AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIANS SECTION

Resolution: 4
(I-25)

Introduced by: Connie DiMari, MD

Subject: The Crisis in the Availability of Primary Care: Halt the Required Participation of Small Practices in Value-Based Payment (VBP) Models

Referred to: PPPS Reference Committee
(xxxx, MD, Chair)

Whereas, the COVID-19 pandemic revealed the strength of U.S. physicians' professionalism and intrinsic motivation as physicians (and other healthcare professionals) learned rapidly and did what needed to be done—no performance measures or financial incentives from value-based programs (VBPs) were required to prompt their efforts; and

Whereas, VBP models risk undermining these strengths and our greatest resource for improving care[1]; and

Whereas, VBP model metric reporting and demoralizing score boosting tasks coupled with the burden of an average of 7.3 hours in electronic health records per eight hours of scheduled patients have led to a "burnout" epidemic among primary care clinicians[2, 3, 4]; and

Whereas, the work of VBP programs was acknowledged by the Centers for Medicare & Medicaid Services as they relieved physicians of reporting requirements "so the healthcare delivery system can direct its time and resources toward caring for patients"[5]; and

Whereas, in 2024, compliance costs of the Merit-Based Incentive Payment System resulted in penalties for 32 percent of small practices and 46 percent of solo practitioners[6]; and

Whereas, free medical education appears ineffective at encouraging students to pursue primary care as evidenced by 2024 data showing U.S. medical school graduates filled only 35 percent of categorical internal medicine residency positions and non-U.S. citizen international graduates filled 30 percent[7]; and

Whereas, worrisomely, a 2023 Elsevier survey revealed that over half of U.S. medical students envisioned their education as a stepping stone to careers outside direct patient care[8]; and

Whereas, the Pay Primary Care Providers Act, currently before the 119th Congress, seeks to increase primary care physician reimbursement in hopes of bolstering primary care but also seeks to move more physicians and patients into VBP arrangements (capitation); and

Whereas, these measures are not expected to save money and doubling down on VBP models will exacerbate the exodus of physicians from primary care fields[9,10]; and

Whereas, it is evident that relying on physician resilience, dedication, adjustments to VBP programs, streamlining reporting requirements (Data-Driven Performance System proposed by the AMA), team-based care, efforts to increase the number of students pursuing primary care, optimizing technology, forthcoming advances promised by artificial intelligence, and even

increasing compensation for primary care physicians are insufficient to address the crisis in the availability of primary care physicians; and

Whereas, ignoring this crisis will, ultimately, relegate our patients to a lower standard of care, as numerous county and state health commissioners support independent practice by physician assistants and nurse practitioners to alleviate the shortage of primary care physicians; and

Whereas, the consensus opinion is that the vast majority of VBP models have failed to reduce healthcare expenditures or improve the quality of life meaningfully with considerable evidence that they have resulted in the opposite—increasing costs and declining quality of care[11,12,13,14]; and

Whereas, small independent practices (ten or fewer physicians) have 33 percent fewer preventable hospital admissions and lower per-beneficiary spending than larger practices, thus removing obstacles to their survival is an efficient way to lower costs and improve the quality of care[15,16,17]; therefore be it

RESOLVED, that our American Medical Association will take a stand against the detrimental effects of value-based programs (VBPs) on small practices, primary care in particular, and advocate for the immediate discontinuation of required participation in VBP arrangements for practices with ten or fewer physicians, regardless of practice revenue (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

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RELEVANT AMA POLICY

Value-Based Insurance Design H-185.939

Our American Medical Association supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.
i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).

Citation: CMS Rep. 2, A-13; Reaffirmed in lieu of: Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmed: I-16; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: Joint CMS/CSAPH Rep. 01, I-18; Reaffirmed; CMS Rep. 06, A-19; Reaffirmed: BOT Rep. 14, A-23.

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998

1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.

2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.

3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.

4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.

Citation: Res. 247, A-18; Reaffirmed: BOT Rep. 13, I-20