REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-22

Subject: Prospective Payment Model Best Practices for Independent Private Practice (Resolution 122-J-21)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

At the June 2021 Special Meeting, the House of Delegates referred Resolution 122, "Developing Best Practices for Prospective Payment Models," which was sponsored by the Integrated Physician Practice Section. Resolution 122-J-21 asked the American Medical Association (AMA) to "study and identify best practices for financially viable models for prospective payment health insurance, including but not limited to appropriately attributing and allocating patients to physicians, elucidating best practices for systems with multiple payment contracts, and determining benchmarks for adequate infrastructure, capital investment, and models that accommodate variations in existing systems and practices" and to "use recommendations generated by its research to actively advocate for expanded use and access to prospective payment models."

Testimony was generally supportive of the intent of Resolution 122-J-21. Testimony also cited longstanding AMA support for pluralism and noted that payment systems are complex and may affect various medical specialties differently. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report acknowledges a vast wealth of AMA policy outlining best practices for prospective payment models. In addition, physicians practicing in large integrated systems have those systems to provide guidance. Accordingly, while addressing practices that affect large integrated systems, the Council also focuses this report on the development of principles to guide physicians in non-integrated (independent) private practice wishing to enter into contractual agreements with other physician practices to form clinically integrated networks (CINs) for the purposes of engaging in prospective payment models.

BACKGROUND

The move to value-based payment by both public and private payers has been advancing for more than a decade, driven by concerns with quality outcomes and accelerating health care costs. The AMA, in two qualitative studies conducted with the RAND Corporation, has examined the effects of these new payment models, often referred to as "Alternative Payment Models" or APMs, on physician practices and found that as recently as 2018, there remained significant barriers to the adoption of such models.[1] These barriers include:

- Lack of timely/accessible data for practices;
- Operational errors in payment models;
- Challenges related to interactions between payment models;
- Accelerated pace of change in payment models;
- Sudden or unexpected discontinuations of APMs; and
- Increasing complexity of payment models.

With the onset of the COVID-19 pandemic in 2020, adoption of value-based payment models slowed as the health care system managed the intense pressure of providing critical care for millions of severely ill patients. Most health care offices were forced to limit visits, many patients avoided and delayed seeking treatment, and many hospitals and outpatient facilities greatly reduced or canceled elective surgeries.[2] While all health care facilities and practices experienced serious financial disruption and many were forced to furlough or eliminate staff, suggestions have arisen that primary care practices who were in prospective payment models, such as per-member-per-month (PMPM), were able to manage the financial disruption more readily than those who were mostly dependent on fee-for-service (FFS) payments.[3]

Appropriately funded prospective payment models offer one solution to provide potential stability and predictability of payment for some practices when demand for services decreases. Such models include capitation, global payments, PMPM payments and can provide physicians with more predictable financial resources to conduct care coordination activities that can improve outcomes, decrease more costly visits to hospitals, and reduce readmissions. Funding for these models should be sufficient to address the social determinants of health (SDOH) for the target population.

Prospective payment models can take many forms. They can coexist with shared savings models and can be found among APMs. Numerous prospective payment models are being implemented currently, while others have been cancelled. In the Medicare program, Medicare Advantage plans receive capitation payments, and some pay their network physicians on a capitated basis, although many still pay on a per-service basis. For a listing of models in the traditional Medicare program, please visit the Centers for Medicare & Medicaid Services (CMS) sites for approved Alternative Payment Models and the CMS Center for Medicare & Medicaid Innovation (CMMI).[5,6]

CONSIDERATIONS FOR PROSPECTIVE PAYMENT MODELS

Consistent with robust AMA policy, the AMA has been highly engaged with CMS, CMMI, and commercial health plans regarding physician concerns that payment reform models should enable rather than impede the provision of appropriate and necessary care. Longstanding AMA Policy H-385.926 supports the freedom of physicians to choose their method of earning a living, a concern raised during testimony on Resolution 122-J-21. For physicians exploring the opportunities to engage in prospective payment models, the following factors should be considered.

Attribution

Current retrospective statistical attribution methodologies often fail to accurately assign to physicians the patients they cared for and the services they delivered. The purpose of attribution and corresponding performance measures should be to ensure that physicians are responsible only for the costs they can control and not for costs they cannot control. Physicians in private practice can be particularly impacted when inpatient and specialty care are inappropriately attributed to them. These are costs that such physicians might not be able to control.

Attribution methods that rely solely on retrospective claims are problematic. Physicians providing telehealth services and fewer in-person visits need to use an additional payment code (i.e., modifier 95) to have the patient attributed to them. Various attribution methods could provide mixed results for physicians regarding who is responsible for delivering efficient care. Any delay in providing physicians with lists of attributed patients in real-time stifles timely care coordination. Additionally, errors can occur where patients rarely or never seen by a physician are attributed to them, or conversely, patients to whom they have provided extensive services to are attributed to someone else. Adjudicating these attribution lists can be extremely time consuming, particularly

for private practices with limited staffing and resources. Furthermore, such inaccuracies may negatively affect a physician's payment rate especially if the corresponding quality and cost of care data associated with these patients are adverse.

Performance Targets

It is a priority that performance targets are clinically meaningful and parsimonious for physicians, including privately practicing physicians. Performance targets must be logically relevant for each specialty and evidence-based. Unachievable and irrelevant performance targets may discourage physicians from participating in evolving payment models and undermine the goals of value-based payment.

Risk Adjustment

The resources needed to achieve appropriate patient outcomes during an episode of care depend heavily on the individual needs of each patient as well as their ability to access care and properly adhere to prescribed treatment plans. Many risk adjustment methods only explain a small amount of variation, and typically focus on variation in spending, not on patient factors. Risk adjustment generally relies on historical claims data, so it may not account for significant changes in the patient's health status that affect their current needs for services. Further exacerbating data deficiencies is that most risk adjustment systems give little or no consideration to the factors other than health status that can affect patient needs, such as functional limitations, access to health care services, and other SDOH.

An additional concern is that most risk adjustment methods do not adequately account for socio-demographic factors, such as community supports, on the cost and outcomes of care. Flawed risk adjustment methods have the unwanted effect of inappropriately penalizing the physicians and health systems caring for sicker patients and individuals with socio-demographic challenges while rewarding those who do not care for these patients. As an unintended consequence, it may be harder for higher-need patients to access care and for physicians caring for these patients to maintain a sustainable practice.

Data and Health Information Technology

Costly health information technology (IT) continues to be one of the greatest drags on efficiency and satisfaction in the practice of medicine and a significant barrier to the development and implementation of care delivery and payment reform. Independently practicing physicians may lack IT systems sufficient to engage in a prospective payment model. Alternatively, any practice with a robust IT system still requires reliable data to reach their potential. Innovative payment models depend on access to high quality, real-time actionable data at the point of care. Physicians' ability to participate in new payment models often hinge on health IT systems that support and streamline participation. Without the appropriate tools, physicians will continue to struggle to track the metrics necessary to inform and improve care delivery. Physicians must have the guidance and technical assistance to meaningfully participate in prospective payment models and other APMs. Barriers to interoperability and access to patient data must be overcome if APMs are to enjoy widespread acceptance and participation.

Telehealth

The COVID-19 pandemic accelerated uptake of telehealth. In 2020, physicians and health systems quickly deployed and expanded telehealth technology to diagnose, treat, and advise millions of patients. Before the pandemic, telehealth accounted for less than one percent of Medicare expenditures for physician services. It rose to as high as 16 percent during the spring of 2020 and then stabilized at between four and six percent for the remainder of that year. Medicare spent $4.1 billion on physician telehealth services in all of 2020 and $2 billion in the first six months of 2021.[4]

The adoption of telehealth illustrates how payment policy can serve as a catalyst to reform. The rapid expansion of telehealth services in response to the COVID-19 pandemic was possible after long-standing payment barriers were removed. Telehealth payment enables physicians to provide needed services to homebound and remote patients, as well as minimizing patient time away from work and other responsibilities.

Increasingly, physicians and patients deploy telehealth services. AMA Physician Practice Benchmark Survey data show that, in 2020, 79 percent of physicians were in practices that used any type of telehealth and 70 percent were in one that used video conferencing with patients. Still, some patients lack the access to technology such as broadband, which is necessary to deploy advanced telehealth technologies and many lack the skills needed to receive care via telehealth. Similarly, many physicians and health systems lack the capital needed to purchase necessary services and equipment to provide secure telehealth services. Ultimately, these barriers disproportionately impact physicians in rural areas, safety net providers, and patients from historically marginalized and minoritized communities.

AMA POLICY

The AMA has a wealth of policy directly related to prospective payment models, including policy addressing persistent concerns with value-based payment and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849), specific physician-led payment reforms (Policies D-390.953, H-390.844, H-450.931, H-450.961, and D-35.985), the importance of physician involvement in health IT (Policies D-478.972, D-478.995, D-478.996, H-450.933, and H-478.984), telehealth (Policies D-480.963, H-478.980, H-478.996, D-480.965, H-480.946, H-390.889, D-480.969, H-450.941, and Policy D-155.987), and improving risk adjustment (Policy H-385.907 and H-285.957).

In addition, Policies H-165.844 and H-385.926 reiterate the AMA's long-standing commitment to pluralism and physician freedom of enterprise.

AMA ADVOCACY

The AMA continues to carefully examine APMs that are developed by CMS and provides feedback to the agency regarding needed modifications to enable physicians to deliver high-quality care. The AMA has also expressed concern if APMs could impose unreasonable requirements on physicians or require them to shoulder excessive financial risk. When the AMA identifies problems with an APM, it advocates for appropriate changes which have resulted in improvements in some current APMs. Examples of AMA advocacy to improve Medicare APMs include:

- The AMA has testified to Congress about the importance of having physicians involved in designing APMs in order for the APMs to be successful.

- AMA regularly submits comments to CMS identifying problems with the APMs that CMS has developed, including recommendations for improvements.
- AMA submits comments to CMS each year describing ways to improve the overall regulations that define what qualifies as an APM and what physicians must do to meet the requirements of Medicare's Quality Payment Program.
- AMA has worked closely with national medical specialty societies and other national organizations, as well as state medical associations, to develop and recommend changes in public policy on APMs.

CMMI recently published its "strategy refresh," describing new objectives for CMMI based on its experience with APMs during its first 10 years.[7] A number of the policies outlined in the CMMI strategy are encouraging as they would implement recommendations made to CMMI leadership in a May 2021 letter from the AMA and many national specialty societies, as well as in several meetings.[8] These include CMMI plans to:

- Make APM parameters, requirements, and other critical details as transparent and easily understandable as possible for participants;
- Reduce administrative burdens from APM participation requirements;
- Make available and increase uptake of actionable data, learning collaboratives, and payment and regulatory flexibilities to participants, especially those treating the underserved;
- Improve testing and analysis of benchmarks and risk adjustment methods;
- Deepen and sustain outreach and solicitation of input from patient and physician groups;
- Explore model tests for specialty care payment models; and
- Identify ways to align or integrate episode payment models with accountable care models.

AMA Physician Practice Benchmark Survey

The AMA's Physician Practice Benchmark Survey has been conducted on a biennial basis starting in 2012. The 6th iteration of this nationally representative survey is planned for fall 2022. A primary focus of the survey is physician practice characteristics including employment status (whether a physician is an employee, an owner/partner, or an independent contractor), practice type (e.g., solo practice, single specialty practice, or multi-specialty practice), practice ownership (e.g., physician-owned or hospital/health system-owned), practice size (measured by number of physicians), and use of non-physician providers. A second focus of the survey is the payment methods in place between practices and payers. Methods asked about include FFS, pay-for-performance, bundled payments, shared savings, and capitation. Reports based on these topics are available on the AMA website.[9] Relevant to Resolution 122-J-21, in 2020, an average of 6 percent of practice revenue was paid through capitation.

Professional Satisfaction and Practice Sustainability

The AMA's Professional Satisfaction and Practice Sustainability (PS2) unit continues to support effective development and implementation of sustainable physician payment models through research, development of tools and resources, and support of the spread of effective models through learning collaboratives and engagement with commercial health plans and large employers. An enhanced focus on sustainable physician-owned practices has been launched through its Private Practice Initiative, which offers resources such as its new series on Payor Contracting and forming Clinically Integrated Networks.[10,11]

DISCUSSION

The AMA has robust policy articulating best practices and principles for APMs, including prospective payment models (see Appendix). These policies guide continued AMA advocacy for the development and implementation of such models, including the necessary resources to make them successful. The Council recommends reaffirming policies that support a commitment to pluralism and the ability of physicians to choose their method of earning a living. The Council also recommends reaffirming policies that address the areas of concern highlighted by Resolution 122-J-21, as detailed in the Appendix regarding attribution, risk adjustment, physician involvement in contract negotiations, access to data reports, infrastructure, and capital investment (including for the delivery of telehealth), technical support and payment updates.

Consistent with Resolution 122-J-21, the Council recommends new policy to support increased inclusion of elements of prospective payment models for independent practices in the development of payment reform. The Council also recommends new principles to address the unique needs of independently practicing physicians wishing to address the challenges of contracting for prospective payments with other independent physicians. Principles should include the following:

- Compensation should incentivize the interdependence of the physician group members and foster collegiality between specialties.
- Attribution, performance targets and risk adjustment are likely to benefit from clinical data in addition to claims data.
- Any quality metrics should be clinically meaningful and developed with physician input.
- Models should strive to address community social determinants of health, with attention to patient attribution and contracted payers.
- Physicians should be leaders in their model's governance, which must be autonomous to monitor performance targets and price transparency, and to ensure that socio-demographic factors impacting overall patient health are addressed. In addition, model governance should address the purchase and leverage of high-quality health IT for better patient care and leverage group purchasing organizations to lower cost of telehealth technology.

The Council encourages the AMA and other entities, such as state and specialty medical societies, to continue to provide the guidance and infrastructure needed to allow physicians to join with other physicians.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 122-J-21, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles. (New HOD Policy)

2. That our AMA support the following principles to support physicians who choose to participate in prospective payment models:
    a. The AMA, state medical associations, and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allow independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.

b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.
c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
d. Governance within the model must be physician-led and autonomous.
e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians.(New HOD Policy)

3. That our AMA reaffirm Policies H-165.844 and H-385.926, which support pluralism and the freedom of physician enterprise. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.907, which supports fair and accurate risk adjustment. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policies H-385.913, D-478.972, D-478.995, H-478.984, H-478.980, D-480.965, H-480.946, D-480.969 and H-285.957, which collectively address the concerns raised in Resolution 122-I-21. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Rand Corporation. Effects of Health Care Payment Models on Physician Practice in the United States: Follow-Up Study. Available at: https://www.rand.org/pubs/research_reports/RR2667.html. Accessed 4-1-22.
[2] United States Department of Health and Human Services. Assistant Secretary for Planning and Evaluation Office of Health Policy. The Impact of COVID-19 Pandemic on Medicare Beneficiary Utilization and Provider Payments: Fee-For- Service (FFS) Data for 2020. Available at: https://aspe.hhs.gov/sites/default/files/documents/fc9316ab391e6b6a18fde3e8fca68685/medicare-ffs-utilization-spending-ib.pdf. Accessed 4-1-22.
[3] American Academy of Pediatrics. The Role of COVID-19 in Transitioning to a Better Pediatric Payment Model. Available at: https://publications.aap.org/pediatrics/article/147/1/e2020008672/33423/The-Role-of-COVID-19-in-Transitioning-to-a-Better. Accessed 4-1-22.
[4] American Medical Association. Changes in Medicare Spending During the COVID-19 Pandemic. Available at: https://www.ama-assn.org/system/files/2021-03/prp-covid-19-medicare-physician-spending.pdf. Accessed 4-1-22.
[5] Centers for Medicare and Medicaid Services: Quality Payment Program. Resource Library. Available at: https://qpp.cms.gov/resources/resource-library. Accessed 4-1-22.
[6] Centers for Medicare and Medicaid Services. Innovation Models. Available at: https://innovation.cms.gov/innovation-models#views=models&stg=accepting%20letters%20of%20intent,accepting%20applications,ongoing. Accessed 4-1-22.
[7] Centers for Medicare and Medicaid Services. Centers for Medicare and Medicaid Services Innovation Center Strategic Direction. Available at: https://innovation.cms.gov/strategic-direction. Accessed 4-1-22.
[8]American Medical Association. Sign on Letter to Elizabeth Fowler, Deputy Administrator and Director, CMMI, May 25, 2021. Available at: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-5-25-CMMI-Sign-on-letter-re-APM-recommendations.pdf. Accessed 4-1-22.

[9] American Medical Association. Physician Practice Benchmark Survey. Available at: https://www.ama-assn.org/about/research/physician-practice-benchmark-survey. Accessed 4-1-22.
[10] American Medical Association. AMA Private Practice Sustainability: Getting Started. Available at: https://www.ama-assn.org/practice-management/private-practices/ama-private-practice-sustainability-getting-started. Accessed 4-1-22.
[11] American Medical Association. Private Practice Checklist: Key Considerations in Forming, Operating or Joining a Clinically Integrated Network (CIN). Available at: https://www.ama-assn.org/system/files/private-practice-checklist-cin-considerations.pdf. Accessed 4-1-22.

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Policy Appendix

Policy H-165.844 Educating the American People About Health System Reform
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Res. 717, I-07 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19)

Policy H-285.957 Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts
The AMA will work with interested medical organizations in urging state Medicaid programs and other third party payers to assure the inclusion of risk adjustment mechanisms in capitation rates paid to physicians providing care to chronically ill children and adults enrolled in managed care plans. (Sub. Res. 128, A-96 Reaffirmed: CMS Rep. 8, A-06 Modified: CMS Rep. 01, A-16)

Policy H-385.907 Improving Risk Adjustment in Alternative Payment Models
Our AMA supports:
(1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications;
(2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost;
(3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost;
(4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and
(6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19)

Policy H-385.913 Physician-Focused Alternative Payment Models
1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
A. Be designed by physicians or with significant input and involvement by physicians;
B. Provide flexibility to physicians to deliver the care their patients need;
C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
G. Avoid placing physician practices at substantial financial risk;
H. Minimize administrative burdens on physician practices; and
I. Be feasible for physicians in every specialty and for practices of every size to participate in.

3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
A. Identify leading health conditions or procedures in a practice;
B. Identify barriers in the current payment system;
C. Identify potential solutions to reduce spending through improved care;
D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
E. Define services to be covered under an APM;
F. Identify measures of the aspects of utilization and spending that physicians can control;
G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
I. Identify mechanisms for ensuring adequacy of payment; and
J. Seek support from other physicians, physician groups, and patients.
4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. (CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 10, A-17 Reaffirmed: CMS Rep. 10, A-19 Reaffirmed: BOT Rep. 13, I-20)

Policy H-385.926 Physician Choice of Practice
Our AMA: (1) encourages the growth and development of the physician/patient contract;
(2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.);
(3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and
(4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance. (BOT Rep. QQ, I-91 Reaffirmed: BOT Rep. TT, I-92 Reaffirmed: Ref. Cmte. A, A-93 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed: CMS Rep. G, A-93 Reaffirmed: CMS Rep. E, A-93 Reaffirmed: Sub. Res. 701, A-93 Reaffirmation A-93 Reaffirmed: BOT Rep. 25, I-93 Reaffirmed: CMS Rep. 5, I-93 Reaffirmed: CMS Rep. 10, I-93 Reaffirmed: BOT Rep. 40, I-93 Reaffirmed: Sub. Res. 107,

I-93 Res. 124, I-93 Reaffirmed: Sub. Res. 127, A-94 Reaffirmed: BOT Rep. 46, A-94 Reaffirmed: Sub. Res. 132, A-94 Reaffirmed: BOT Rep. 16, I-94 Reaffirmed: CMS Rep. 8, A-95 Reaffirmed: Sub. Res. 109, A-95 Reaffirmed: Sub. Res. 125, A-95 Reaffirmed: Sub. Res. 109, I-95 Reaffirmation A-96 Reaffirmation I-96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-99 Appended by Res. 127, A-98 Reaffirmed: CMS Rep. 6, A-99 Reaffirmation A-00 Reaffirmation A-00 Sub. Res. 116, I-00 Reaffirmation & Reaffirmed: Res. 217, A-01 Reaffirmation A-04 Consolidated and Renumbered: CMS Rep. 7, I-05 Reaffirmation A-07 Reaffirmation A09 Reaffirmed: CMS Rep. 3, I-09 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation I-13 Reaffirmation A-15 Reaffirmed: CMS Rep. 5, I-15 Reaffirmed: CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 07, A-17 Reaffirmed: CMS Rep. 6, A-21)

Policy D-478.972 EHR Interoperability
Our AMA:
(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
(2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
(3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
(4) will continue efforts to promote interoperability of EHRs and clinical registries;
(5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
(6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
(9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Sub. Res. 212, I-15 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: Res. 221, I-16 Reaffirmed in lieu of: Res. 243, A-17 Reaffirmed: CMS Rep. 10, A-17 Appended: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Appended: Res. 202, A-18 Appended: Res. 226, I-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

Policy H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Res. 208, I-18 Reaffirmed: CMS Rep. 7, A-21)

Policy H-478.984 Prohibition of Clinical Data Blocking
Our AMA will advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care. (Res. 222, I-16 Reaffirmed: CMS Rep. 10, A-17)

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians. (Res. 730, I-04 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 16, A-11 Modified: BOT Rep. 16, A-11 Modified: BOT Rep. 17, A-12 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed: BOT Rep. 24, A-13 Reaffirmed in lieu of Res. 724, A-13 Appended: Res. 720, A-13 Appended: Sub. Res. 721, A-13 Reaffirmed: CMS Rep. 4, I-13 Reaffirmation I-13 Appended: BOT Rep. 18, A-14 Appended: BOT Rep. 20, A-14 Reaffirmation A-14 Reaffirmed:

BOT Rep. 17, A-15 Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmation I-15 Reaffirmed: CMS Rep. 07, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 227, A-17 Reaffirmed in lieu of: Res. 243, A-17 Modified: BOT Rep. 39, A-18 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 3, I-19)

Policy D-478.996 Information Technology Standards and Costs
1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. (Res. 717, A-04 Reaffirmation, A-05 Appended: Sub. Res. 707, A-06 Reaffirmation A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation I-08 Reaffirmation I-09 Reaffirmation A-10 Reaffirmation I-10 Reaffirmed: Res. 205, A-11 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed in lieu of Res. 724, A-13 Reaffirmation I-13 Reaffirmation A-14 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 204, I-17 Reaffirmation: I-17 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

Policy D-480.965 Reimbursement for Telehealth
Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. (Res. 122, A-19)

Policy D-480.969 Insurance Coverage Parity for Telemedicine Service
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16 Reaffirmed: CMS Rep. 1, I-19 Reaffirmed: CMS Rep. 7, A-21)