American Medical Group Association's
Healthcare Reform Principles

The following is a proposal by the American Medical Group Association (AMGA) for comprehensive healthcare reform and real change in the system for delivering and reimbursing health care. This proposal outlines achievable improvements that would dramatically change the way America treats patients, purchases health care, and practices medicine.

AMGA improves health care for patients by supporting multispecialty medical groups and other organized systems of care. More than 95,000 physicians practice in AMGA member organizations, providing healthcare services for approximately 95 million Americans (more than one in four Americans).

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AMGA's Healthcare Reform Principles

I. All Americans Should Have Access to Health Care

Changes among all payers will be necessary.

II. Delivery System Reform

The healthcare delivery system must be transformed from a fragmented non-system to an organized system of care.

III. Multispecialty Medical Groups/Organized Systems of Care

The multispecialty medical group and organized systems of care delivery model should be supported as a matter of national policy.

IV. Community-Based Accountability for Healthcare Services

Those who deliver health care should be accountable for their services to the communities served.

V. Shift Payments from Volume to Value

The healthcare reimbursement system must shift from pay-for-volume to pay-for-value.

VI. Incentives

Incentives should be in place to encourage coordinated care and are needed to expand health information technology.

VII. Professional Liability (Medical Malpractice) Reform

Professional liability (medical malpractice) reform must be a component of healthcare reform.

VIII. Comparative Effectiveness

Comparative effectiveness must be a component of healthcare reform.

IX. Prevention and Wellness

Preventive measures and wellness practices should be adopted to address chronic disease and obesity.

X. Enhancing the Healthcare Workforce

Increase numbers, expand loans and grants, and address payment inequities.

XI. Transparency in Business Relationships

Those with involvement in patient care should make public their significant financial, ownership, or similar relationships.

I. All Americans Should Have Access to Health Care

The number of people without health insurance coverage was 45.7 million (15.3 percent) in 2007 according to the U.S. Census Bureau publication *Income, Poverty, and Health Insurance Coverage in the United States: 2007.*[1] No discussion of healthcare reform can avoid discussion of this gap.

The American Medical Group Association (AMGA) believes that universal access to healthcare services by all Americans is a necessary and achievable objective. The foundation for attaining this objective should be the current, pluralistic system, i.e., a blend of public and private insurance coverage. It should have as its objectives a "safety net" expansion perspective which prioritizes making coverage available first to those who are least able to afford it and are most vulnerable: children. This should be followed by coverage for adults. Numerous proposals have been forthcoming and much innovation has begun at the state level.

A number of changes need to be undertaken by all payers to expand current successful Federal and state programs such as the State Children's Health Insurance Program (SCHIP), Medicaid, and Medicare. All impoverished uninsured children should be eligible for SCHIP, and this could be achieved by setting eligibility criteria with varying levels of the Federal poverty line, a sliding scale based on income, health status, cost of living, and similar variables. Medicaid eligibility should be expanded to include all low-income uninsured adults, including single adults, with eligibility based on a sliding scale of qualifications as determined by the states.

Medicare should be strengthened by making changes in the reimbursement system for physicians to guarantee broad participation, thus assuring access to care for beneficiaries. Furthermore, Medicare payments to doctors should be sufficient to take into account increases in practice costs and should be linked to broader economic measures, as are all other components of Medicare reimbursement. Medicare should be a purchaser of goods and services that are effective, efficient, and value-based. Medicare provider participants should receive incentives for electronic medical records, data registries, and electronic prescribing in order to improve and strengthen their electronic infrastructural capabilities and uses.

In addition, tax credits should be offered to low-income parents who purchase insurance for their children; this will serve to promote expanded private-sector coverage. Eligibility criteria should be pegged at those with 100-200 percent of the Federal poverty level. Finally, since several states have made great strides in expanding healthcare coverage, there should be an increase in Federal funding for state "experiments" to achieve expanded access to healthcare services.

II. Delivery System Reform

The nation is experiencing a healthcare crisis, the result of a non-system that is fragmented, costly, and unable to provide coverage to millions of Americans. The Institute of Medicine (IOM), in its seminal work *Crossing the Quality Chasm*, emphasized that the fragmented healthcare delivery system yields a complex morass that is difficult for patients to navigate and produces care that is largely uncoordinated, inefficient, often of questionable effectiveness, and with great geographical variation in treatment and utilization. This non-system is particularly apparent in the treatment of chronically ill patients.

As the IOM surmised: "The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."[2]

In order to transform the current environment into a high-performing and coordinated system, the IOM recommends the following structural changes:

- Use of evidence-based care practices
- Effective use of information technology
- Knowledge and skills management
- Developing effective teams
- Coordinating care
- Measuring quality improvement and accountability[3]

The IOM's recommendations have been described as a virtual blueprint for utilizing multispecialty medical groups and other organized systems of care as the foundation for a 21st century healthcare system.[4]

III. Multispecialty Medical Groups/Organized Systems of Care

Studies suggest that multispecialty groups are more likely to use care management processes and may use fewer resources. Medical groups are more likely to invest in health information technology, form teams of providers, collect and analyze data, and provide direct physician feedback on clinical care. Further, evidence shows there is greater collaboration among physician specialties and allied health professionals in large multispecialty medical groups, which is a key component to successful care coordination. This collaboration results in team-based care which may lead to improved quality and reduced costs.[5]

Recently, the Centers for Medicare and Medicaid Services (CMS) described the second year results of the Physician Group Practice demonstration as evidence that multispecialty medical groups work in innovative ways that result in high-quality care and more value for the Medicare dollar. CMS highlighted the medical groups' use of electronic health records and patient registries which easily allowed practices to identify gaps in care, alert physicians to these gaps during patient visits, and provide care teams with interim feedback on performance.[6]

As evidence of the strengths and advantages of the multispecialty medical group model continues to grow, health policy researchers have considered ways to create payment incentives that support more organized systems of care. The Medicare Payment Advisory Commission (MedPAC) stated that creating incentives "to encourage physicians to form or join high-performing multispecialty medical groups could achieve more organized systems of care and thereby improve the health care provided to Medicare beneficiaries while reducing costs."[7]

In its March 2007 report to the Congress, MedPAC addressed developing payment incentives for physicians to provide "desired activities." MedPAC defined "desired activities" as:

- Quality measurement and improvement
- Use of evidence-based medicine
- Care coordination
- IT use
- Efficient provision of care
- Compensation practices that promote these objectives[8]

Rewarding physicians who perform "desired activities" will incentivize more integrated forms of care and will begin a shift away from volume-based payments that contribute to the delivery of fragmented care. Paying for "desired activities" will also provide incentives for care coordination, which is crucial in the treatment of chronically ill patients.

IV. Community-Based Accountability for Healthcare Services

Our current system does not hold providers accountable for the care they provide. Moreover, physicians are not accountable for providing the full spectrum of care. Creating accountability in the system is impossible until we transform the current volume-based system into one that pays providers based on outcomes or value. Once a link has been made between compensation and results, provider accountability will grow.

However, accountability may be difficult for physicians that practice alone or in small groups. This lack of size and scope generally results in inadequate resources for electronic medical records (EMRs) and health information technology (HIT) use, which can result in less teamwork and significantly lower the likelihood that quality data will be collected and reported.[9] To create a new system of care, AMGA supports the creation of "accountable care systems or ACSs," an idea similar to what MedPAC terms "accountable care organizations" or ACOs.

According to MedPAC, the "goal of an ACO is to promote accountability for quality and resource use over an extended period of time for a population of patients. Under an ACO, physicians and other providers are encouraged to work together and improve care coordination. Over time, such organizations might control growth in the volume of services provided and improve the quality of their services."[10]

AMGA defines an ACS as an entity that has physician leadership and internal structures, methods, and systems for measuring, assessing, and advancing the effectiveness and efficiency of patient care; provides a longitudinal, coordinated continuum of healthcare services that crosses provider settings; and is willing to be held accountable for the clinical results to the community served by them. ACSs are entities, either by ownership or by "virtual" networking, with the attributes stipulated.

ACSs could work in tandem with medical homes, which in many cases may be too small to support full accountability. MedPAC's Report states that large, multispecialty medical groups and integrated delivery systems might already function as ACOs and could serve as models to test the concept.

V. Shift Payments from Volume to Value

The United States spends an enormous amount on health care, with estimates as high as 15 percent of the gross domestic product, much more than any other developed nation.[11] Despite these high costs, there is not a significant correlation with safety, quality, timeliness, or effectiveness in the care delivered. Health care is reimbursed by payment for actions tendered in an episodic rather than comprehensive, systemic fashion, with more actions yielding greater reimbursement.

AMGA supports a vision for healthcare quality that links payments for services directly to the quality of care provided as an evolutionary step to what we believe to be the optimal payment scheme: payment for results. Such a results-based payment system would include these dimensions to assess the effectiveness of clinical pathways in a provider system and ultimately link payments to the appropriate results that flow from them:

- Did the patient achieve an appropriate clinical outcome?
- Did the patient receive all the care and only the care necessary in an efficient manner?
- Was the care provided in a timely manner?
- Is the decision made in the context of patient centricity (i.e., patient preferences)?
- Was the care provided in a coordinated system?

A results-based payment system holds physicians accountable for the patient achieving appropriate clinical outcomes. This system rewards coordinated care which adds quality and value to the healthcare system.

AMGA supports the evolution to a new payment model that ultimately compensates providers according to the results they achieve for patients, not just on the amount of services they deliver. Transforming our medical reimbursement system from its current approach (paying for volume of services) to a system that rewards providers for delivering high-quality and efficient clinical care, culminating in a system that pays for results, is a pivotal step in healthcare reform.

VI. Incentives

Incentives for Care Coordination

Incentives to provide care coordination are absent in the Medicare program. This lack of care coordination has negative ramifications. According to a recent study, patients who reported seeing four or more physicians were three times as likely to report at least one type of adverse event (e.g., medication or lab).[12]

AMGA supports a Chronic Care Model (Model) that provides the components for effective care coordination. The Model would encourage care coordination across practice settings and disease conditions.

Importantly, the Model would focus on patient-centered care that includes: proactive monitoring of health status; reinforcement of self-care behaviors; early detection of problems and intervention; and coordination of and collaboration among healthcare disciplines. Treating the "whole" patient is most successful when supported by innovative technologies including EMRs, patient registries, and home monitoring or telephonic devices that allow the sharing of patient-specific information when and where it is needed.

AMGA believes the Model will provide beneficiaries with the right care at the right time in the most appropriate setting. Moreover, the Model could produce significant cost savings due to decreased utilization and duplication of services. In a Veterans Health Administration clinical demonstration project that targeted high-cost/use veterans and utilized care coordinators and home monitoring devices, emergency room (ER) visits were reduced by 40 percent, hospital admissions were reduced by 63 percent, and hospital bed days of care (BDOC) were reduced by 60 percent. Nursing home admissions were reduced by 64 percent and nursing home BDOC were reduced by 88 percent. Most importantly, quality of life indicators, as measured by patient survey responses, were significantly improved for participating veterans.[13]

Incentives to Expand Health Information Technology

Despite technological advances in other industries, the healthcare sector remains a paper-based system. Approximately two thirds of hospitals and more than 80 percent of physicians use paper-based health records. This reliance on paper has dramatic consequences. According to the IOM, 1.5 million preventable medical errors occur every year and these preventable medical errors cost close to 100,000 lives annually.[14] Use of information technology will dramatically improve these numbers.

HIT, in the form of EMRs, e-prescribing, and registries, reduces duplication of tests, which saves lives and money. Use of EMRs allows providers to clearly see their patient's tests, procedures, and results, allowing the physician to set a proper course of treatment. EMRs may also provide clinical support to providers.

With the exception of e-prescribing, however, there are no incentives for providers to purchase or use HIT. Many medical groups have already made multimillion-dollar investments in sophisticated EMR systems without any reimbursement from Medicare or private sector payers (though the savings created by HIT use go directly to payers). AMGA recommends that Congress provide incentives to stimulate the acquisition and use of HIT. Incentives might include low- or no-interest loans, tax credits and grants for HIT purchases, and reimbursement for physicians and medical groups that have already made HIT investments.

VII. Professional Liability (Medical Malpractice) Reform

No discussion of changing the delivery system is complete without discussing professional liability and related tort reforms. The high costs of professional liability insurance coverage, more commonly known as medical malpractice insurance, continue to be an unabated problem. Medical malpractice insurance costs have skyrocketed due to oftentimes frivolous lawsuits and excessive jury awards. These high costs have resulted in physicians avoiding or refusing high-risk cases, reduced access to care, and increased overall healthcare spending.[15] Further, most physicians practice defensive medicine, i.e., undertaking unnecessary, duplicative, or excessive diagnostic testing and other treatments as a preemptive measure to stave off accusations of medical negligence or "failure to diagnose."[16]

Tort reform for medical malpractice insurance could reduce the high cost of claims by placing a cap on non-economic damage costs. With tort reform changes and caps on damages, physicians will have a reduced fear of damaging lawsuits, insurance companies will be able to lower premiums for medical liability insurance, and physicians will regain confidence in high-risk cases like delivering babies and performing high-risk surgeries. This change would maximize patient recovery of awarded damages and place structured limits on attorney contingency fees.

In addition to tort reform, proper use of evidence-based guidelines should provide mitigating protections in professional liability cases and, under certain circumstances, immunity. Evidence-based medicine provides the best research evidence to make decisions about medical care and helps doctors properly diagnose illnesses and select the best treatments. In addition to improving patient treatment and outcomes, evidence-based medicine can help physicians and institutions measure performance and identify areas for further study and improvement.

States should also be allowed to retain or enact their own reform limits that are equal to or greater than those for Medicare beneficiaries. In order to avoid frivolous lawsuits, penalties should be placed on plaintiffs or attorneys if the court deems lawsuits to be frivolous.

Qualifications should be set for people to serve as expert witnesses in medical malpractice litigation (for example, must be a local physician, practicing in the same specialty as the defendant). Traditional rules regarding "joint liability," under which the entire award may be recovered from any defendant, should be modified to that of "several liability" which requires payment of damages only proportional to defendants' fault or responsibility.

VIII. Comparative Effectiveness

Comparative effectiveness analysis compares the clinical effectiveness of a particular service with its alternatives. Currently, significant geographic variations in spending on health care exist within the U.S., and these variations do not necessarily translate into higher quality care or greater life expectancy.[17] The current healthcare delivery system operates without enough credible, empirically-based information.[18] The need to find solutions to contain healthcare spending while improving care (also known as increasing efficiency) underscores the need for comparative effectiveness analysis in reforming healthcare delivery.

The Agency for Healthcare Research and Quality (AHRQ), MedPAC, and Congress have all recognized the value of comparative effectiveness research in reforming the nation's healthcare system. According to the IOM, comparative effectiveness research provides a mechanism to address many of the complex and persistent health policy challenges facing our nation, including the potential to direct healthcare expenditures more efficiently toward care that is effective, and reducing geographic variations in the use of healthcare services.[19]

Use of comparative effectiveness information would facilitate and strengthen provision of patient care and related financial determinations. By knowing what works best in treating patients, the nation's healthcare delivery system could make substantial strides toward improving clinical outcomes, closing gaps in geographic variations while reducing healthcare expenditures.

AMGA supports the fundamental concepts of comparative effectiveness information use in healthcare delivery, but tempers that view with a caution that such information must be developed by disinterested parties, using objective means, and must be equally applied.

IX. Prevention and Wellness

Chronic illnesses such as heart disease, diabetes, cancer, and stroke afflict nearly half of Americans,[20] account for 70 percent of deaths,[21] and cost $1 trillion annually,[22] consuming 78 percent of all healthcare spending.[23] Our healthcare system does little to address and treat the underlying causes of chronic illness.

Adopting a more healthful lifestyle that includes smoking cessation, increased physical activity, good nutrition, and appropriate screening, could reduce up to 40 percent of cancers, dramatically reduce heart disease, and reduce type 2 diabetes and strokes by up to 80 percent.[24] These reductions would save lives, improve quality of life and productivity, and potentially reduce healthcare spending. Focusing our healthcare delivery system on measures to prevent and better manage these chronic illnesses is necessary. Achieving this shift will entail an emphasis on funding and reimbursement for a number of initiatives and services:

- Expanded coverage and payment for smoking cessation and nutrition programs that have demonstrated success in changing and supporting healthful choices;
- Federal grants to states to implement innovative, evidence-based prevention and wellness programs at the local level;
- Tax incentives to small businesses in particular to offer employees programs that support proven wellness and related programs; and
- Expanded access to screening for chronic diseases.

Adopting preventive measures will require reimbursement reform to support wellness and clinical preventive services, which could result in a reduction in obesity and chronic diseases.

X. Enhancing the Healthcare Workforce

Primary care is an important underpinning of our healthcare delivery system. The U.S. faces a shortage of primary care physicians in the near future.[25] Furthermore, there is mounting evidence that such shortages will be most detrimental to the old, poor, and those living in rural America and in its urban core.[26]

AMGA believes that a number of actions, primarily but not exclusively in the Federal realm, must be taken to assure that the public does not face a shortage of primary care physicians with all of the attendant access and care problems:

- Increasing the number of medical school graduates to train more physicians overall. More loans and grants, accelerated loan forgiveness, etc. to those training and working in primary care, particularly for those serving in areas targeted as a matter of public policy.
- Addressing imbalances in reimbursements for primary care physicians to attract more graduates to become primary care doctors.
- Supporting a tiered system of reimbursements for care coordination, particularly for those with chronic conditions, as proposed by AMGA.
- Bolstering Community Health Centers, those safety net providers providing primary care for vulnerable Americans.
- Expanding the National Health Service Corps, a means by which primary care doctors can be dispatched to targeted areas to repay their medical school loans for a period of service.

To assure that the physician workforce—particularly for the specialties of internal medicine, family medicine, and pediatrics—is adequate to meet future needs, AMGA recommends the actions stipulated. These and similar reforms will forestall access problems as the population grows and ages.

XI. Transparency in Business Relationships

AMGA has six major values that drive its work and contribute to its culture. Among those is the value of transparency and accountability for clinical care outcomes. Many doctors and others involved in patient care have relationships with industry that often help foster new and improved products, drugs, devices, and services. In furtherance of its values and to eliminate potential conflicts of interest or the appearance of undue influence on patient care and related decisions, AMGA calls for transparency about such matters.

All business relationships involving significant compensation, income, or similar involvements between physicians and others in a position of organizational leadership, who render or oversee patient care treatment decisions, should publically disclose the names of companies with which they have collaborations or other arrangements. This disclosure should apply broadly to relationships with the pharmaceutical, device manufacturers, and consulting firms, among others.

Endnotes

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