

REPORT 10 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Alternative Payment Models and Vulnerable Populations
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked: That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

Health care disparities often occur in the context of wider inequality. It has been shown that if patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. And because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, as Resolution 712 points out, value-based payment programs can disproportionately penalize physicians serving the poorest and most vulnerable populations. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council's recommendations build upon the AMA's current policy on value-based payment programs and social determinants of health. The Council recommends reaffirming existing AMA policies to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients, and the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations.

The Council understands and agrees with the sponsor's concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 10-A-19

Subject: Alternative Payment Models and Vulnerable Populations
(Resolution 712-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

1 At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was
2 introduced by the New England Delegation and assigned to the Council on Medical Service for
3 study. Resolution 712-A-18 asked:

4
5 That our American Medical Association (AMA): (1) study the impact of current advanced
6 Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable
7 populations; and (2) advocate legislatively that advanced APMs examine the evaluation of
8 quality performance (for bonus or incentive payment) of providers caring for vulnerable
9 populations in reference to peer group (similarities in SES status, disability, percentage of dual
10 eligible population).

11
12 This report provides an overview of vulnerable populations and the emergence of APMs, highlights
13 numerous APMs and value-based care initiatives incorporating social determinants of health into
14 their models, summarizes relevant AMA policy, provides a summary of AMA advocacy activities,
15 and recommends policy to encourage the development of APMs that serve vulnerable populations
16 while protecting physicians from being financially penalized.

17 18 BACKGROUND

19
20 The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable
21 Growth Rate (SGR) formula and created new ways for the Medicare program to pay physicians for
22 the care they provide to Medicare beneficiaries. Specifically, MACRA's physician payment
23 program is the Quality Payment Program (QPP). The QPP has two tracks of participation: APMs
24 and the Merit-based Incentive Payment System (MIPS). As part of the QPP's drive to value-based
25 care, it creates incentives for physicians to participate in APMs, which aim to provide greater
26 flexibility to manage the health of patient populations by aligning provider incentives with cost and
27 quality goals. MACRA specifically encourages the development of Physician-Focused Payment
28 Models (PFPMs), which are APMs wherein Medicare is the payer, physician group practices or
29 individual physicians are APM participants, and the focus is on the quality and cost of physician
30 services. MACRA established the Physician-Focused Payment Model Technical Advisory
31 Committee (PTAC) to review and assess PFPM proposals submitted by stakeholders to the
32 committee based on certain criteria defined in regulations. The PTAC is an 11-member
33 independent federal advisory committee. Since its inception, the PTAC has received 31 proposals
34 for consideration, a few of which have not been reviewed yet by PTAC. Of those proposals, PTAC
35 has recommended 15 proposals to the Secretary of Health and Human Services (HHS) to test in
36 various ways.

1 As the national push toward value-based payment and care delivery continues, many studies have
2 demonstrated substantial evidence linking social circumstances to health and health outcomes.¹ It is
3 now understood that non-medical factors, such as social determinants of health (SDH), account for
4 about 60 percent of a person's health outcomes.² Together, the drive toward value and recognition
5 of SDH impacts on health are fueling interest in the ways in which addressing SDH may be
6 incorporated into new payment and delivery models like APMs. Within an APM, physicians often
7 are financially rewarded for keeping patients healthy and out of the hospital and emergency
8 departments. To achieve this goal, APMs often have the flexibility to support services that can
9 significantly improve health outcomes. Therefore, physicians can respond to APM incentives by
10 improving care coordination and integration, which may be particularly beneficial for vulnerable
11 populations.

12
13 However, APMs may inadvertently create incentives for physicians to avoid caring for vulnerable
14 patients who are at increased risk for high costs and poor outcomes that are beyond the physician's
15 control.³ In order to increase health equity and to fully realize the benefits of APMs, APMs must
16 contemplate and account for vulnerable populations.

17
18 *Impact of Vulnerable Population Status on Patient Outcomes*

19
20 Vulnerable populations in health care include the economically disadvantaged, racial and ethnic
21 minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups; uninsured individuals;
22 rural individuals who may have trouble accessing care; and those with stigmatized chronic
23 conditions such as severe mental illness or human immunodeficiency virus (HIV).⁴ These
24 populations may be more likely to suffer from hunger and access to healthy food options, lack
25 social and economic support, have lower education levels, live in unsafe neighborhoods devoid of
26 parks and playgrounds, and often are subjected to discrimination.⁵

27
28 Vulnerable populations are less likely to have health coverage, struggle with health care access,
29 and often have little interaction or trust in the health care system. They are less likely to receive
30 preventive services and are more likely to go to the emergency department or hospital for a
31 condition that might have been treated in a lower cost facility.⁶ As a result, their medical
32 interventions generally come much later and at significantly higher cost than for other populations.
33 Moreover, lower income populations are twice as likely as those with higher incomes to have
34 behavioral health problems, three times as likely to be socially isolated, and 10 times more likely to
35 experience food insecurity.⁷ Additionally, there is considerable overlap in vulnerable populations.
36 For example, Black and Hispanic American minorities are significantly more likely than Whites to
37 be uninsured, live below the poverty line, and have higher rates of HIV or AIDS diagnosis and
38 death rates.⁸

39
40 Though access to health care is essential for well-being, it is not the greatest health determinant.⁹
41 Zip Code™ now is understood to be a stronger predictor of quality of health than even genetic
42 code. Research suggests that health-related behaviors such as smoking, diet, and exercise, are more
43 important determinants of early death than health care itself. Furthermore, there is a growing
44 consensus that non-medical factors shape an individual's ability to engage in health behaviors. For
45 example, children born to parents who have not completed high school are more likely to live in an
46 environment that poses barriers to health such as lack of safety, exposed garbage, and substandard
47 housing.¹⁰ Such environmental factors may have multi-generational impacts.

48
49 Generally, the current health care system is not built around the poorest and most vulnerable.
50 Exacerbating the ability to effectively care for these populations is the fact that many physicians
51 are not able to identify high-risk patients. Some of the current risk algorithms used by payers were

1 originally developed without access to electronic medical record (EMR) data, so many current
2 predictive risk tools have limited utility. The link between non-medical factors and poor health
3 outcomes is well-documented, but few traditional payment and delivery models are equipped to
4 address these non-medical factors that drive high health care costs and poor outcomes.

5
6 *Addressing the Unique Needs of Vulnerable Populations in Payment and Delivery*

7
8 There are a growing number of initiatives to address SDHs and challenges unique to vulnerable
9 populations within and outside of the health care system. These include multi-payer federal and
10 state initiatives, Medicaid initiatives led by states or health plans, and physician-level activities
11 focused on identifying and addressing the social needs of their patients. APMs can provide
12 opportunities to cover services that can help provide care and support that vulnerable or high-risk
13 populations need but that are generally not available under traditional payment models. Examples
14 of such initiatives are highlighted below and include: Accountable Health Communities, the
15 Chinese Community Accountable Care Organization (ACO), the Acute Unscheduled Care Model,
16 and the Patient-Centered Opioid Addiction Treatment (P-COAT) APM.

17
18 Accountable Health Communities

19
20 In 2016, the Center for Medicare and Medicaid Innovation (CMMI), which was established by the
21 Affordable Care Act, announced the Accountable Health Communities model, which is focused on
22 connecting Medicare and Medicaid beneficiaries with community services to address health-related
23 social needs.¹¹ The model provides funding to examine whether systematically identifying and
24 addressing social needs of beneficiaries through screening, referral, and community navigation
25 services affects health costs and reduces health care utilization. In 2017, CMMI awarded grants to
26 organizations to participate in the model over a five-year period.¹²

27
28 Twenty awardees will encourage partner alignment to ensure that community services are available
29 and open to the needs of beneficiaries. To implement the alignment approach, bridge organizations
30 will serve as “hubs” in their communities that will identify and partner with clinical delivery sites
31 to conduct systematic screenings of beneficiary health-related social needs and make referrals to
32 community services that may be able to address the recognized social needs; coordinate and
33 connect beneficiaries to community service providers through community service navigation; and
34 align model partners to optimize community capacity to address these social needs.

35
36 The Chinese Community ACO

37
38 The Chinese Community ACO (CCACO) is a community-based physician-owned ACO that serves
39 about 12,000 Medicare fee-for-service (FFS) beneficiaries in the Chinese communities in New
40 York City.¹³ The aim of the model is to reduce overall health care costs and disparities by
41 identifying high-risk individuals and undertaking proactive disease management. The CCACO
42 establishes a network of organizations by partnering with hospitals, nursing homes, home health
43 agencies, senior centers, and others to facilitate coordinated care. The model anticipates that, due to
44 care coordination efforts, it will prevent emergency room visits and hospital readmissions in this
45 population.

46
47 Acute Unscheduled Care Model (AUCM) Enhancing Appropriate Admissions from the American
48 College of Emergency Physicians (ACEP)

49
50 The AUCM was developed by the ACEP. The particular payment model was submitted to the
51 PTAC, and the PTAC subsequently recommended to the Secretary of HHS that the model be

1 implemented. It centers on incentivizing improved quality and decreased costs associated with the
2 discharge decisions made by emergency department (ED) physicians.¹⁴ The model proposes that it
3 may reduce Medicare spending and improve quality care by reducing avoidable hospital inpatient
4 admissions and observation days by giving ED physicians the ability to coordinate and manage
5 post-discharge home services. The model is a bundled payment, and the episode of care begins
6 with a qualifying ED visit and ends after 30 days or with the patient's death.¹⁵ All of the Medicare
7 services received within that 30-day window are included in the bundle. To assist in care
8 transformation efforts, the model also uses several waivers in order to allow ED physicians to offer
9 telehealth services, bill for transitional management codes, and permit clinical staff to offer home
10 visits.

11

12 Patient-Centered Opioid Addiction Treatment (P-COAT) APM

13

14 The P-COAT model is a payment model created jointly by the American Society of Addiction
15 Medicine (ASAM) and the AMA. The model proposes to manage opioid use disorder, a highly
16 stigmatized condition, by increasing utilization of and access to medications for the treatment of
17 opioid use disorder by providing the appropriate financial support to successfully treat patients and
18 broaden the coordinated delivery of medical, psychological, and social supports.¹⁶ The current
19 payment system offers little support for the coordination of behavioral and social supports that
20 patients being treated for opioid use disorder need. Therefore, under P-COAT, treatment teams are
21 eligible to receive two new types of payments that would be expected to provide the necessary
22 financial support to enable providers to deliver the appropriate opioid addiction treatment.¹⁷

23

24 AMA POLICY

25

26 The AMA has a wealth of policy on both APMs and SDH. Regarding APMs, Policy H-385.913
27 promulgates goals for physician-focused APMs, develops guidelines for medical societies and
28 physicians to begin identifying and developing APMs, encourages the Centers for Medicare &
29 Medicaid Services (CMS) and private payers to support assistance to physician practices working
30 to implement APMs, and states that APMs should account for the patient populations, including
31 non-clinical factors. Policy H-385.908 states that the AMA will continue to urge CMS to limit
32 financial risk requirements to costs that physicians participating in an APM have the ability to
33 control or influence, will work with stakeholders to design risk adjustment systems that identify
34 new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a
35 patient's health and success of treatment, such as disease stage, access to health care services, and
36 socio-demographic factors.

37

38 Moreover, AMA policy is committed to promoting physician-led payment reform programs that
39 serve as models for others working to improve patient care and lower costs. Policy D-390.953
40 directs the AMA to advocate with CMS and Congress for alternative payment models developed in
41 concert with specialty and state medical organizations. Policy H-390.844 emphasizes the
42 importance of physician leadership and accountability to deliver high quality and value to patients
43 and directs the AMA to advocate for providing opportunities for physicians to determine payment
44 models that work best for their patients, their practices, and their regions. Policy H-450.961 states
45 that incentives should be intended to promote health care quality and patient safety and not
46 primarily be intended to contain costs, provide program flexibility that allows physicians to
47 accommodate the varying needs of individual patients, adjust performance measures by risk and
48 case-mix to avoid discouraging the treatment of high-risk individuals and populations, and support
49 access to care for all people and avoid selectively treating healthier patients. Additionally, Policy
50 D-35.935 supports physician-led, team-based care delivery recognizing that the interdisciplinary
51 care team is well equipped to provide a whole-person health care experience.

1 The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA
2 continues to exercise leadership aimed at addressing disparities (Policies H-350.974, D-350.991,
3 D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943,
4 H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the
5 AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and
6 states that the elimination of racial and ethnic disparities in health care are an issue of highest
7 priority for the organization. The policy encourages the development of evidence-based
8 performance measures that adequately identify socioeconomic and racial/ethnic disparities in
9 quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote
10 the consistency and equity of care for all persons. Moreover, the policy actively supports the
11 development and implementation of training regarding implicit bias and cultural competency.
12 Policy H-280.945 calls for better integration of health care and social services and supports while
13 Policy H-160.896 calls to expand payment reform proposals that incentivize screening for social
14 determinants of health and referral to community support systems. Additionally, Policy D-350.995
15 promotes diversity within the health care workforce, which can help expand access to care for
16 vulnerable and underserved populations.

17
18 Recognizing that current risk adjustment and performance measure systems may disincentivize
19 caring for the most vulnerable, Policy H-450.924 supports that hospital program assessments
20 should account for social risk factors so that they do not have the unintended effect of financially
21 penalizing hospitals, including safety net hospitals, and physicians that may exacerbate health care
22 disparities.

23

24 AMA ACTIVITY

25

26 The AMA continues to work to aid physicians in the implementation of MACRA and by
27 encouraging and enabling physician participation in APMs. The AMA has been active in
28 educational activities including webinars and regional conferences for physicians and staff and will
29 be continuing these activities. Recent AMA advocacy activity has called for improvements in the
30 methodologies behind APMs. Such areas for improvement in methodology include performance
31 targets, risk adjustment, and attribution. The AMA recognizes that proper methodologies enable
32 more physicians to participate in APMs and promotes design of APMs in such a way that
33 prioritizes the patient's need.

34

35 The AMA continues to strive to ensure that all communities of Americans receive equal access to
36 quality health care. The AMA is committed to working toward the goal of all Americans having
37 access to affordable and meaningful health care. It is addressing this issue systemically by striving
38 for health equity by mitigating disparity factors. For example, the AMA has developed numerous
39 resources including a Health Disparities Toolkit that helps connect physicians and care teams to
40 chronic disease prevention programs in the community. The AMA STEPSForward™ module
41 entitled Addressing Social Determinants of Health describes how a practice can select and define a
42 plan to address SDH issues. Additionally, steps toward health equality are being taken in the
43 AMA's effort toward creating the medical school of the future. Within the AMA's Accelerating
44 Change in Medical Education (ACE) initiative, some medical schools are incorporating education
45 on disparities within their curricula while others are addressing diversity in the health care
46 workforce by changing admissions and pipeline programs to ensure that our nation has the diverse
47 workforce that it needs.

48

49 Additionally, the AMA is integrating SDH into its Integrated Health Model Initiative (IHMI), a
50 collaborative effort that supports a continuous learning environment to enable interoperative
51 technology solutions and care models that evolve with real world use and feedback. IHMI's

1 collaborative platform is discussing SDH with the goal of identifying those factors that should be
2 incorporated into the IHMI data model. Moreover, the IHMI team has delivered a module that
3 incorporates two of the widely accepted SDH: the nine-digit Zip Code™ where one lives and those
4 who are dually-eligible for Medicaid and Medicare.

5
6 Importantly, the AMA recognizes that health quality can only happen in concert with efforts to
7 improve physician satisfaction and wellbeing. Therefore, the AMA is helping create an engaged
8 workforce and mitigating burnout. To that end, the AMA has developed STEPSForward™
9 resources and Burnout Assessment Tools to allow physicians to assess their practices and find
10 ways to leverage their entire care team to improve physician and patient experience and care. The
11 AMA knows that advocating for physicians and patients is critical to achieve health equity. Patients
12 and the public are partners in the quest for equitable access to quality health and health care.

13
14 Moreover, the AMA is establishing a new Health Equity Center with the goal of enabling optimal
15 health for all with an eye on social justice. The Center will serve as a demonstration of the AMA's
16 long-term and enduring commitment to health equity.

17 18 DISCUSSION

19
20 Health care disparities often occur in the context of wider inequality. It has been shown that if
21 patients' basic needs are not met, they are not likely to stay healthy regardless of the quality of
22 health care received. Because APMs are typically designed to be flexible to compensate for care
23 that is not traditionally reimbursed, they present an opportunity to better care for and serve
24 vulnerable populations. However, several studies have demonstrated that value-based payment
25 programs disproportionately penalize physicians serving the poorest and most vulnerable
26 populations, possibly disincentivizing physicians from caring for them. Therefore, the Council
27 offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and
28 events. In doing so, the Council recommends ways in which the health care system can do more to
29 address non-medical factors that often go undetected and untreated among vulnerable populations
30 within the context of a changing payment and delivery system.

31
32 The Council's recommendations build upon the AMA's current policy on value-based payment
33 programs and social determinants of health. The Council notes that reaffirming existing AMA
34 policies helps to highlight the need for health equity across populations and the corresponding need
35 for APMs and risk adjustment methodologies to protect against financially penalizing the
36 physicians who care for and serve populations who are overwhelmingly sicker and poorer. The
37 Council is sensitive to concerns that APMs may have the impact of not only financially penalizing
38 physicians caring for at-risk populations, but also causing adverse selection in patient treatment.
39 The Council believes that it is critical that social determinants of health be meaningfully
40 incorporated into APM quality measures to encourage and support physicians to care for these
41 patients. The current health care system was not built for vulnerable populations, and they remain
42 woefully underserved. Therefore, the Council recommends that APMs be designed with the
43 flexibility needed to address the unique challenges of vulnerable populations and believes that
44 PFPMs provide an excellent opportunity to transform care delivery to better meet the needs of
45 underserved populations.

46
47 The Council understands and agrees with the sponsor's concern that APMs may have adverse
48 effects on vulnerable populations because current risk adjustment methodologies are not accurate
49 enough to distinguish between suboptimal care and high-quality care provided to high-risk
50 individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate
51 for appropriate risk adjustment of performance results based on clinical and social determinants of

1 health. The Council is steadfast in its belief that the structure and quality reporting of APMs must
2 protect against penalizing physicians whose performance and aggregated data are impacted by
3 factors outside of the physician's control. Furthermore, because of the Council's commitment to
4 this principle, the Council believes that the topic of risk adjustment warrants revisiting and notes
5 that at the 2019 Interim Meeting, it will present a report specifically addressing ways in which risk
6 adjustment methodology and implementation can be improved.

7
8 RECOMMENDATIONS

9
10 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
11 712-A-18 and the remainder of the report be filed:

- 12
13 1. That our American Medical Association (AMA) support alternative payment models (APMs)
14 that link quality measures and payments to outcomes specific to vulnerable and high-risk
15 populations and reductions in health care disparities. (New HOD Policy)
16
- 17 2. That our AMA continue to encourage the development and implementation of physician-
18 focused APMs that provide services to improve the health of vulnerable and high-risk
19 populations. (New HOD Policy)
20
- 21 3. That our AMA continue to advocate for appropriate risk adjustment of performance results
22 based on clinical and social determinants of health to avoid penalizing physicians whose
23 performance and aggregated data are impacted by factors outside of the physician's control.
24 (New HOD Policy)
25
- 26 4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician
27 accountability to aspects of spending and quality that they can reasonably influence; APMs
28 should understand their patient populations, including non-clinical factors; and support new
29 data sources that enable adequate analyses of clinical and non-clinical factors that contribute to
30 a patient's health and success of treatment. (Reaffirm HOD Policy)
31
- 32 5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for
33 APMs limiting the financial risk requirements to costs that physicians participating in an APM
34 have the ability to control or influence and work with stakeholders to design risk adjustment
35 systems that identify new data sources to enable adequate analyses of clinical and non-clinical
36 factors that contribute to a patient's health and success of treatment, such as severity of illness,
37 access to health care services, and socio-demographic factors. Moreover, Policy H-385.908
38 recognizes that technology should enable the care team and states that the AMA should work
39 with stakeholders to develop information technology (IT) systems that support and streamline
40 clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm
41 HOD Policy)
42
- 43 6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities
44 is a major public health problem, stating that the elimination of racial and ethnic disparities in
45 health care is an issue of highest priority for the AMA, and supporting education and training
46 on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)
47
- 48 7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care
49 recognizing that interdisciplinary physician-led care teams are well equipped to provide a
50 whole-person health care experience. (Reaffirm HOD Policy)

- 1 8. That our AMA reaffirm Policy D-350.995 promoting diversity within the workforce as one
2 means to reduce disparities in health care. (Reaffirm HOD Policy)
3
- 4 9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs) recognizing
5 that they play a critical role as bridgebuilders between underserved communities and the health
6 care system and calling for sustainable funding mechanisms to financial CHW services.
7 (Reaffirm HOD Policy)
8
- 9 10. That our AMA reaffirm Policy H-450.924 supporting that hospital program assessments should
10 account for social risk factors so that they do not have the unintended effect of financially
11 penalizing safety net hospitals and physicians that exacerbate health care disparities. (Reaffirm
12 HOD Policy)
13
- 14 11. That our AMA reaffirm Policy H-280.945 supporting better integration of health care and
15 social services and supports. (Reaffirm HOD Policy)
16
- 17 12. That our AMA reaffirm Policy H-160.896 calling to expand payment reform proposals that
18 incentivize screening for social determinants of health and referral to community support
19 systems. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Gottlieb, L., Colvin, J.D., Fleegler, E. et al. J GEN INTERN MED (2017) 32: 345. Available at: <https://doi.org/10.1007/s11606-016-3920-y>
- ² Cityblock: Better Care for Healthier Neighborhoods. Available at: <https://www.cityblock.com/mission>
- ³ Joynt Maddox, K. N Engl J Med 2018; 378:977-979. Alternative Payment Models Help or Hurt? Available at: <https://www.nejm.org/doi/full/10.1056/NEJMp1715455>
- ⁴ The American Journal of Managed Care. Vulnerable Populations: Who Are They? Available at: <https://www.ajmc.com/journals/supplement/2006/2006-11-vol12-n13suppl/nov06-2390ps348-s352>
- ⁵ Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
- ⁶ Riley, P. The Commonwealth Fund. Making Health Care Work Better for Vulnerable Patients. Available at: <https://www.commonwealthfund.org/blog/2018/making-health-care-work-better-vulnerable-patients>
- ⁷ Riley, P. The Commonwealth Fund. Making Health Care Work Better for Vulnerable Patients. Available at: <https://www.commonwealthfund.org/blog/2018/making-health-care-work-better-vulnerable-patients>
- ⁸ Orgena, K., Artiga, S. Kaiser Family Foundation. Disparities in Health and Health Care: Five Key Questions and Answers. Available at: <https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/>
- ⁹ Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
- ¹⁰ Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
- ¹¹ Artiga, S., Hinton, E. Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Available at: <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>
- ¹²Centers for Medicare and Medicaid Services. Accountable Health Communities Model. Available at: <https://innovation.cms.gov/initiatives/ahcm/>
- ¹³ Chinese Community Accountable Care Organization. Available at: <http://www.ccaco.org/about/mission/>
- ¹⁴ The Physician-Focused Payment Model Technical Advisory Committee. Report to the Secretary of Health and Human Services Comments and Recommendation on the Acute Unscheduled Care Model (AUCM): Enhancing Appropriate Admissions American College of Emergency Physicians. Available at: https://aspe.hhs.gov/system/files/pdf/255726/ReportToTheSecretary_ACEP_10.20.18.pdf
- ¹⁵ Firth, S. Medpage Today. PTAC Backs New Payment Models for Emergency, Primary Care. Available at: <https://www.medpagetoday.com/publichealthpolicy/medicare/75025>
- ¹⁶ American Medical Association. ASAM, AMA Announce Model to Improve Treatment of Opioid Use Disorder. Available at: <https://www.ama-assn.org/press-center/press-releases/asam-ama-announce-model-improve-treatment-opioid-use-disorder>
- ¹⁷ American Society of Addiction Medicine. Patient-Centered Opioid Treatment Alternative Payment Model. Available at: <https://www.asam.org/advocacy/advocacy-principles/cover-it/p-coat-apm>