

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-24)

Introduced by: Florida

Subject: Medicaid Patient Accountability

Referred to: Reference Committee B

- 1 Whereas, most Medicaid managed care plans assign patients who do not select their own
2 primary care physician (PCP) randomly to a physician of the plan's choosing; and
3
4 Whereas, despite their best efforts, physicians at times are unable to persuade these Medicaid
5 patients to come into the office for wellness visits, immunization updates, or their childhood
6 check-up visit; and
7
8 Whereas, parents in many states have the ability to opt out of vaccines and other treatments for
9 pediatric patients through state approved religious or medical exemptions; and
10
11 Whereas, physicians are responsible for their assigned patients completing visits to record
12 Healthcare Effectiveness Data and Information Set (HEDIS) measures; and
13
14 Whereas, physicians may be given bonuses/incentives or be penalized based on their HEDIS
15 star rating score; therefore be it
16
17 RESOLVED, that our American Medical Association advocate that physicians' Healthcare
18 Effectiveness Data and Information Set and other quality scores and ratings not be affected by
19 non-compliant patients or patients whose parents exercise state exemptions from
20 recommended treatment. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/3/2024

Relevant AMA Policy

Retroactive Assignment of Patients by Managed Care Entities H-285.947

Our AMA opposes the practice of "retroactive or late assignment" of patients by managed care entities, noting that "retroactive or last assignment" includes: (a) the practice of failing to require enrollees in a capitated plan to select a responsible physician(s) at the time of enrollment; (b) the practice of failing to inform the responsible physician(s) of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and (c) the practice of failing to pay the responsible physician the capitated rate until after the patient has sought care.

Sub. Res. 719, A-97Reaffirmation I-01Modified: CMS Rep. 7, A-11Reaffirmation: A-19

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

- a) promote improved patient access to high-quality, cost-effective care;
- b) be designed with input from the physician community;
- c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
- d) not require budget neutrality within Medicare Part B;
- e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
- f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
- g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
- h) use adequate risk adjustment methodologies;
- i) incorporate incentives large enough to merit additional investments by physicians;
- j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
- k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
- l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
- m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Policy Timeline

CMS Rep. 6, A-09Reaffirmation A-10Appended: Res. 829, I-10Appended: CMS Rep. 1, A-11Appended: CMS Rep. 4, A-11Reaffirmed in lieu of Res. 119, A-12

Reaffirmed in lieu of Res. 122, A-12Modified: CMS Rep. 6, A-13Reaffirmation I-15Reaffirmation: A-16Reaffirmed in lieu of: Res. 712, A-17

Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17 Reaffirmation: A-19

Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19

Reaffirmed: Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmation: A-22 Modified: CMS Rep. 04, A-23 Reaffirmed: Res. 214, A-23 Reaffirmation: A-23

Work of the Task Force on the Release of Physician Data H-406.991

Principles for the Public Release and Accurate Use of Physician Data

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:

1. Patient Privacy Safeguards

- All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).
- Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).

2. Data Accuracy and Security Safeguards

- Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).
- Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).
- Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).

3. Transparency Requirements

- When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).
- The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).
- Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).

4. Review and Appeal Requirements

- Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).
- When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).

5. Physician Profiling Requirements

- The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).
- Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (H-450.951).

- When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used.
- Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services.
- Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes.

6. Quality Measurement Requirements

- The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).
- Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).
- These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data.

7. Patient Satisfaction Measurement Requirements

- Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).
- Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms.
- As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication.

Policy Timeline

BOT Rep. 18, A-09 Reaffirmed A-10 Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10

Reaffirmation I-10 Reaffirmed in lieu of Res. 808, I-10 Reaffirmed in lieu of Res. 824, I-10 Reaffirmation A-11 Reaffirmed: BOT Rep. 17, A-13 Reaffirmed: Res. 806, I-13

Reaffirmation: A-19