

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Title: Limit Quality Metrics
Introduced by: Lee P. Begrow, DO, for the Kent County Delegation
Original Author: Jayne Courts, MD
Referred to: Reference Committee A
House Action: **APPROVED AS AMENDED**

Whereas, providing high quality care in a cost-effective manner encompasses two aims of the "Triple Aim" of health care delivery, and

Whereas, reimbursement models for primary care are increasingly utilizing quality metrics as a measure of high quality care, and the level of reimbursement for primary care is increasingly based on meeting these quality metrics, and

Whereas, each third-party payer has elected to monitor multiple quality metrics, while supporting evidence for many of these quality metrics to truly affect the quality and cost of care provided is lackluster or lacking, and

Whereas, the number of quality metrics is excessive and ever-changing, leaving primary care physicians with limited ability to meet these metrics despite trying to provide quality care, and

Whereas, access to primary care physicians is worsening, partially due to decreased interest by physicians to pursue primary care, and

Whereas, physicians may advise patients to obtain a test to meet a quality metric with no guarantee that the patient will follow through on the physician's excellent medical advice, and

Whereas, the physician has no opportunity for improved reimbursement with this dependency on patient compliance, potentially further decreasing interest in providing primary care; therefore be it

RESOLVED: That MSMS work with the appropriate stakeholders to align and restrict the maximum number of quality metrics for a primary care physician to follow each year to ten quality metrics; and be it further

RESOLVED: That MSMS advocate that third-party payers refrain from modifying more than two quality metrics in any given calendar year to allow more consistency in quality and cost in the delivery of health care.

WAYS AND MEANS COMMITTEE FISCAL NOTE: NONE

Relevant MSMS Policy:

Specialty Society Clinical Care Guidelines

MSMS supports the implementation of clinical care guidelines developed by recognized national medical specialty societies to enhance state-of-the-art, quality care for patients. (See Addendum F in website version) (Res76-90A & 1990 Board Annual Report)
– Edited 1998

Excessive Medical Administrative Costs

MSMS opposes additional regulatory requirements that place a financial burden on the physicians or hospitals without compensation. (Res81-90A)

– Edited 1998

Relevant AMA Policy:

Strategies to Address Rising Health Care Costs H-155.960

Our AMA:

- (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
- (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
- (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
- (d) promote "value-based decision-making" at all levels;
- (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
- (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
- (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
- (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
- (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
- (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
- (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

Hospital-Based Physicians and the Value-Based Payment Modifier D-450.961

Our AMA encourages national medical specialty societies to pursue the development of relevant performance measures that demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs.

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942

The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not

to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies.

Medical Information and Its Uses H-406.987

DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY

Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals

Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.

Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.

Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.

Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.

Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources

Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.

Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.

Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.

Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.

Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency

Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.

Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.

Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers.