

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808  
(I-16)

Introduced by: Medical Student Section

Subject: A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities

Referred to: Reference Committee J  
(Candace E. Keller, Chair)

- 
- 1 Whereas, The Centers for Medicare & Medicaid (CMS) is committed to using measures of  
2 hospital quality that directly reflect the patient perspective to improve the overall quality of  
3 hospital care;<sup>1</sup> and  
4  
5 Whereas, In accordance with the Affordable Care Act, CMS initiated the Hospital Value-Based  
6 Purchasing (VBP) Program, which rewards acute-care hospitals with incentive payments for the  
7 quality of care they provide Medicare beneficiaries;<sup>2</sup>  
8  
9 Whereas, The Hospital Consumer Assessment of Healthcare Providers and Systems  
10 (HCAHPS) survey is a data collection methodology for measuring patients' perceptions of their  
11 hospital experience;<sup>3</sup> and  
12  
13 Whereas, The HCAHPS survey creates standardized, publicly-reported metrics that allow for  
14 fair comparisons of patient experience in hospitals across the nation;<sup>4</sup> and  
15  
16 Whereas, The HCAHPS survey is the most studied system for measuring patients' experience  
17 of their care on an individual and hospital level and it is one measure within the HVBP program;<sup>4</sup>  
18 and  
19  
20 Whereas, To withhold payouts due to poor quality of care for Medicare beneficiaries fails to  
21 account for situations in which high-value care is at odds with patient satisfaction and may  
22 disincentivize physicians to care for patients who are perceived as difficult to please, that is,  
23 underserved minorities, those with lower socioeconomic status, and those with mental health  
24 concerns;<sup>5</sup> and  
25  
26 Whereas, Safety net hospitals<sup>6</sup> typically do worse on patient experience metrics than their  
27 counterparts that provide less care to underserved populations;<sup>6</sup> and

<sup>1</sup> CMS Quality Strategy (2016). Available at: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/downloads/cms-quality-strategy.pdf>

<sup>2</sup> HCAHPS: Patients' Perspectives of Care Survey. Centers for Medicare & Medicaid Services. Available at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html>

<sup>3</sup> Tefera L, Lehrman W, Conway P. Measurement of the Patient Experience Clarifying Facts, Myths, and Approaches. JAMA Network 2016. Available at: <http://jama.jamanetwork.com/article.aspx?articleid=2503222>. Accessed March 27, 2016.

<sup>4</sup> Jha AK, Orav EJ, Zheng J, Epstein AM. Patients' perception of hospital care in the United States. N Engl J Med. 2008;359(18):1921-1931.

<sup>5</sup> Mehta SJ. Patient Satisfaction Reporting and Its Implications for Patient Care. The AMA Journal of Ethics 2015;17(7):616-621. doi:10.1001/journalofethics.2015.17.7.ecas3-1507

<sup>6</sup> The Institute of Medicine defines safety net providers as "providers that organize and deliver a significant level of both health care and other health-related services to the uninsured, Medicaid, and other vulnerable populations," as well as providers "who by mandate or mission offer access to care regardless of a patient's ability to pay and whose patient population includes a substantial share of uninsured, Medicaid, and other vulnerable patients." <https://aspe.hhs.gov/report/environmental-scan-identify-major-research-questions-and-metrics-monitoring-effects-affordable-care-act-safety-net-hospitals/c-definition-safety-net-hospitals> .

1 Whereas, If institutions that have a greater safety net function have more challenging patient  
2 populations and fewer resources to devote to improving low scores, financial incentives could  
3 exacerbate existing inequities in care;<sup>6</sup> and  
4

5 Whereas, Existing AMA policy D-450.962 calls for the AMA to urge CMS to (a) evaluate the  
6 relationship and apparent disparity between patient satisfaction, using the Hospital Consumer  
7 Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient  
8 Experience of Care (ED-PEC) survey, and hospital performance on clinical process and  
9 outcome measures used in the hospital value based purchasing program; therefore be it

10  
11 RESOLVED, That our American Medical Association study the potential healthcare disparities  
12 caused by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in  
13 Medicare reimbursement. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 09/29/16

#### RELEVANT AMA POLICY

**Improve the HCAHPS Rating System D-450.960** - Our AMA will urge the Centers for Medicare & Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients.

Res. 806, I-13

**Pain Management and the Hospital Value-Based Purchasing Program D-450.962** - 1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain.

2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined. BOT Rep. 9, A-13 Modified: BOT Rep. 5, I-15  
**Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment D-385.958** - Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that (1) subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment; and (2) physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician.

Res. 102, A-13 Reaffirmed: Res. 806, I-13 Reaffirmed in lieu of Res. 814, I-14

**Establishing Capitation Rates H-400.955** - 1. Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the

individual level with improved risk adjustors that include demographic factors, health status, and other useful and cost-effective predictors of health care use. 2. Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care. 3. Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations. 4. Our AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts.

CMS Rep. 3, A-95 CMS Rep. 7, I-95 Modified and Reaffirmed: Sub. Res. 120, A-97  
Reaffirmation A-99 Reaffirmed: CMS Rep. 4, I-99 Reaffirmation A-00 Reaffirmation A-05  
Reaffirmed: CMS Rep. 1, A-15

**American Health Care Access, Innovation, Satisfaction and Quality D-450.966** - Our AMA will begin an international comparative study on health care quality that is a comprehensive and balanced study including comparisons of patient satisfaction, cancer outcomes, outcomes among more severe illnesses and injuries, rapidity of access and patient satisfaction as end points, and present their findings to the AMA House of Delegates at the 2012 Annual Meeting. Res. 104, A-11

**Patient Satisfaction and Quality of Care H-450.982** - Our AMA believes that: (1) much may be gained by encouraging physicians to be sensitive to the goals and values of patients; and (2) efforts should be continued to improve the measurement of patient satisfaction and to document its relationship, if any, to favorable outcomes and other accepted criteria of high quality. CMS Rep. E, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CMS Rep. 6, A-10  
Reaffirmed BOT Rep. 9, A-13

**Accountable Care Organization Principles H-160.915** - Our AMA adopts the following Accountable Care Organization (ACO) principles: 1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient. 2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first. A. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues. B. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors. C. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area. D. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board. 3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be

voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

A. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

B. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

C. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.

D. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

E. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and

practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently. 8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results. 9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards. 10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted. 11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law. 12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality. 13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

Res. 819, I-10 Reaffirmation A-11 Reaffirmed: Res. 215, A-11 Reaffirmation: I-12 Reaffirmed: CMS Rep. 6, I-13 Reaffirmed: Sub. Res. 711, A-15 Reaffirmation I-15 Reaffirmation: A-16

**Monitoring Medicaid Managed Care H-290.985** - As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries: (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment. (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers. (3) Geographic dispersion and accessibility of participating physicians and other providers. (4) Education of beneficiaries regarding appropriate use of services, including the emergency department. (5) Availability of off-hours, walk-in primary care. (6) Coverage for clinically effective preventive services. (7) Responsiveness to cultural, language and transportation barriers to access. (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers. (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied. (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs. (11) Ability of plan participating

physicians to determine how many beneficiaries and the type of medical problems they will care for under the program. (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers. (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services. (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care. (15) Preservation of private right of action for physicians and other providers and beneficiaries. (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization. (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan. (18) Absence of gag rules. (19) Fairness in procedures for selection and deselection. (20) Realistic payment levels based on costs of care and predicted utilization levels. (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions. (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis.

CMS Rep. 5 A-96 Reaffirmed and Appended: Sub. Res. 704, I-97 Reaffirmation A-00  
Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14

**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 (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 (no current policy exists). - 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 (no current policy exists). - 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 (no current policy exists). 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 (no current policy exists). 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 (no current policy exists). - 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 (no current policy exists).

BOT Rep. 18, A-09 Reaffirmation 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

**Pain Medicine D-450.958** - Our AMA: (1) continues to advocate that the Centers for Medicare & Medicaid Services (CMS) remove the pain survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); (2) continues to advocate that CMS not incorporate items linked to pain scores as part of the CAHPS Clinician and Group Surveys (CG-CAHPS) scores in future surveys; and (3) encourages hospitals, clinics, health plans, health systems, and academic medical centers not to link physician compensation,

employment retention or promotion, faculty retention or promotion, and provider network participation to patient satisfaction scores relating to the evaluation and management of pain.  
BOT Rep. 5, I-15

**AMA Principles on Maintenance of Certification (MOC) H-275.924** - 1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content. 2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomats about the requirements for participation. 3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC. 4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities. 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties. 7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities. 8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation. 9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomats are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomat's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomat will be required to complete CME credits (AMA PRA Category 1 Credit?, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)." 10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME. 11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians. 12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care. 13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice. 14. MOC should be used as a tool for continuous improvement. 15. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment. 16. Actively practicing physicians should be well-represented on specialty boards developing MOC. 17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards. 18. MOC activities and measurement should be relevant to clinical practice. 19. The MOC process should not be cost prohibitive or present barriers to patient care. 20. Any assessment should be used to guide physicians' self-directed study. 21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely



manner. 22. There should be multiple options for how an assessment could be structured to accommodate different learning styles. 23. Physicians with lifetime board certification should not be required to seek recertification. 24. No qualifiers or restrictions should be placed on diplomats with lifetime board certification recognized by the ABMS related to their participation in MOC. 25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12 Reaffirmed in lieu of Res. 313, A-12 Reaffirmed: CME Rep. 4, A-13 Reaffirmed in lieu of Res. 919, I-13 Appended: Sub. Res. 920, I-14 Reaffirmed: CME Rep. 2, A-15 Appended: Res. 314, A-15 Modified: CME Rep. 2, I-15 Reaffirmation A-16 Reaffirmed: Res. 309, A-16

**Appropriate Payment Level Differences by Place and Type of Service H-330.925** - Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery.

Sub. Res. 104, A-98 Reaffirmation I-98 Appended: CMS Rep. 7, A-99 Reaffirmation A-00 Reaffirmation I-03 Reaffirmation A-11 Reaffirmed: CMS Rep. 3, A-13 Reaffirmed: Sub. Res. 104, A-14 Reaffirmed: Res. 116, A-14 Modified: CMS Rep. 3, A-14 Reaffirmation A-14 Reaffirmation A-15

**Remove Pain Scores from Quality Metrics D-450.955** - Our AMA will work with the Centers for Medicare and Medicaid Services to remove uncontrolled pain scores from quality metrics that impact reimbursement for services rendered in the nursing facilities and from the five star rating system for nursing facilities.

Res. 236, A-16

**CMS - Standards of Care, Hospital Admissions H-335.994** - The AMA supports federal government funding for an independent study to examine and assess the present impact on the quality of medical care from mandated utilization review, medical necessity standards, methods of reimbursement, denial of hospital admissions for illness, and surgical or invasive procedures. Sub. Res. 25, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CMS Rep. 4, A-08