it on hold*

--subspecialist physician, hospital-affiliated small single-subspecialty practice

Conflicting models

- The cacophony of measures persists, even for large practices with market power

Administrative simplicity means two completely different things whether you're looking at it from the payer's side or from the provider's side. And they're almost antithetical. *So administrative simplification to us complicates matters for the payer, and administrative simplification for the payer… complicates things for us. …The quality side of value-based payment is really a disaster, I would say, and actually MIPS is going to make it worse.* ***And so, the big thing that we did, which we actually had done by 2014, is we just decided to accept that fact and that we were never going to be able to change it, that everybody was going to make up their own quality measures and they wouldn't be the same across payers***. *And we tried and are still trying to get the commercial payers to kind of go more towards the Medicare model of using clinical data that's derived from actual clinical records. But so far, we haven't been successful…*

--Physician leader of a large multi-specialty practice participating in ACOs, capitation, PFP

Practices' strategies for alternative payment models (persistent)

New capabilities

- Primary care practices becoming more comprehensive

*So we have a **medical home care coordinator program** at the clinics, those are expanding, but also their job roles are expanding to include things like **social determinants of health assessment** and dealing with issues like transportation and referral to agencies. We're **embedding behavioral health providers in the primary care clinics**, so we have an entire training program online and in person for both therapy folks, as well as the pediatricians, to prescribe medications. **We even have a substance abuse program**, where we're prescribing medications for opioid withdrawal in some of our primary care practices, that's like world changing.*

--physician leader of large multispecialty practice

New capabilities

- New informatics capabilities

When my patient goes to the emergency room, I receive an alert via the ACO's app. It's going to tell me Mr. Smith is in the emergency room at Hospital [X]. Mr. Smith has been discharged from Hospital [X]. So once I get that, I can talk to the patient or the family and say I am aware that they are there, that I can help. I can provide the doctors with more information. And once I know that the patient was discharged, then me or my staff can call the patient and say, "You've been discharged from Hospital [X]. I'd like you to come Thursday so we can review your medications.

--Physician in a primary care practice participating in a local ACO

Investment in data & analysis

- Internal tracking capabilities

We follow our own measures… I have the target goals right here …it's in the system. ***We have a scorecard that we're able to look at, and it's updated on a weekly basis****. So I can see where we fall. I can see what measures we're doing really well on, I can see what measures we're still struggling with,* ***and I can dive down to the provider and I can see which provider is struggling with which measure****. I can also identify the missed opportunities that the provider had. So, you know, of these patients that walked in to see you in the month of March, or in the month of February… hypothetically speaking, 200 were in need of these screenings and only 100 got screened. So what happened to the other 100? …I'm able to get that report to that level.*

--clinic administrator within a large multispecialty practice participating in capitation and PFP

Incentives modified within practices

- Quality incentives passed through, but only after modification in most cases
- Cost incentives almost never passed through as individual physician financial incentives

*There's no differential payment of individual member practices, according to their [total medical expenditure] or quality performance, but **every one of us got A's in college, at least, and a lot of us got A's in medical school**, and if you send me a report that says that I'm a bottom feeder, I'm pretty bent out of shape, and I want to get those A's.*

--physician leader and practicing physician in a primary care practice within large organization

New: Accelerating Pace of Change

Accelerating pace of change

- Multiple interviewees described current pace as being greater than in prior periods of change

*[HMOs and HIPAA each] were just kind of like one big pill we had to swallow. Whereas, with the ACA now …and PQRS going from an incentive to becoming punitive…and Meaningful Use and ICD-10 and now with MIPS this year we have clinical practice improvement activities and then next year we have the resource use piece of MIPS coming in. And the rules for leaving MIPS to join the APM—or now they're calling them AAPMs—**the rules are changing multiple times during the year** and all of the different measures that they're following and they care about and the requirements for submitting them. …What we're seeing right now is just a lot of these what I would call like big pills to swallow all in a very short time period of the seven to eight years, where **it seems like almost every year there's a major shift that you have to make**.*

--local medical society leader

Accelerating pace of change

- Some vendors are having a tough time keeping up
    - Makes it harder for practices to get advice

With a lot of the so-called experts that are out there, there's a lot of mismanagement of information. The solo docs especially, I mean, they can't even afford to have their own front-office people go out to get educated at places like the MGMA. …I was on the phone earlier today with the owner of a billing company in my area and she was telling me, "I never got involved in any of this stuff because I'm about five years away from retirement, so why would I get involved with all this new ACA, the PQRS, the Meaningful Use, MACRA, and all this stuff? It's just not worth it. It's so complex, it's so complicated. And I know how to do what I know how to do, so I'm gonna stick with the specialties that don't really depend on that."

--MGMA chapter leader

Accelerating pace of change

- Some practices explicitly wished for a pause in the pace of change

We need to call a time out. We need to create a moratorium … Nothing against academics, nothing against new ideas, but before you implement new ideas, let the old ideas get into effect. Many of my colleagues, including me, really have to keep up to understand what is HEDIS, what is MACRA, what is Meaningful Use, when is Meaningful Use phased out, when is MACRA phased in? We don't even have time to take a deep breath in order to digest what is important.

--physician owner of primary care solo practice

Unexpected APM reversals

- Sudden or unexpected changes in payment models due to discontinuities across administrations

*Oh, this is just kind of crazy. Let me think back on it. We were in the bundled payment system for Medicaid [in 2014], and that was proposed by the surgeon general at the time, who was under [the previous] governorship. And the [new] governor came in, he fired the surgeon general. So we have a new surgeon general …and so some of those episodes of care have kind of dwindled. …[However], **it improved care anyway** because we strictly forbade the residents to give antibiotics for upper respiratory infections. So I think [bundled payment] made a big difference…[But] it's hard in this day and time to keep anything going and, as you know, with like TV, the focus is about 30 seconds and then you're off to something else.*

--physician owner of a small primary care practice

Unexpected APM reversals

- Effects on investments, practice finances, relationships

[Under mandatory cardiac bundled payments, hospitals] were really after the cardiologists. And some people have sold and so people were promised to buy or promised they'd be bought and that kind of went on hold and halted. Of course, a lot of people have bad blood because of that. [Cardiologists said], "You promised me to do this and now you're not going to do it," and the hospital said, "Well, I wanted to do it but now I can't do it because it's changed." Same for the orthopedic surgeons.

--medical society leader, describing effects of discontinuing mandatory bundled payments in Medicare

Unexpected APM reversals

- There were also notable shifts back to FFS in two markets
  - Possibly due to employers increasingly using HDHPs instead of managed care plans
  - Effects on morale for physicians accustomed to VBP

[Our practice has become] almost exclusively and primarily concerned with volume because of this change [to FFS], which is nothing like we ever were before. And what I am seeing with that change is a decrease in quality, a decrease in patient satisfaction, a decrease in all things that I hold most important, and that's part of why I'm leaving.

--primary care physician within a large multispecialty practice that swung back toward FFS since 2014 (involuntarily)

New: Complexity of Payment Models

Complexity of payment models

- Practices making significant investments to understand & comply with APM requirements

Finding qualified people to run this program has been awful *and especially with what the physicians would want to pay to get that quality. You've got to know IT. You've got to know some medicine. You've got to know how to put documents together. You've got to know how to work Excel. You've got to know how to do presentations. You've got to know how to do all of it, you know, the blah-blah—I mean it goes on and on and on—if you're going to do it right. You have to do budgets for CPC. You have to show them how you spent the money. You've got to make sure you're legal doing this or they can come in and take all of your money back from you that you've already used to pay people…*

--office manager of medium-sized primary care practice, discussing CPC+

Complexity of payment models

- Some practices have delegated their APM engagement strategies to vendors

Our EHR is the one that basically does MACRA for us. So in the licensing terms that we have with our EHR, [the vendor] is the one that basically runs the reports, submits the data for MACRA, all that kind of stuff. It tells us, basically, what the new measurements are going to be, what packages that they have to assist the doctors and meeting those measurements and whether we're interested or not—you know, that type of sort of thing. ***I've done MACRA research on my own just to get prepared but it hasn't been in-depth, again because [EHR vendor] is the one who does who does everything for us.***

--office manager of a medium-sized single-subspecialty practice

Complexity of payment models

- Understanding APM rules has enabled new strategies
  - Example: actively managing patient attribution, without changing care

One of the things that we did early in the ACOs was offload the cost of skilled nursing care*. It's almost always the primary care physician that's responsible for that if that person is also in the ACO. All of the costs for the [most expensive] patients, even with a high risk-adjustment factor, are saddled back to the ACO. …[Savings seemed to come from] people managing the cost of nursing home care better, and that's why they stayed in the green, the shared savings. What they are kind of missing is that most of that occurred because somebody created a separate tax ID for the work in the nursing home so that it didn't impact the ACO.* ***Didn't change cost structure. Didn't change the acuity of the patient. It just subtracted that ugly cost from the ACO.***

--leader of MSSP ACO

New: Risk aversion more prominent

Risk aversion

- Affecting model choice
    - Avoiding downside risk, if inexperienced with taking on such risk or had past losses

We did an upside only, an MSSP Track 1. We didn't take a risk contract. …[W]e did an operating analysis and felt like we had the systems in place so we could handle it. But when we did the financial analysis, and we looked at the shared savings and the shared risk models, the shared risk models offered very little additional upside, but the downside was dramatic. And we just said for $2 million more, we're not willing to take $17 million [potential] hit, right? So it just didn't make sense. Now CMS is going to—they're going to force the hand.

--administrative leader of large multispecialty practice

Risk aversion

- Practices offloading downside risk to partners
    - Example: device manufacturers

We're looking at BPCI-A, the advanced version. …So [hospital and device manufacturers] have been doing bundled payment stuff as a facilitator or convener for a long time. We got what seemed like reasonable proposals from both of them. ***The [device manufacturer] one, for example, they'll take all the downside risk, and they want a 30 percent cut of the upside****. So okay, that seems reasonable, since we're getting into stuff that we don't know…and wouldn't be doing on our own. So if it's a downside, it's their problem; if it's an upside, it's found money for us.*

--physician leader of small orthopedic practice

Risk aversion

- Shifting risk back onto payers
  - Practices learning from past losses
  - Willing to forgo some bonuses to get protection

If you can cure Hepatitis C, and there's a cohort of tens of thousands of people out there with Hepatitis C, you're not seriously going to ask us to withhold those drugs because we're not going to. That's unethical. And yet you will hold us accountable for the cost of those drugs. So, let me get this right, and this is what happened two years ago, is Sovaldi, ***we lost in our commercial contracts because of Sovaldi****, we paid penalties to the commercial payers who had to purchase those drugs, right? So, we are then paying pharma for their price escalations…* ***[But] the payers are negotiating with pharma, right?*** *So that's just wrong. That is just completely wrong. Makes us furious. We have negotiated, we have made it clear how we feel about this and that is definitely not risk we should be taking on.* ***…[Now] we have some protection****. It's some complicated thing, which is sort of a retrospective if certain price trends hit certain thresholds…****we don't pay a penalty, but we don't get any of the shared savings [if we save on drugs****].*

--physician leader of large multispecialty practice, regarding a shared savings payment model

Conclusions

- Simpler APMs might help practices focus on improving patient care
- Practices would benefit from a stable, predictable, moderately-paced pathway for APMs
- Practices need new capabilities and timely data to succeed in APMs
- Reducing practices' access to upside-only APMs risks disengaging them
- Designing APMs to encourage clinical changes that individual physicians see as valuable might improve their effectiveness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2019 Medicare payment policy: Everything you need to know

1:00 p.m. – 2:20 p.m. | Friday, November 9 | Potomac 1 & 2 | Gaylord National Resort and Convention Center

INTEGRATED PHYSICIAN PRACTICE SECTION

1:00 p.m. – 2:20 p.m. 2019 Medicare payment policy: Everything you need to know

Join Molly MacHarris, program lead, Merit-Based Incentive Payment System (MIPS), Centers for Medicare & Medicaid Services (CMS) to learn about changes to MIPS for 2019 and how they will impact your integrated system. Finally, Barbara Levy, MD, Co-Chair AMA CPT/RUC Workgroup on E&M will discuss current efforts to improve Evaluation and Management coding and reduce documentation burdens.

Molly MacHarris
Program Lead, MIPS
Center for Clinical Standards and Quality
Center for Medicare & Medicaid Services

Molly MacHarris is a program lead in the Center for Clinical Standards and Quality at CMS. She is the lead for the Merit-Based Incentive Payment System (MIPS) program under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Prior to this role, Molly ran the development of policies and operations on the Physician Quality Reporting System (PQRS) and Electronic Prescribing (eRx) Incentive Programs. In this capacity, Molly provides leadership and input to a variety of aspects of the programs, including stakeholder engagement, operations, policy development and alignment with other quality programs.

Barbara S. Levy, MD
Vice President, Health Policy
American College of Obstetricians and Gynecologists (ACOG)

Dr. Barbara S. Levy is the Vice President, Health Policy and administers ACOG's Office of Global Women's Health programs to improve patient safety and quality of women's health worldwide. Dr. Levy also supervises The Alliance for Innovation on Maternal Health program (AIM), Voluntary Review of Quality of Care, Safety Certification for Outpatient Practice Excellence for Women's Health, American Indian/Alaska Native Health Program, Health Economics, Strategic Health Care Initiatives department and programs for Maternal Mortality and Fetal & Infant Mortality.

Dr. Levy has been a member of the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) since 1999 and in 2015 she completed serving two consecutive terms as Chair of the RUC. The RUC is an expert panel of volunteer physicians and providers that issues recommendations to CMS regarding the relative work and direct practice expenses required to perform medical services.

Before joining ACOG, Dr. Levy was in private ob-gyn practice and medical director of the Women's Health and Breast Center and Women's and Children's Services for the Franciscan Health System in Tacoma, Washington. Recognized in 2015 by Modern Healthcare magazine as one of the 50 Most Influential Physician Executive and Leaders, she has published and co-authored more than 80 studies and articles related to her primary research interests: hysterectomy, endoscopic surgery, pelvic pain, surgical outcomes, and physician payment policy.

Dr. Levy graduated magna cum laude with an undergraduate degree in psychology from Princeton University and received her medical degree from the University of California, San Diego, followed by an internship and residency in ob-gyn at University of Oregon Health Sciences Center (now Oregon Health & Sciences University) in Portland.

Program slides coming soon

REPORT OF THE INTEGRATED PHYSICIAN PRACTICE SECTION
GOVERNING COUNCIL

GC Report A-I-18

Subject: IPPS Review of House of Delegates Resolutions & Reports

Presented by: Peter Rutherford, MD, Chair

IPPS Governing Council Report A identifies resolutions and reports relevant to integrated health care delivery groups or systems that have been submitted for consideration by the AMA House of Delegates (HOD) at the 2018 AMA Interim Meeting. This report is submitted to the Assembly for further discussion and to facilitate the instruction of the IPPS Delegate and Alternate Delegate regarding the positions they should take in representing the Section in the HOD.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS (AMA CONSTITUTION, AMA BYLAWS, ETHICS)

No items under consideration by the Reference Committee on Amendments to Constitution and Bylaws.

REFERENCE COMMITTEE B (LEGISLATION)

(1) 216-I-18: Medicare Part B Competitive Acquisition Program (CAP)
Introduced by the American Society of Clinical Oncology

RESOLVED, That our American Medical Association advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

(1) it must be genuinely voluntary and not penalize practices which choose not to participate;

(2) it should provide supplemental payments to support complex care coordination and management for cancer patients, including reimbursement for costs associated with the administration of anticancer drugs such as special handling and storage for hazardous drugs;

(3) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP- acquired drugs at multiple office locations;

(4) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;

(5) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician; and

(6) it should not be tied to negotiated discounts such as rebates to pharmacy benefit managers given in exchange for implementing utilization management policies like step therapy. (New HOD Policy)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Resolution 216.

(2) 217-I-18: Opposition to Medicare Part B to Part D Changes
Introduced by the American Society of Clinical Oncology

RESOLVED, That our American Medical Association advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D. (New HOD Policy)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Resolution 217.

(3) 225-I-18: Surprise Out of Network Bills
Introduced by New York

RESOLVED, That our American Medical Association advocate that any federal legislation on "surprise" out of network medical bills be consistent with AMA Policy H-285.904, "Out-of Network Care," and apply to ERISA plans not subject to state regulation (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that such federal legislation protect state laws that do not limit surprise out of network medical bills to a percentage of Medicare or health insurance fee schedules. (New HOD Policy)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Resolution 225.

(4) 227-I-18: CMS Proposal to Consolidate Evaluation and Management Services
Introduced by American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Neurology, American Academy of Physical Medicine and Rehabilitation, American Association of Clinical Endocrinologists, American Clinical Neurophysiology Society, American Gastroenterological Association, American Psychiatric Association, American Society of Clinical Oncology, Endocrine Society, Infectious Diseases Society of America, Maryland, North American Neuro-Ophthalmology Society, Society for Investigative Dermatology, Kentucky, Georgia

RESOLVED, That our American Medical Association actively seek and support congressional action before January 1, 2019 that would prevent implementation of changes to consolidate evaluation and management services as put forward in the CY 2019 Medicare physician fee schedule proposed rule if CMS in the final rule moves forward with the consolidation of evaluation and management services. (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Resolution 227.

REFERENCE COMMITTEE C (MEDICAL EDUCATION)

(5) CME 3-I-18 Developing Physician-Led Public Health/Population Health Capacity in Rural Communities
Introduced by the AMA Council on Medical Education

The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of the report be filed

1. That Policy D-295.311, "Developing Physician Led Public Health / Population Health Capacity in Rural Communities," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy)

2. That our American Medical Association (AMA) reaffirm the following policies: D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum" D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion" D-305.974, "Funding for Preventive Medicine Residencies" H-425.982, "Training in the Principles of Population-Based Medicine" D-440.951, "One-Year Public Health Training Options for all Specialties" H-440.954, "Revitalization of Local Public Health Units for the Nation" H-440.888, "Public Health Leadership" H-440.969, "Meeting Public Health Care Needs Through Health Professions Education" (Reaffirm HOD Policy)

3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially to women and those who are underrepresented in medicine. (Directive to Take Action)

4. That our AMA encourage public health leadership programs to evaluate the effectiveness of various leadership interventions. (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of CME 3.

REFERENCE COMMITTEE F (AMA GOVERNANCE AND FINANCE)

(6) 604-I-18 – Physician Health Policy Opportunity
Introduced by Washington

RESOLVED, That our American Medical Association, working with the state and specialty societies, make it a priority to give physicians the opportunity to serve in federal and state health care agency positions by providing the training and transitional opportunities to move from clinical practice to health policy (Directive to Take Action); and be it further

RESOLVED, That our AMA study and report back to the House of Delegates at the 2019 Interim meeting with findings and recommendations for action on how best to increase opportunities to train physicians in transitioning from clinical practice to health policy (Directive to Take Action); and be it further

RESOLVED, That our AMA explore the creation of an AMA health policy fellowship, or work with the Robert Wood Johnson Foundation to ensure that there are designated physician fellowship positions within their Health Policy Fellowship program to train physicians in transitioning from clinical practice to health policy (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Resolution 604.

REFERENCE COMMITTEE J (MEDICAL SERVICE, MEDICAL PRACTICE, INSURANCE)

(7) BOT 9 -Hospital Closures and Physician Credentialing
Introduced by the AMA Board of Trustees

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)

2. That our AMA develop model state legislation and regulations that would require hospitals to: (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action)

3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of BOT 9.

(8) CMS 4-I-18 The Site-of-Service-Differential
Introduced by the Council on Medical Service

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 817-I-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more aggressive implementation by the US Department of Health and Human Services of existing provisions in federal legislation calling for equity in payment between services provided by hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare & Medicaid Services (CMS) to define Medicare services consistently across settings and adopt payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm HOD Policy

3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense relative value units reflect the true cost of performing office procedures. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare. (Reaffirm HOD Policy)

5. That our AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. (New HOD Policy)

6. That our AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting. (New HOD Policy)

7. That our AMA urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. (New HOD Policy

8. That our AMA encourage CMS to both: a) base disproportionate 1 share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy)

9. That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Assembly discuss CMS 4.

(9) 802-I-18: Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (up and down side risk)
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

RESOLVED, That our American Medical Association advocate for the continuation of up side only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups (New HOD Policy); and be it further

RESOLVED, That our AMA develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. (Directive to Take Action)

Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the AMA House of Delegates be instructed to support the intent of Resolution 802.

REFERENCE COMMITTEE K, (SCIENCE AND PUBLIC HEALTH)

No items under consideration by the Reference Committee K.

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Future IPPS Meetings

	Annual Meeting	**Interim Meeting**
2019	June 6-7, Hyatt Regency, Chicago, IL • Thursday, June 6, IPPS GC Meeting • Friday, June 7, IPPS Assembly Meeting	Nov. 14-15, Manchester Grand Hyatt, San Diego, CA • Thursday, Nov. 14, IPPS GC Meeting • Friday, Nov. 15, IPPS Assembly Meeting
2020	June 4-5, Hyatt Regency, Chicago, IL • Thursday, June 4, IPPS GC Meeting • Friday, June 5, IPPS Assembly Meeting	Nov. 12-13, Manchester Grand Hyatt, San Diego, CA • Thursday, Nov. 12, IPPS GC Meeting • Friday, Nov. 14, IPPS Assembly Meeting
2021	June 10-11, Hyatt Regency, Chicago, IL • Thursday, June 10, IPPS GC Meeting • Friday, June 11, IPPS Assembly Meeting	Nov. 11-12, Walt Disney World Swan and Dolphin Resort, Orlando, FL • Thursday, Nov. 11, IPPS GC Meeting • Friday, Nov. 12, IPPS Assembly Meeting
2022	June 9-10, Hyatt Regency, Chicago, IL • Thursday, June 9, IPPS GC Meeting • Friday, June 10, IPPS Assembly Meeting	Nov. 9-10, Hilton Hawaiian Village, Honolulu, HI • Thursday, Nov. 9, IPPS GC Meeting • Friday, Nov. 10, IPPS Assembly Meeting

Future IPPS elections

Elections for the IPPS Governing Council are held every two years. The next scheduled election will be at the IPPS Annual Meeting, June 7, 2019. All seats will be open for election or re-election. For more information, please contact carrie.waller@ama-assn.org