

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Impact of Patient Non-adherence on Quality Scores
(Reference Committee G)

EXECUTIVE SUMMARY

Policy [D-450.950](#) was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized and identify equitable and actionable solutions. This report discusses quality of care metrics, measuring patient adherence, the role of coding in value-based care (VBC), patient adherence models, and includes several policy recommendations.

As quality metrics assess the effectiveness of health care processes, outcomes, patient perceptions, and organizational structures or systems to meet assigned goals, they have increasingly been tied to payment in VBC. Poor patient adherence to physician recommendations obscures quality metrics and results in poor outcome measures. Many factors outside of the control of a physician impact the adherence of a patient to physician recommendations. Patient adherence can be measured in three ways: objective, subjective, and biomedical strategies.

In 2003, the World Health Organization (WHO) released a report which provided a critical review of potential solutions to improve adherence, including the WHO Multidimensional Adherence Model, which considers extrinsic factors impacting a patient. There are several additional adherence models that may provide a roadmap to improve patient adherence. While there is no "gold" standard to improve adherence, there may be opportunities based on a combination of methods enhancing patient self-regulation or self-management.

The Council on Medical Service recommends new policy supporting the removal of outcome scores that are unfairly tied to patient non-adherence and the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. The Council also recommends additional research on the intricacies of non-adherence and potential models to improve adherence.

Additionally, the Council recommends amending Policy D-450.958 to capture that patient non-adherence to physician recommendations should not be evaluated in the Hospital Consumer Assessment of Healthcare Providers and Systems and Clinician and Group Consumer Assessment of Healthcare Providers and Systems surveys nor should physician compensation, employment retention or promotion, faculty retention or promotion, or provider network participation be linked to patient non-adherence. Furthermore, the Council recommends reaffirming Policies H-450.947 and H-450.966 to illustrate the AMA's principles and guidelines for pay-for-performance payment systems as well as the principles to consider when assessing quality and performance measures. Lastly, the Council recommends reaffirming Policy H-390.837 to emphasize the AMA's position regarding the Medicare Access and CHIP Reauthorization Act system.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-25

Subject: Impact of Patient Non-adherence on Quality Scores

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee G

Policy [D-450.950](#) was adopted at the 2024 Annual Meeting and asks our American Medical Association (AMA) to study the issue of patients and parents not adhering to physicians' recommendations such as preventive screenings and vaccinations resulting in a deficiency of quality metrics by physicians for which the physicians are penalized and identify equitable and actionable solutions. This report discusses quality of care metrics, measuring patient adherence, the role of coding in value-based care (VBC), patient adherence models, and includes several policy recommendations.

BACKGROUND

The National Academy of Medicine defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹ Quality metrics assess the effectiveness of health care processes, outcomes, patient perceptions, and organizational structures or systems to meet assigned goals, such as safe, efficient, patient-centered, equitable, and timely care.² Increasingly, these quality measures are being linked to payment to ensure quality health care. For Medicare and Medicaid beneficiaries, the Centers for Medicare & Medicaid Services (CMS) uses measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting. Private payers are also increasingly measuring the performance of physicians, with the intent to provide financial incentives to improve health care delivery and establish transparency programs to allow comparison among physicians. While more than half of health care payments are still fee-for-service, CMS continues to expand its value-based payment and alternative payment model programs.³ In 2022, CMS launched its National Quality Strategy which, “aims to promote the highest quality outcomes and safest care for all individuals” and instills a person-centered approach to the broader goal of quality by focusing on the overall care trajectory across the continuum of care. Further, the approach seeks to reduce provider burden, advance equity, aid in the transition from manual to digital reporting, and clarify comparison between quality and VBC programs.

Broadly speaking, quality can be measured in three ways: structure, process, and outcome.⁴ Structural measures focus on the attributes of a setting in which the care is received. Some examples of structural measures include whether the health care organization uses electronic medical records, the number or proportion of board-certified physicians, or the ratio of providers to patients.⁵ Process measures assess the interaction between the physician and patient and include the percentage of people receiving preventive services (such as mammograms or immunizations) or the percentage of people with diabetes who have their blood sugar evaluated and controlled.⁶ Lastly, outcome measures address morbidity or quality of life. Examples of outcome measures include the percentage of patients who die because of surgery (surgical mortality rates) or the rate of surgical

1 complications or hospital-acquired infections.⁷ Some other examples of measurable care include:
 2 patients' reports on the care and service they receive from the hospital (process, structure, or
 3 outcome), provision of care instructions upon hospital discharge for certain conditions (process),
 4 percentage of patients receiving recommended hospital care for specific conditions such as heart
 5 attack (process), pneumonia care (process), and prevention of surgical infection (outcome), rates at
 6 which patients fall and incur injury during a hospital stay (outcome), and number of beds and the
 7 types of services available (structure).⁸

8
 9 Unique challenges have arisen during the transition to VBC. For instance, the distinct values,
 10 perspectives, and self-interests of health care stakeholders have made it difficult to clarify what
 11 should be assessed. Beyond this, the considerable variety of quality measures has caused confusion
 12 as they do not share a common theme. Further, the increased requirement to report quality
 13 measures (quantity or complexity) leads to increased reporting burden. While the Medicare Merit-
 14 based Incentive Payment System (MIPS) is well intentioned, the reporting requirements are
 15 burdensome to physician practices and often appear to be irrelevant. MIPS is not unique in that the
 16 nature of having to report any quality measures creates a burden. It may be presumed that
 17 improving care is ancillary to "checking a box." Further, despite the current efforts to prioritize
 18 effective and relevant metrics to determine quality care, the problems within the current framework
 19 remain. According to the Commonwealth Fund, many primary care physicians have decided not to
 20 participate in value-based models based on "imperfect performance measures," as they believe that
 21 quality suffers because of these measures.⁹ Indeed, commercial insurers often use the same, or
 22 similar, quality measures as CMS to adjust physician payment.

23
 24 Beyond poor outcome scores, a physician can feel the negative impacts of VBC in a myriad of
 25 ways. For instance, there is financial risk associated with changing the payment structure. If the
 26 physician, or practice, does not meet targets or costs exceed what is expected, this can be a
 27 significant deterrent to VBC.¹⁰ The financial risk can be especially pronounced if the practice does
 28 not have the infrastructure or resources to manage the consequences. Beyond this, data
 29 interoperability brought forth by fragmented health care data systems makes it difficult to obtain a
 30 complete understanding of the patient and their outcomes, which is critical for VBC.¹¹
 31 Additionally, the administrative burden associated with VBC can be onerous, a transition to VBC
 32 may require a workflow redesign, and lack of technology and resources may impede the ability of
 33 the physician or practice to participate in VBC.¹²

34
 35 Ideally, VBC would improve the quality of care and patient experience while decreasing health
 36 care costs. However, it is unclear whether that is the case. In some studies, there is evidence
 37 demonstrating its benefits.¹³ Other studies contradict those sentiments.^{14,15} Patient non-adherence to
 38 medication protocol, for instance, continues to be a significant issue.¹⁶ One recent estimate
 39 revealed that morbidity and mortality associated with non-optimized prescription drug regimens,
 40 with non-adherence playing a significant role, cost \$528.4 billion per year on average in the United
 41 States (U.S.).¹⁷ Beyond this, health care costs have continued to rise during the transition to VBC.
 42 The cost of disease progression, readmissions, wasted resources, labor burden, and insurance costs
 43 represent three to ten percent of total health care costs in the U.S.¹⁸ Indeed, one meta-analysis
 44 showed that all-cause non-adherence costs ranged from \$5,271 to \$52,341 per person.¹⁹

45
 46 Poor patient adherence can obscure a prescribed treatment's effectiveness, or whether it results in
 47 avoidable hospitalization, increased mortality, and/or increased health care costs. Physicians may
 48 change the regimen with the belief that the health care provided is not improving the patient's
 49 outcome, thereby unintentionally negatively impacting a patient, and further complicating the cost
 50 or complexity of the health care provided. In addition, a physician may receive a poor-quality score
 51 despite providing evidence-based care.²⁰ However, if a physician provides care that focuses on the

1 patient's experience (e.g., choosing a lower cost alternative treatment at the patient's request) and
2 the patient fails to improve, the physician is deemed to have provided poor quality care. For
3 diabetes patients, for example, an individual may have a remarkably high blood sugar level when
4 they begin seeing their physician. Over time, the blood sugar level may improve significantly due
5 to the provision of evidence-based care, but the physician's care will be rated as poor quality if it
6 does not meet a certain threshold.²¹ Alternatively, if a patient cannot afford medication and the
7 physician provides alternative mechanisms that are cost-effective but do not significantly improve
8 blood sugar levels, the care is considered "poor quality."
9

10 Similarly, a physician may have a low MIPS score despite providing evidence-based care. One
11 study suggests that MIPS score was inconsistently associated with performance on process and
12 outcome measures as the MIPS program may be ineffective at measuring and incentivizing quality
13 improvement among U.S. physicians.²² Further, it was found that physicians caring for medically
14 complex and socially vulnerable patients were more likely to receive low MIPS scores, even when
15 they delivered relatively high-quality care.²³ In another study, it was proposed that safety-net
16 hospitals are more likely to serve patients with higher risk factors and thus have worse performance
17 measures, on average.²⁴ Hospital-based value-based payment programs may unintentionally
18 increase financial penalties for social safety-net hospitals. Therefore, some VBC payment systems
19 may be ineffective at evaluating and providing payment for quality of care in certain
20 circumstances.
21

22 Furthermore, to understand the limitations of quality measures, it is important to consider
23 disparities, structural racism, and discrimination. In 2003, the Institute of Medicine published the
24 report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," which
25 provided specific recommendations to reduce disparities by improving financing, allocation of
26 care, communication, and community-based care.²⁵ The report outlined that racial and ethnic
27 disparities are consistent across a range of illnesses and health care services. Racial and ethnic
28 disparities remain even after adjustment for socioeconomic differences and other health care access
29 related factors.²⁶ Moreover, while disparities based on race or ethnicity are pervasive, it is
30 important to note that other forms of discrimination impact the health of a patient. For instance,
31 sex, gender, sexual orientation, disability, and socioeconomic status can impede effective health
32 care and create disparate outcomes. Further, while discrimination, bias, and disparities are
33 prevalent in health care, they are also ubiquitous throughout society. Outcome measures evaluate
34 physicians by the outcome of the patient, but many factors outside the physician's control, yet
35 affect a patient's access. In some circumstances, a physician may help by creating alternative
36 options for payment, testing, or treatment. However, many social drivers of health (SDOH) are
37 beyond the control of a physician.
38

39 MEASURING PATIENT ADHERENCE

40

41 Patient adherence emphasizes the patient's active involvement and decision-making process in
42 following treatment recommendations, suggesting that the patient understands, agrees with, and
43 takes responsibility for their health behaviors. As VBC relies on outcome-based measures, patient
44 adherence becomes a critical factor for tying physician payment to measurement since measures
45 assume patient adherence with prescribed treatments. Unfortunately, patient adherence is
46 contingent on many factors outside the control of a physician. Further, tying physician payment to
47 measures that focus on patient adherence may improperly penalize physicians who are otherwise
48 providing quality care.
49

50 The World Health Organization (WHO) defines adherence as "the extent to which a person's
51 behavior – taking medication, following a diet, and/or executing lifestyle changes, corresponds

1 with agreed recommendations from a health care provider.”²⁷ Measuring adherence involves
2 objective, subjective, and biomedical strategies. Subjective strategies can include questionnaires,
3 diaries, and interviews. Objective strategies can include counting remaining dosages, table counts,
4 patterns of missed dosages, treatment attendance, or electronic monitoring devices which record
5 the time and date when a medication container was opened. Biochemical measures usually involve
6 the detection of a metabolite or marker in bodily fluids. There are drawbacks to each of the
7 methods. For instance, subjective ratings may lead to overestimates of adherence and
8 underestimates of non-adherence. Objective strategies, such as electronic monitoring devices or the
9 use of pharmacy databases may be expensive and time consuming. Biochemical measures might
10 not account for variability in areas such as drug-drug interactions, drug-food interactions, and
11 individual pharmacokinetics of the drug. The most accurate approach may include a combination
12 of all three.

13
14 Patient adherence research has focused on the determinants of non-adherence, extent of non-
15 adherence, and strategies to improve adherence. Failure to address the patient’s perspective in
16 adherence research has led to a lack of progress in research as well as the lack of understanding
17 physicians’ prescribing practices. Furthermore, individual bias, or prejudice, is a key factor when
18 understanding non-adherence. Physician bias, for instance, may impact care. A physician may
19 unintentionally associate the patient’s attributes with the care they receive because of ignorance of
20 social or cultural norms.²⁸ Additionally, physicians, like others in our society, are affected by
21 stereotypes.²⁹ These impediments to good health care outcomes, and effective care, may make it
22 difficult for a patient to follow physician recommendations.

23
24 Furthermore, patient non-adherence to screening tests and vaccinations continues to be a significant
25 impediment to quality metrics. Despite the importance of chronic disease screening,
26 underutilization persists. Even though there is a preponderance of data explicating the usefulness of
27 vaccines, there continues to be concern about their side effects. Parents may be hesitant to
28 vaccinate their children due to concerns about long-term side effects, a lack of trust in medical
29 authorities, and doubt about the benefits of vaccines.³⁰ Globally, while there was an improvement
30 in vaccination rates in 2022 as compared to 2021, they still remain below 2019 rates.³¹ In screening
31 for lung cancer, patient adherence was found to be lower for high-risk individuals – people who
32 smoke, those who are not white, or individuals older than 65.³² Therefore, it was suggested that
33 interventions to promote adherence should prioritize current smokers and smokers from minority
34 populations.³³ While lung cancer screening is underutilized by minority populations, cancer
35 screening, in general, continues to be underutilized for all populations despite its benefits to reduce
36 morbidity and mortality.³⁴ Further, adherence to recommended blood-based screening is
37 underutilized, which is troubling as it is an option for early detection and management of cancers or
38 other chronic diseases.³⁵

39
40 However, some key themes within studies give credence to ways to improve adherence. Physician
41 recommendations significantly improve cancer screening rates among most populations.³⁶ While
42 physician recommendations are necessary to improve adherence, they are not the only
43 consideration, as the quality and content of the patient/parent-physician discussion also play key
44 roles in the level of adherence since they foster shared decision making.³⁷ Limited success is also
45 seen with vaccine counseling, as it continues to be the most significant way to improve vaccination
46 rates, especially when coupled with technology such as sending text message reminders and
47 allowing patients to make vaccine reservations.³⁸

THE ROLE OF CODING IN VALUE-BASED CARE

As mentioned previously, SDOH factors outside of the control of a physician may impact health care outcomes. Some of these factors may be captured in the *Current Procedural Terminology* (CPT®) nomenclature, particularly with Category II codes.³⁹ Category II CPT codes are optional, supplemental codes used for performance measurement and intended to facilitate data collection about quality of care by reporting certain services and/or test results that support performance measures.⁴⁰ In addition to performance measure codes, performance measure modifiers are used to account for reporting measure exceptions due to the inability to meet the denominator action of the measure for medical, patient, or system reasons.⁴¹

Research has been compiled toward understanding how the CPT code set can help physicians adapt to VBC arrangements. Recently, the AMA developed an issue brief in conjunction with Manatt Health Strategies, “[Accelerating the Adoption of Value-Based Care with the CPT Code Set](#),” which outlines how the CPT code set supports current VBC arrangements and opportunities for continued evolution.⁴² The issue brief synthesizes the feedback received from 34 organizations representing VBC provider organizations, health plans, integrated delivery systems, VBC enablement organizations, and health technology organizations, identifying three areas where codes are successfully enabling VBC adoption.⁴³ Interviewees suggested a variety of opportunities for the CPT code set to support accelerated adoption of VBC models, such as, “considering how CPT might address new types of health care services being delivered, such as how to best account for the delivery of services cognizant of patients’ SDOH factors.”⁴⁴ However, it is important to note that revision or expansion of the CPT code set must be done independent of the AMA HOD, as Policy [H-70.919](#) attests that the CPT Editorial Panel maintains autonomy in the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements, and modifiers.

There are limitations associated with Category II CPT codes, namely that CMS has replaced most Category II CPT codes with Healthcare Common Procedure Coding System (HCPCS) Level II codes. HCPCS Level II codes identify professional services and temporary procedures (G codes) as well as medical services (M codes) and can be used to report services such as the administration of a vaccine, ultrasound, or mammogram.⁴⁵ Furthermore, HCPCS Level II codes are used in the MIPS Value Pathways program to identify specific subsets of measures and activities to meet MIPS reporting requirements.⁴⁶ While HCPCS Level II codes were initially developed for Medicare claims, many private payers have adopted them. HCPCS Level II codes were selected as part of the Health Insurance Portability & Accountability Act (HIPAA) standard procedural code set for describing services, health care equipment, or supplies not represented in CPT.⁴⁷ One of the advantages of HCPCS Level II codes is that they allow for more specificity than CPT codes. For example, HCPCS Level II codes can identify durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies (like surgical bandaging or splints/casts).⁴⁸ While HCPCS Level II codes provide a standardized system for reporting across different payers, they have some drawbacks, as well. The complexity of the HCPCS Level II coding nomenclature necessitates specialized knowledge and can present obstacles for health care systems.⁴⁹ Additionally, selecting an incorrect code may lead to improper payment or a denial of claims which can result in recoupment or actions against the physician. Furthermore, the code set is updated throughout the year, which can make it difficult to stay up to date on the coding infrastructure.

WORLD HEALTH ORGANIZATION MULTIDIMENSIONAL ADHERENCE MODEL (WHO-MAM)

In 2003, the WHO released, “[Adherence to Long Term Therapies: Evidence for Action](#),” which provided a critical review of what is known about and potential solutions to improve adherence.⁵⁰

The report was developed as a result of the WHO Adherence to Long-term Therapies Project, a global initiative launched in 2001 by the Noncommunicable Diseases and Mental Health Cluster of the WHO. The tenets include:⁵¹

- Poor adherence to treatment of chronic diseases is a worldwide problem of striking magnitude.
- The impact of poor adherence grows as the burden of chronic disease grows worldwide.
- The consequences of poor adherence to long-term therapies are poor health outcomes and increased health care costs.
- Improving adherence also enhances patients' safety.
- Adherence is an important modifier of health system effectiveness.
- Increasing the effectiveness of adherence interventions may have a far greater impact on the health of the population than any improvement in specific medical treatments.
- Health systems must evolve to meet new challenges.
- Patients need to be supported, not blamed.
- Adherence is simultaneously influenced by several factors.
- Patient-tailored interventions are required.
- Adherence is a dynamic process that needs to be followed up.
- Health professionals need to be trained in adherence.
- Family, community, and patients' organizations: a key factor for success in improving adherence.
- A multidisciplinary approach towards adherence is needed.

In addition, the report introduced five dimensions of adherence. The multidimensional interplay between these factors determines adherence to treatment. As the report mentions, "the common belief that patients are solely responsible for taking their treatment is misleading and most often reflects a misunderstanding of how other factors affect people's behavior and capacity to adhere to their treatment." However, the model may provide a solution to equitably promote adherence to physician recommendations. The dimensions of adherence include:⁵²

- A. Social and economic factors – negative impacts can include poor socioeconomic status, poverty, illiteracy, low level of education, unemployment, lack of effective social support networks, unstable living conditions, long distance from treatment center, high cost of transport, high cost of medication, changing environmental situations, culture and lay beliefs about illness and treatment, and family dysfunction.
- B. Health care team and system-related factors – negative impacts can include poorly developed health services with inadequate or non-existent payment by health insurance plans, poor medication distribution systems, lack of knowledge and training for health care providers on managing chronic diseases, overworked health care providers, lack of incentives and feedback on performance, short consultations, weak capacity of the system to educate patients and provide follow-up, inability to establish community support and self-management capacity, lack of knowledge on adherence and of effective interventions for improving it.
- C. Condition-related factors – condition-related factors represent illness-related demands faced by the patient.
- D. Therapy-related factors – the most notable therapy-related factors are the complexity of the medical regimen, duration of treatment, previous treatment failures, frequent changes in treatment, the immediacy of beneficial effects, side-effects, and the availability of medical support to deal with them.
- E. Patient-related factors – patient-related factors represent the resources, knowledge, attitudes, beliefs, perceptions, and expectations of the patient.

ADDITIONAL ADHERENCE MODELS

Besides WHO-MAM, there are other models to consider that could provide a roadmap to equitably improve adherence, such as:

- Medication Adherence Model (MAM):⁵³ This option was developed to address medication adherence in patients with hypertension. Its three core concepts are: a) purposeful action; b) patterned behavior; and c) feedback. Patients' initiating and sustaining medication adherence are dependent on the deliberate decision to take medications based on perceived need, effectiveness, and safety (Purposeful Action). Then they establish medication-taking patterns through access, routines, and remembering (Patterned Behavior). Individuals use information, prompts, or events (Feedback) during the appraisal process to evaluate health treatment that, in return, influences individuals' levels of Purposeful Action and Patterned Behavior.
- Hierarchical Model for Medication Adherence (HMMA):⁵⁴ The HMMA was developed in consideration of Maslow's hierarchy of needs. In this model, an individual acquires certain skills/beliefs/behaviors at lower levels to achieve the higher level of medication adherence behavior. At the base level, every individual should have adequate health literacy. Once the patient understands their disease and treatment, the beliefs component comes into play. The next phase in the model is an individual's belief in their medicines. The final stage of the hierarchical model is self-efficacy.
- Transtheoretical Model (TTM):⁵⁵ The TTM is a theory of change that a common set of change processes can be replicated across behaviors and situations. TTM posits that health behavior change involves progress through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination. The stages are transtheoretical and integrate principles of change from across a variety of theories. Each stage brings an individual closer to behavioral changes.
- Three Factor Heuristic Model:⁵⁶ The model comprises three important clinical actions: (1) insuring that patients have the right information and know how to adhere – including listening to patients' concerns, encouraging their participation and partnership in decision-making, building trust and empathy, and enhancing recall; (2) helping patients believe in their treatment and become motivated to commit to it - that is, addressing the cognitive, social, cultural normative and contextual factors that affect patients' beliefs, attitudes and motivation; and (3) assisting patients to overcome practical barriers to treatment adherence and develop a workable strategy for long-term disease management - including assessing and enhancing patients' social support, identifying and treating their depression and helping patients overcome cost-related treatment barriers.
- Health Belief Model (HBM):⁵⁷ HBM allows physicians, and other health care professionals, access and assess the patient's behavior by breaking down their beliefs. Following the HBM, a health care provider should: verify the patient's understanding of the potential consequences of their disease; make sure the patient knows that they are susceptible to those consequences, and that they have a degree of control over the outcome; assess the patient's understanding of the benefits of the treatment to ensure they fully understand those benefits; and make sure that the patient has a realistic understanding of side effects to ensure that if side effects manifest, they do not undermine the perceived value of the behavior change.

- Theory of Planned Behavior (TPB):⁵⁸ TPB suggests that people will at least form the intention to conduct a given behavior if all three of the domains – beliefs about a behavior, the perception of a subjective norm, and the perception of control – come together. TPB adds an important social element because people are social and have strong reactions to behaviors that are perceived to affect social standing. To apply the TPB, health care providers should consider the following suggestions: ask the patient how difficult they think it will be to carry out suggestions and follow the prescription, ask the patient what they think might lead to failure, inquire about the degree to which the people close to the patient will either help or hinder behavior changes, and discuss the patient’s perception of what other people or society in general might feel about the condition or treatment behaviors.

While there is an array of options to help assuage non-adherence, it is important to highlight that no one option is the “gold-standard.” Indeed, none of the options boast a wide array of studies to verify legitimacy. Therefore, more research should be compiled to evaluate the most effective models.

IMPROVING PATIENT ADHERENCE

There may be opportunities to help improve patient adherence in an equitable way. According to the WHO report, some innovative interventions can target the patient, physician, and the health care system as outlined below. For example, the AMA Improving Health Outcomes (IHO) Group supports physicians, care teams and the patients they serve to prevent cardiovascular disease. IHO found that a lack of blood pressure measurement protocol contributes to variation and inaccurate measurements. As a result, patients with uncontrolled hypertension are sub-optimally treated, which frequently leads to non-adherence of medications and treatment plans. In response, IHO created the MAP (Measure Accurately, Act Rapidly, and Partner with Patients) Framework to address the systemwide problem.⁵⁹

While the WHO report did not identify a single intervention as most effective, promising methods include a combination of the following strategies:⁶⁰

- Patient Education
- Behavioral Skills
- Self-Rewards
- Social Support
- Telephone Follow-up

Further, it was found that the most effective interventions directed at patients aim to enhance self-regulation or self-management capabilities, such as:⁶¹

- Self-Monitoring
- Goal Setting
- Stimulus Control
- Behavioral Contracting
- Commitment Enhancement
- Creating Social Support
- Relapse Prevention
- Corrective Feedback

1 However, as the WHO's report outlines, "even the most efficacious patient-focused interventions
2 have no substantial effects on adherence behavior over the long term." Therefore, further study is
3 required to understand viable options to improve adherence behavior long-term.

4 5 AMA POLICY

6
7 Policy H-450.947 outlines Principles for Pay-for-Performance and Guidelines for Pay-for-
8 Performance, which support the formation, implementation, and assessment of fair and ethical Pay-
9 for-Performance programs. Further, the principles and guidelines reinforce the importance of a
10 patient-centered approach and evidence-based performance measures.

11
12 Policy H-450.966 supports the need for the AMA, national medical specialty societies, state
13 medical associations, and physicians to actively participate in the development, implementation,
14 and assessment of quality and performance measures. Policy H-410.960 encourages physicians to
15 support the development and usage of quality improvement standards and indicators for
16 measurement of quality practice.

17
18 Policy H-390.837 encourages CMS to simplify MIPS, advocates for appropriate scoring
19 adjustments for physicians treating high-risk beneficiaries in the Medicare Access and CHIP
20 Reauthorization Act (MACRA) system, and urges CMS to study whether the MACRA system
21 disincentives physicians to provide care to sicker Medicare patients. In addition, there are several
22 policies that are more specific about the removal of measures or metrics within quality scores.
23 Policy D-450.955 supports asking CMS to remove pain scores from quality metrics that impact
24 payment from nursing facilities, while Policy D-450.958 advocates that CMS remove pain survey
25 questions from the Hospital Consumer Assessment of Healthcare Providers and Systems and
26 Clinician and Group Consumer Assessment of Healthcare Providers and Systems and encourages
27 health care systems not to link physician compensation and attainment to patient pain scores.

28 29 DISCUSSION

30
31 While the Council recognizes the importance of performance measures and values their
32 contribution to VBC, many require patient adherence which is not always controlled by the
33 physician. In addition, the Council believes that physicians have a significant role to play in the
34 development, assessment, and implementation of quality measures.

35
36 Quality metrics are specific, quantifiable measures used to evaluate the quality of care provided to
37 patients. The metrics assess various aspects of health care delivery, including patient outcomes,
38 safety, efficiency, and patient satisfaction. While these metrics are important in the evaluation of
39 the care provided, unique challenges have been identified. For instance, quality metrics may not
40 account for the progression of a patient. While a patient may get significantly better, they may not
41 meet a certain threshold indicating so-called "good" care. Further, patient adherence may be a
42 significant issue. A patient may not take medication because of social stigma or cultural
43 differences. Beyond this, quality metrics do not consider the systemic issues that impede quality of
44 care. Structural racism is a significant factor in the health care outcomes of patients, as is
45 discrimination in other forms – such as disability, sex, gender, and socioeconomic status.
46 Therefore, the Council supports the modification of quality measures and removal of outcome
47 scores that are unfairly tied to patient non-adherence. Further, the Council recommends amending
48 Policy D-450.958, to remove patient outcomes and patient non-adherence to treatment from the
49 HCAHPS and to remove patient outcomes and adherence to treatment from the evaluation of
50 physician compensation, retention, promotion, and provider network participation. The Council

recommends reaffirming Policy H-450.947, which outlines the Principles for Pay-for-Performance and Guidelines for Pay-for-Performance to highlight best practices when developing VBC.

Significant problems continue to exist with MIPS, leading the Council to believe that the unique challenges of MIPS are an organic extension of the issues related to VBC. As such, the Council recommends reaffirming Policy H-390.837, which encourages CMS to improve MIPS to a simplified quality and payment system. Furthermore, the Council believes that physicians must have a significant role in the assessment of quality and performance measures. Therefore, the Council recommends reaffirming Policy H-450.966, which provides the principles to consider while assessing quality and performance measures and the need for the AMA, national medical specialty societies, and state medical associations to be involved in the assessment, as well as the development and implementation of quality measures.

The importance of patient adherence in VBC cannot be overstated. VBC relies on outcome measures which are determined by the ability of the patient to adhere to prescribed treatments. However, patient adherence is contingent on many factors outside a physician's control. Research on patient adherence is lacking, specifically a patient's perspective, which has led to a lack of knowledge about how to address long-term adherence. Therefore, the Council recommends that additional research be conducted to understand patient non-adherence, and potential models or strategies to improve adherence. Furthermore, many models have been developed to address patient adherence and holistically improve health care outcomes. The most notable is the WHO-MAM, which was introduced in 2003, providing a critical review of what is known about and potential solutions to equitably improve adherence. Fourteen tenets captured the findings of the report, and five dimensions of adherence were outlined to diagram the multidimensional interplay that determines adherence. Therefore, the Council recommends support for these types of models to provide guidance to improve patient adherence.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the removal of physician outcome scores that are unfairly tied to patient non-adherence. (New HOD Policy)
2. That our AMA support the development of models that provide guidance for physicians, medical practices, and health care teams to improve patient adherence in an individualized, continuous, and multidisciplinary way. (New HOD Policy)
3. That our AMA support additional research to understand the intricacies of non-adherence and potential models/strategies to improve adherence. (New HOD Policy)
4. That our AMA amend Policy D-450.958, "Pain Medicine," by addition and deletion, including a change in title:

PAIN MEDICINE AND PATIENT ADHERENCE IN QUALITY CARE ASSESSMENT,
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 the Centers for Medicare & Medicaid Services CMS not incorporate items linked to pain scores and adherence

- 1 to physician recommendations as part of the Consumer Assessment of Healthcare Providers
2 and Systems CAHPS Clinician and Group Surveys and the Hospital Consumer Assessment of
3 Healthcare Providers and Systems scores in future surveys; and (2) ~~(3)~~ encourages hospitals,
4 clinics, health plans, health systems, and academic medical centers not to link physician
5 compensation, employment retention or promotion, faculty retention or promotion, and
6 provider network participation to patient satisfaction scores relating to the evaluation and
7 management of pain and better adherence to physician recommendations. (Revise HOD Policy)
8
- 9 5. That our AMA reaffirm Policy H-450.947, which outlines the Principles for Pay-for-
10 Performance and Guidelines for Pay-for-Performance. (Reaffirm HOD Policy)
11
- 12 6. That our AMA reaffirm Policy H-450.966, which provides the principles to consider while
13 assessing quality and performance measures and the need for the AMA and state medical
14 societies to be involved in the assessment, as well as the development and implementation, of
15 quality measures. (Reaffirm HOD Policy)
16
- 17 7. That our AMA reaffirm Policy H-390.837, which encourages the Centers for Medicare &
18 Medicaid Services (CMS) to revise the Merit-Based Incentive Payment System to a simplified
19 quality and payment system, asks the AMA to advocate for appropriate scoring adjustments for
20 physicians treating high risk beneficiaries in the Medicare Access and CHIP Reauthorization
21 Act (MACRA) program, and urges CMS to continue studying whether MACRA creates a
22 disincentive for physicians to provide care to sicker Medicare patients. (Reaffirm HOD Policy)
23
- 24 8. Rescind Policy D-450.950, as having been completed with this report. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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**Council on Medical Service Report 7-A-25
Impact of Patient Non-adherence on Quality Scores
Policy Appendix**

Quality Management H-450.966

1. Our AMA continues to advocate for quality management provisions that are consistent with AMA policy.
2. Our AMA seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures.
3. Our AMA continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures.
4. Our AMA emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts.
5. Our AMA urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures.
6. Our AMA advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts:
 - a. Standards and measures shall have demonstrated validity and reliability.
 - b. Standards and measures shall reflect current professional knowledge and available medical technologies.
 - c. Standards and measures shall be linked to health outcomes and/or access to care.
 - d. Standards and measures shall be representative of the range of health care services commonly provided by those being measured.
 - e. Standards and measures shall be representative of episodes of care, as well as team-based care.
 - f. Standards and measures shall account for the range of settings and practitioners involved in health care delivery.
 - g. Standards and measures shall recognize the informational needs of patients and physicians.
 - h. Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.
 - i. Standards and measures shall recognize the importance and implications of patient choice and preference.
 - j. Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.
 - k. Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.

BOT Rep. 35, A-94 Reaffirmed: CMS Rep. 10, I-95 Reaffirmed: CMS Rep. 7, A-05 Modified:
CMS Rep. 6, A-13 Reaffirmed in lieu of Res. 714, A-14 Reaffirmed in lieu of Res. 814, I-14
Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmed in lieu of

Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed: CMS Rep. 02, I-17 Reaffirmation: A-22

Quality Patient Care Measures H-410.960

Our American Medical Association encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice.

Res. 811, I-02 Reaffirmed: CSAPH Rep. 1, A-12 Reaffirmed: CSAPH Rep. 1, A-22

Pay-for-Performance Principles and Guidelines H-450-947

The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
 - Evidence-based quality of care measures must be the primary measures used in any program.
 1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
 2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
 3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
 4. Performance measures should be scored against both absolute values and relative improvement in those values.
 5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
 6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
 7. Performance measures must be selected for clinical areas that have significant promise for improvement.
 - Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
 - Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
 - PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
 - PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
 - Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
 - Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.
- Patient/Physician Relationship
- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
 - Programs must not create conditions that limit access to improved care.
 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
 - Programs must neither directly nor indirectly encourage patient de-selection.
 - Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.
- Physician Participation
- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
 1. Programs should provide physicians with tools to facilitate participation.
 2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
 1. Programs should use accurate administrative data and data abstracted from medical records.
 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
 3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
 1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
 2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

BOT Rep. 5, A-05 Reaffirmation A-06 Reaffirmed: Res. 210, A-06 Reaffirmed in lieu of Res. 215, A-06 Reaffirmed in lieu of Res. 226, A-06 Reaffirmation I-06 Reaffirmation A-07 Reaffirmation A-09 Reaffirmed: BOT Rep. 18, A-09 Reaffirmed in lieu of Res. 808, I-10 Modified: BOT Rep. 8, I-11 Reaffirmed: Sub. Res. 226, I-13 Appended: BOT Rep. 1, I-14 Reaffirmed in lieu of Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmation I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmation: A-18 Reaffirmation: A-22

MACRA and the Independent Practice of Medicine H-390.837

1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.
2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.

3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

Alt. Res. 206, A-17 Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

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

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

Use of CPT Editorial Panel Process H-70.919

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers.

BOT Rep. 4, A-06 Reaffirmation A-07 Reaffirmation I-08 Reaffirmation A-09 Reaffirmation A-10 Reaffirmation A-11 Reaffirmation I-14 Reaffirmed: CMS Rep. 4, I-15 Reaffirmation A-16

Reaffirmed in lieu of: Res. 117, A-16 Reaffirmed in lieu of: Res. 121, A-17 Reaffirmation: A-18 Reaffirmation: I-18 Reaffirmed: Res. 816, I-19