

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-23

Subject: ACO REACH
(Resolution 822-I-22)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

1 At the 2022 Interim Meeting, the House of Delegates referred Resolution 822, Monitoring of
2 Alternative Payment Models within Traditional Medicare. Introduced by the Medical Student
3 Section, the resolution asked the American Medical Association (AMA) to: 1) “monitor the
4 Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH)
5 program for its impacts on patients and physicians in Traditional Medicare, including the quality
6 and cost of health care and patient/provider choice, and report back to the House of Delegates on
7 the impact of the ACO REACH demonstration program annually until its conclusion; ” 2)
8 “advocate against any Medicare demonstration project that denies or limits coverage or benefits
9 that beneficiaries would otherwise receive in Traditional Medicare; ” and 3) “develop educational
10 materials for physicians regarding the ACO REACH program to help physicians understand the
11 implications of their or their employer’s participation in this program and to help physicians
12 determine whether participation in the program is in the best interest of themselves and their
13 patients.”

14
15 The report of Reference Committee J from the 2022 Interim meeting recommended that Policies
16 H-160.915, D-385.953, H-373.998, and D-160.923 be reaffirmed in lieu of Resolution 822-I-22.
17 In this report, the Council provides background information on the ACO REACH program and
18 addresses common misconceptions about the program, summarizes extensive AMA policy and
19 concurs with the sentiment of Reference Committee J at the 2022 Interim meeting regarding
20 reaffirmation of policy in lieu of Resolution 822-I-22.

21

22 BACKGROUND

23

24 Accountable Care Organizations (ACOs) were developed to reform the regular Medicare payment
25 system by making a model available that links payment to the quality of care and not just the
26 number of services delivered. Holistically, the goal of the ACO programs is to improve the patient
27 care experience, improve population health, and reduce per capita costs of health care. The
28 Medicare Physician Group Practice Demonstration program, which began in 2005, was the Centers
29 for Medicare & Medicaid Services’ (CMS) first attempt at an ACO model. Under this model,
30 physicians were awarded bonus payments for improving cost efficiency and for their performance
31 on different care quality measures. Results for this program were mixed. In 2010, the Affordable
32 Care Act (ACA) formally introduced the ACO model as a permanent addition to the Medicare
33 program, not just a demonstration. The ACA also created the CMS Innovation Center, which has
34 evaluated ACO models, in addition to the permanent Medicare Shared Savings Program (MSSP).
35 For example, in January 2012, Medicare launched the Pioneer ACO program, and this was
36 followed by the introduction of the Global and Professional Direct Contracting (GPDC) Model,
37 which preceded ACO REACH.¹

1 ACO REACH is a voluntary Centers for Medicare and Medicaid Innovation (CMMI) model
2 scheduled to operate for four years from January 2023 to December 2026. ACO REACH is a
3 redesign of the GPDC model in response to feedback and Administration priorities. ACO REACH
4 is intended to better reflect CMMI's focus on advancing health equity and improving beneficiary
5 care. ACO REACH retains the basic design elements of the GPDC global and professional tracks
6 and adds new requirements to advance equity, promote physician governance, and protect
7 beneficiaries. To continue participation in ACO REACH, participants in the GPDC model needed
8 to meet ACO REACH model requirements by January 1, 2023. Appendix A provides a summary of
9 the differences between the GPDC and ACO REACH models.

10
11 Changes to the ACO REACH governance structure include an increase in physician and other
12 participating health professionals' membership on each ACO's governing board from 25 percent to
13 75 percent. Each board must also include a separate beneficiary and consumer advocate with voting
14 rights. In the ACO REACH model, CMS has increased monitoring and compliance requirements to
15 track and respond to issues that may arise.²

16
17 The ACO REACH model has specific health equity requirements for participation. CMS requires
18 all participating ACOs to develop a health equity plan and collect beneficiary-reported
19 demographic and social needs data. Additionally, CMS has implemented an enhanced health equity
20 benchmark to incentivize care delivery to underserved populations and has increased the range of
21 services that can be provided by nurse practitioners under the model. For example, in ACO
22 REACH, nurse practitioners can certify the need for hospice care; certify the need for diabetic
23 shoes; order and supervise cardiac rehabilitation; establish, review, sign, and date home infusion
24 therapy plans of care; and make referrals for nutrition therapy. The Council encourages continued
25 monitoring of these expanded services and emphasizes that all patient care be performed under the
26 supervision of a physician. Finally, under the ACO REACH model, CMS has reduced the
27 benchmark discount from a maximum of 5 percent to 3.5 percent and has reduced the quality
28 withhold from 5 percent to 2 percent.³

30 ACO REACH MISCONCEPTIONS

31
32 The Council believes it is crucial to address misconceptions about ACO REACH in order to
33 effectively evaluate the program's impact.

34
35 First, it is important to recognize that this model is a time-limited model test and does not replace
36 regular Medicare. During its implementation from January 2023 to December 2026, ACO REACH
37 will be continuously evaluated to monitor its impact. Only if the model is shown to improve quality
38 without increasing costs, reduce costs without negatively impacting quality, or improve quality and
39 reduce costs will expansion or extension of the program be considered.

40
41 Second, ACO REACH beneficiaries continue to be covered by regular Medicare, and not Medicare
42 Advantage (MA). Beneficiaries may receive care from any Medicare physician of their choice and
43 can switch physicians at any time.⁴

44
45 Third, beneficiaries will only be included in the program if they already receive a majority of their
46 primary care services from an ACO REACH participating physician or if they voluntarily notify
47 CMS that they wish to be assigned to an ACO REACH participating physician. Accordingly,
48 attribution in ACO REACH is similar to that in existing MSSP models. ACOs must alert
49 beneficiaries who have been aligned to an ACO and inform them of their right to opt-out of CMS
50 data sharing with the ACO.⁵ It should be noted that despite their data not being shared with CMS

1 directly, these patients will still be included in ACO REACH as long as they receive a majority of
 2 their care from a physician participating in ACO REACH. Program enrollment does not change
 3 covered benefits and patients can still see and receive any service covered by fee-for-service
 4 Medicare.

5
 6 Fourth, CMS has implemented a monitoring plan to protect beneficiaries and address potential
 7 program integrity risks from bad actors. ACO REACH participants will be subject to audits of
 8 charts, medical records, implementation plans, and other data.⁶

9
 10 **DIRECT CONTRACTING ENTITIES AND CODING CONCERNS**

11
 12 The transition to ACO REACH addresses issues with the GPDC model and transparency,
 13 specifically related to upcoding. Under the Direct Contracting Entity (DCE) model, there were
 14 strong incentives for plans to “upcode” patient diagnoses, which affects the risk-adjusted payments
 15 plans receive. A 2020 study from the Department of Health and Human Services (HHS), shows
 16 that enrollees in Medicare Advantage plans generate 6 percent to 16 percent higher diagnosis-based
 17 risk scores than they would under regular Medicare where diagnoses do not affect most provider
 18 payments.⁷ The HHS study estimates that upcoding generates billions of dollars in excess public
 19 spending and significant distortions to both health care entity and individual consumer behavior.
 20 Critics of GPDC caution that these newer ACO models could employ similar tactics to those used
 21 by MA where plans add unnecessary diagnosis codes to inflate risk scores of Medicare
 22 beneficiaries, resulting in a higher payment from Medicare.⁸

23
 24 Lawmakers in Congress expressed concern with automatically including DCEs with a history of
 25 fraudulent behavior and suggested that CMS halt participation by any organizations that have
 26 committed health care fraud and terminate DCEs that do not meet the new standards for the
 27 program. Under the implementation of ACO REACH, CMMI will more stringently monitor
 28 compliance to ensure that there are no inappropriate coding practices.⁹ Additionally, in February
 29 2022, the AMA [signed on to a letter](#) encouraging ongoing transparency and stability in all value-
 30 based care models.

31
 32 **AMA POLICY AND ADVOCACY**

33
 34 The AMA has an extensive policy portfolio regarding ACOs and alternative payment models
 35 (APMs). Policy H-160.915 affirms the AMA’s ACO principles. These principles are inclusive of
 36 all aspects of participating in an ACO, and this policy addresses many of the concerns raised by
 37 Resolution 822-I-22. Importantly, H-160.915 affirms that the goal of an ACO is to increase access
 38 to care, improve the quality of care, and ensure the efficient delivery of care, with the physician’s
 39 primary ethical and professional obligation being the well-being and safety of the patient.
 40 Additionally, the principles affirm that physician and patient participation in an ACO should be
 41 voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization
 42 (including an organization that bills on behalf of physicians under a single tax identification
 43 number) or any other entity that creates an ACO must obtain the written affirmative consent of
 44 each physician to participate in the ACO. Physicians should not be required to join an ACO as a
 45 condition of contracting with Medicare, Medicaid, or a private payer or being admitted to a hospital
 46 medical staff. Furthermore, H-160.915 addresses concerns about equity by affirming that the ACO
 47 benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are
 48 assigned to each ACO, such as income/poverty level, insurance status prior to Medicare
 49 enrollment, race, and ethnicity and health status.

1 Policy D-160.923 states that the AMA will seek objective, independent data on ACOs and release a
2 whitepaper regarding their effect on cost savings and quality of care. In response to this policy, the
3 AMA released [Accountable Care Organizations: How to Perform Due Diligence and Evaluate](#)
4 [Contractual Agreements](#).

5
6 Policy H-373.998 affirms the AMA’s support for patient choice in their health care. Specifically,
7 this policy states that individuals should have freedom of choice of physician and/or system of
8 health care delivery and where the system of care places restrictions on patient choice, such
9 restrictions must be clearly identified to the individual prior to their selection of that system.

10
11 Policy H-160.892 states that the AMA encourages studies into the effect of hospital integrated
12 system ACOs’ ability to generate savings and the effect of these ACOs on medical staff and
13 potential consolidation of medical practices.

14
15 Policy D-385.963 states that the AMA advises physicians to make informed decisions before
16 starting, joining, or affiliating with an ACO. Additionally, this policy states that the AMA will
17 develop a toolkit that provides physicians best practices for starting and operating an ACO, such as
18 governance structures, organizational relationships, and quality reporting and payment distribution
19 mechanisms.

20
21 Policy H-180.944 affirms that health equity, defined as optimal health for all, is a goal toward
22 which our AMA will work by advocating for health care access, research, and data collection;
23 promoting equity in care; increasing workforce diversity; influencing determinants of health; and
24 voicing and modeling commitment to health equity.

25
26 Policy D-385.952(2) was recently amended at the 2023 Annual Meeting and states that the AMA
27 supports APMs that link quality measures and payments to outcomes specific to vulnerable and
28 high-risk populations, reductions in health care disparities, and functional improvements, if
29 appropriate, and will continue to encourage the development and implementation of physician-
30 focused APMs that provide services to improve the health of vulnerable and high-risk populations
31 and safeguard patient access to medically necessary care, including institutional post-acute care.

32
33 Finally, Policy H-160.912 defines “team-based health care” as the provision of health care services
34 by a physician-led team who works collaboratively to accomplish shared goals within and across
35 settings to achieve coordinated, high-quality, patient-centered care.

36 DISCUSSION

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38
39 Referred Resolution 822-I-22 asked the AMA to: 1) “monitor the ACO REACH program for its
40 impacts on patients and physicians in Traditional Medicare, including the quality and cost of health
41 care and patient/provider choice, and report back to the House of Delegates on the impact of the
42 ACO REACH demonstration program annually until its conclusion;” 2) “advocate against any
43 Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would
44 otherwise receive in Traditional Medicare;” and 3) “develop educational materials for physicians
45 regarding the ACO REACH program to help physicians understand the implications of their or
46 their employer’s participation in this program and to help physicians determine whether
47 participation in the program is in the best interest of themselves and their patients.” The first
48 Resolve clause is addressed by ongoing AMA Advocacy efforts and the Council’s ongoing work to
49 review these programs and keep the House informed of any concerns with this or any other
50 demonstration project. The Council will continue to monitor the outcomes of ACO REACH and
51 continue to update the House as needed. The second Resolve clause is addressed by Policy

1 D-385.952(2), which the Council recommends reaffirming. The third Resolve clause is addressed
2 by the 2019 AMA whitepaper titled: [“Accountable Care Organizations: How to Perform Due
3 Diligence and Evaluate Contractual Agreements.”](#)

4
5 The AMA has longstanding, overarching principles to guide ACO participation. The Council
6 believes that it is not necessary to develop novel policy referencing each new ACO model, as the
7 guidelines apply to each new model in perpetuity. The AMA’s principles affirm that patient and
8 physician participation in an ACO should be voluntary – one of the concerns articulated in
9 Resolution 822-I-22. These principles are inclusive of all aspects of participating in an ACO.

10
11 Resolution 822-I-22 raised several concerns with the ACO REACH model, including that the
12 model could worsen the quality of patient care and increase costs by incentivizing ACO REACH
13 entities to restrict care and engage in upcoding, which can be built into MA plans. Under ACO
14 REACH, CMMI will closely monitor compliance with coding practices, addressing upcoding
15 concerns laid out by the resolution.

16
17 CMS plans to continuously monitor the ACO REACH program and AMA policy encourages
18 studies into the effect of hospital integrated system ACOs’ ability to generate savings (H-160.892)
19 and affirms that the AMA will continue to monitor health care delivery and physician payment
20 reform activities and provide resources to help physicians understand and participate in these
21 initiatives (D-385.963). As an example of monitoring the ongoing program, CMS received
22 stakeholder feedback and has announced changes to address concerns beginning in 2024. The
23 changes include financial protections for midyear changes to benchmarks, additions to the Health
24 Equity Benchmark Adjustment to account for more patient characteristics, and updates to its risk
25 adjustment policies. Specifically, there was concern that the current model favored patients who
26 live in rural areas, which tend to be less racially and ethnically diverse. CMS has updated the
27 formula to determine payments to physicians to better account for patients who live in urban areas.
28 The new formula will take into account the number of beneficiaries who get a Medicare Part D
29 low-income subsidy as well as the state-based version of the Area Deprivation Index, not just the
30 national version.^{10,11}

31
32 Additionally, Resolution 822-I-22 expressed concern about the equity of the ACO REACH model.
33 Not only was this model designed with a specific focus on health equity, the AMA has policy
34 clearly affirming support for promoting health equity (H-180.944).

35
36 Given the scope expansion under ACO REACH that allows nurse practitioners to certify the need
37 for hospice care, certify the need for diabetic shoes, order and supervise cardiac rehabilitation,
38 establish, review, sign, and date home infusion therapy plans of care, and make referrals for
39 medical nutrition therapy, the Council recommends reaffirming Policy H-160.912 which highlights
40 the importance of a physician-led care team.

41
42 Finally, it is important to recognize that ACO REACH took effect in January 2023. There is not yet
43 sufficient data to analyze the impact of this model, and it would be premature to draw any
44 conclusions at this time. The Council supports continued AMA monitoring of the effects of ACO
45 REACH, a request sufficiently supported by the AMA policy we recommend for reaffirmation.

46 47 RECOMMENDATIONS

48
49 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
50 822-I-22, and the remainder of the report be filed:

- 1 1. That our American Medical Association reaffirm the following policies:
- 2 a. Policy H-160.915, “Accountable Care Organization Principles”
- 3 b. Policy H-373.998, “Patient Information and Choice”
- 4 c. Policy H-160.892, “Effects of Hospital Integrated System Accountable Care
- 5 Organizations”
- 6 d. Policy D-385.963, “Health Care Reform Physician Payment Models”
- 7 e. Policy H-180.944, “Plan for Continued Progress Toward Health Equity”
- 8 f. Policy H-160.912, “The Structure and Function of Interprofessional Health Care
- 9 Teams”
- 10 g. Policy D-385.952, “Alternative Payment Models and Vulnerable Populations”
- 11 (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹Tu, T, et al. Origins and Future of Accountable Care Organizations. Brookings Institution and Leavitt Partners. May 2015. <https://www.brookings.edu/wp-content/uploads/2016/06/impact-of-accountable-careorigins-052015.pdf>

²CMS.gov. ACO REACH Overview. Accessed: July 6, 2023. [https://innovation.cms.gov/innovation-models/aco-reach#:~:text=The%20ACO%20Realizing%20Equity%2C%20Access%2C%20and%20Community%20Health%20\(REACH,Accountable%20Care%20Organization%2C%20or%20ACO](https://innovation.cms.gov/innovation-models/aco-reach#:~:text=The%20ACO%20Realizing%20Equity%2C%20Access%2C%20and%20Community%20Health%20(REACH,Accountable%20Care%20Organization%2C%20or%20ACO).

³*Ibid.*

⁴The ACO Reach Model: Myths and Facts. Health Care Transformation Task Force. Accessed: July 18, 2023. <https://hctf.org/wp-content/uploads/2022/04/ACO-REACH-Myths-and-Facts.pdf>

⁵*Ibid.*

⁶*Ibid.*

⁷Geruso, M. and Timothy Layton. Upcoding: Evidence from Medicare on Squishy Risk Adjustment. HHS Public Access. March 2020. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7384673/pdf/nihms-1007327.pdf>

⁸King, R. CMS Overhauls Direct Contracting Model to include new requirements on governance, health equity in 2023. Fierce Healthcare. February 24, 2022.

<https://www.fiercehealthcare.com/payers/cms-overhauls-direct-contracting-model-include-new-requirements-governance-and-health-equity>

⁹*Ibid.*

¹⁰Healthcare Finance News. ACO REACH now includes financial protections from midyear benchmark changes. August 15, 2023. <https://www.healthcarefinancenews.com/news/aco-reach-now-includes-financial-protections-midyear-benchmark-changes>

¹¹Politico Pro. CMS to change health equity measures for key payment model. August 14, 2023.

<https://subscriber.politicopro.com/article/2023/08/cms-to-change-health-equity-measures-for-key-payment-model-00111182>

Appendix A Comparing GPDC to the ACO REACH Model

Comparing GPDC to the ACO REACH MODEL		
	Original Global Professional Direct Contracting (GPDC) Model (PY2021-PY2022)	ACO Realizing Equity, Access, and Community Health (REACH) Model (PY2023-PY2026)
Model Goals	<ul style="list-style-type: none"> Improve beneficiary access to providers who are personally engaged in their healthcare delivery. Provide strong incentives to improve quality of care by shifting payment away from fee-for-service towards value-based capitated payments. Allow organizations with prior ACO experience, innovative organizations taking risk in MA or Managed Medicaid, and organizations that focus on complex beneficiary populations to participate. 	<ul style="list-style-type: none"> Improve the focus on: <ul style="list-style-type: none"> Promoting health equity and addressing historical healthcare disparities for underserved communities. Continuing the momentum of provider-led organizations in risk-based models. Protecting beneficiaries and the model with more participant vetting, monitoring and greater transparency
Participants	<ul style="list-style-type: none"> Model participants are called Direct Contracting Entities (DCEs) but are equivalent to ACOs. 	<ul style="list-style-type: none"> Model participants referred to as REACH ACOs.
Governance	<ul style="list-style-type: none"> Participating providers generally must hold at least 25% of the governing board voting rights. Each DCE's governing board must include a beneficiary representative and a consumer advocate, though these representatives may be the same person and neither is required to hold voting rights. 	<ul style="list-style-type: none"> Participating providers generally must hold at least 75% of the governing board voting rights. Each REACH ACO governing board must include a beneficiary representative and a consumer advocate, who must hold governing board voting rights and must be different people.
Health Equity	<ul style="list-style-type: none"> No policies explicitly promoting health equity. 	<ul style="list-style-type: none"> Requirement for all REACH ACOs to develop a Health Equity Plan that must include identification of health disparities and specific actions intended to mitigate the health disparities identified. Introduction of a health equity benchmark adjustment to better support care delivery and coordination for patients in underserved communities. Requirement for all ACOs to collect beneficiary-reported demographic and social needs data. New Benefit Enhancement to increase the range of services that may be ordered by Nurse Practitioners to improve access.
Discount for Global	<ul style="list-style-type: none"> Global DCEs receive 100% of gross savings/losses. A discount is applied to the benchmark before gross savings/losses are calculated, which helps guarantee shared savings for CMS. There is no discount for Professional DCEs. 	<ul style="list-style-type: none"> Reduced discount rate for Global ACOs to 3-3.5% beginning in PY2023 will further CMS' goal of increasing participation in full risk FFS initiatives.
Quality Withhold	<ul style="list-style-type: none"> The quality withhold applied to the benchmarks of both Professional DCEs and Global DCEs is 5%. 	<ul style="list-style-type: none"> Quality hold for both Professional ACOs and Global ACOs is reduced to 2%.
Risk Adjustment	<ul style="list-style-type: none"> Two policies protect against risk coding growth: <ul style="list-style-type: none"> The "Coding Intensity Factor" (CIF) limits risk score growth across the entire model. The CIF applies to all DCEs to limit risk score growth to the average prior to the start of the model. A "Risk Score Growth Cap" limits a DCE's risk score growth to +/- .3% over a 2-year period. The DCE-specific caps on over-coding ensure DCEs are coding appropriately and limit gaming. 	<ul style="list-style-type: none"> Two changes to the "Risk Score Growth Cap" further mitigate potential inappropriate risk score gains: <ul style="list-style-type: none"> Adopt a static reference year population for the remainder of the model performance period. Cap the REACH ACO's risk score growth relative to the DCE's demographic risk score growth, so the +/- .3% cap is appropriately adjusted based on demographic changes in the underlying population over time. (Currently risk score cap is based on HCC growth – this would cap HCC growth relative to demographic growth.)
Monitoring/ Compliance	<ul style="list-style-type: none"> Robust monitoring of all DCEs includes: <ul style="list-style-type: none"> Monitoring for all levels of care provided, Compliance audits conducted throughout the year, Investigation of beneficiary complaints, and Collection of beneficiary surveys (CAHPS) annually to measure changes in beneficiary satisfaction. 	<ul style="list-style-type: none"> Additional monitoring and compliance efforts and analytics will: <ul style="list-style-type: none"> Assess annually whether beneficiaries are being shifted into or out of MA. Examine ACO's risk score growth to identify inappropriate coding practices. Monitor for noncompliance with prohibitions against anti-competitive behavior and misuse of beneficiary data. Increase use of data analytics to monitor use of services over time and compared to a reference population to assess changes in beneficiaries' access to care, including stinting on care. Review marketing materials regularly to ensure information on the Model is accurate and beneficiaries understand their rights and freedom of choice. Verify annually that REACH ACO websites are up to date and provide required information. Audit annually REACH ACO contracts with providers to learn more about their downstream arrangements and identify any concerns. Investigate on a rolling basis any beneficiary and provider complaints and grievances in coordination with 1-800-Medicare, the Innovation Center liaison on models in the Medicare Beneficiary Ombudsman team, CMS regional offices, and others as appropriate.
Benefits and Protections for Medicare Beneficiaries	<ul style="list-style-type: none"> Benefits (applies to all Performance Years of the model) include: <ul style="list-style-type: none"> A higher quality of care and greater clinical support and care coordination for beneficiaries. "Benefit Enhancements" and "Beneficiary Engagement Incentives" offered under the model (e.g., telehealth, post-discharge home visits and waiver of the homebound requirement, Part B cost-sharing support, concurrent care for beneficiaries that elect hospice care). Beneficiary protections (applies to all Performance Years of the model): <ul style="list-style-type: none"> All aligned beneficiaries retain full Original Medicare benefits and can see any Medicare physician. Beneficiaries are proactively notified on an annual basis of their alignment to a DCE/ACO and that their benefits have not changed. Beneficiaries retain all FFS Medicare channels for raising concerns or reporting complaints. 	

Appendix B ACO Comparison Chart



ACO Comparison Chart

This chart details the main elements of Medicare Shared Savings Program (MSSP) and Realizing Equity, Access, and Community Health (REACH) ACOs

Reflects policies in effect for 2023

	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Number of ACOs	27	124	9	10	125	161	24	108
Length of contract	Five years						2021 starters = 5 years + 9 months 2022 starters = 5 years 2023 starters = 4 years	
Participation opportunities	Annual MSSP application cycle opens each spring. ACOs must submit a notice of intent to apply (NOIA) in order to be eligible to submit a full application.						No future application cycles planned at this time.	
Status under MACRA	MIPS APM			Advanced APM				
Governance requirements	ACO participants must hold at least 75% control over the governing board. Each ACO's governing board must include at least one Medicare FFS beneficiary who is served by the ACO, and this beneficiary representative must have full voting rights.						Participant providers must hold at least 75% of governing board voting rights. Each ACO's governing board must include a beneficiary representative and a separate consumer advocate, each with full voting rights.	
Financial Structure								
	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Risk-sharing arrangement	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 40% No loss sharing	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 50% 1st dollar losses at 30%	1st dollar savings up to 75% 1st dollar losses at 40- 75%	1st dollar savings and losses at 50%	1st dollar savings and losses at 100%
Shared savings cap	10% of updated benchmark					20% of updated benchmark	<u>Gross (S/L):</u> < 5%	<u>Cap (S/L):</u> < 25%
Shared losses cap	Not applicable		Lesser of 2% of total Medicare Parts A & B FFS revenue or 1% of updated benchmark	Lesser of 4% of total Medicare Parts A & B FFS revenue or 2% of updated benchmark	Lesser of 8% of total Medicare Parts A & B FFS revenue or 4% of updated benchmark	15% of updated benchmark	5%-10% 10%-15% > 15%	35% 15% 5%
Discount or MSR/MLR	MSR will be 2% to 3.9% depending on number of assigned beneficiaries. Smaller ACOs have higher MSR (5,000 assigned beneficiaries = 3.9% MSR) and larger ACOs have lower MSR. (2% MSR for ACOs with 60,000+ assigned beneficiaries). MLR not applicable.		Prior to entering a two-sided model, the ACO must select its MSR/MLR as part of the application cycle. The choices are: <ul style="list-style-type: none"> • 0% MSR/MLR • Symmetrical MSR/MLR in a 0.5 percent increment between 0.5 and 2.0% • Symmetrical MSR/MLR that varies based on the number of beneficiaries assigned to the ACO. 			<ul style="list-style-type: none"> • No MSR/MLR • No discount 		<ul style="list-style-type: none"> ○ No MSR/MLR ○ Discount applied to the PY benchmark: 3% (PY2023-2024) 3.5% (PY2025-2026)

	Beginning in 2024, low revenue ACOs in the Basic Track may share in a portion of savings if the MSR is not exceeded; Levels A & B at 20%; Levels C, D, & E at 25%		
Transition to two-sided model	New, inexperienced ACOs may participate in Basic Level A for a full 5-year agreement period. In a subsequent agreement period, inexperienced ACOs that remain eligible are permitted to progress through Basic Levels A-E, which provides 2 additional years under upside-only (7 years total before downside risk). If ineligible to continue in the glidepath for the second agreement period, ACOs can participate in Level E for all 5 years of the agreement period.	Optional for all ACOs. ACOs may transition back to Level E from Enhanced.	No one-sided model under ACO REACH.
Benchmark	<p>CMS establishes and rebases MSSP ACO benchmarks based on expenditures from three benchmark years leading up to an agreement period using four beneficiary categories (ESRD, disabled, aged/dual, and aged/non-dual). CMS incorporates regional expenditures into benchmarks starting in an ACO's initial performance year. ACOs with spending higher than their region have a regional adjustment weight of 15%, ACOs with spending lower than their region receive a weight of 35% in the first agreement year. If an ACO is considered a re-entering ACO, CMS will apply the regional adjustment weight that was used in the most recent agreement.</p> <p>Beginning in 2024, CMS will:</p> <ul style="list-style-type: none"> Incorporate a prospective administrative growth factor based on US per capita cost to update an ACO's benchmark each performance year, creating a new three-way blend. The new update factor would look as follows: <ul style="list-style-type: none"> Two-way blend = (National Update Factor x National Weight) + (Regional Update Factor x (1 - National Weight)) Three-way blend = [PY1 ACPT x (1/3)] + [PY1 Two-Way Blend x (2/3)] Account for an ACO's prior savings when establishing benchmarks for renewing and re-entering ACOs. Reduce the cap on negative regional adjustments from -5 to -1.5 percent. 		<p>Prospective blend of historical spending and adjusted Medicare Advantage Rate Book</p> <ul style="list-style-type: none"> Standard ACOs using claims-based alignment: fixed 3-year baseline period (2017-19), with application of a trend adjustment and geographic adjustment Standard ACOs using voluntary alignment, New Entrant ACOs, & High Needs ACOs: only regional expenditures through PY2024 (historical expenditures incorporated beginning PY2025) <p>A health equity benchmark adjustment will be applied based on aligned beneficiaries' social risk. Additional details on benchmark calculations</p>
Risk adjustment	<p>CMS uses an ACO's prospective HCC risk score to adjust the benchmark for changes in severity and case mix in the assigned beneficiary population between BY3 and the performance year. Positive adjustments in prospective HCC risk scores are subject to a cap of 3 percent for each agreement period.</p> <p>Beginning in 2024, CMS will account for changes in demographic risk scores before applying the 3 percent cap and the +3 percent cap will apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual, and aged/non-dual)</p>		<p>CMS will risk adjust historical baseline, regional expenditures, and capitated payments</p> <ul style="list-style-type: none"> For Standard & New Entrant ACOs: CMS-HCC prospective risk adjustment model High Needs ACOs: CMMI-HCC concurrent risk adjustment model for aged & duals, CMS-HCC prospective risk adjustment model for ESRD <p>To control potential increases in coding intensity and risk score growth, CMS will use a normalization factor, a Coding Intensity Factor, and a risk score cap. Additional details on risk adjustment</p>
Payment options	CMS makes all FFS payments		<p>Primary Care Capitation (PCC) = monthly payments for certain primary care services ~2-7% of TCOC (CMS pays)</p> <p>Optional PCC or Total Care Capitation (TCC) = 100% Parts A & B services for aligned beneficiaries</p>

						<ul style="list-style-type: none"> claims for all other services) • Fee reduction required for Participant Providers, optional for Preferred Providers • Optional Advanced Payment (APO) up to 100% of benchmark w/ reconciliation 	<ul style="list-style-type: none"> • Fee reduction required for Participant Providers, optional for Preferred Providers
Reconciliation	Full performance year reconciliation following full claims run out period					Capitation payments not reconciled against actual claims. APO payments reconciled against actual claims. For ACOs electing TCC, CMS will reconcile TCC withhold against actual expenditures incurred by aligned beneficiaries for services provided outside of TCC arrangement.	
Beneficiaries and Alignment							
	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional REACH Global
Minimum number of beneficiaries	5,000					Standard ACOs: 5,000 (≥ 3,000 “alignable” beneficiaries in at least one base year) New Entrant ACOs: 2,000 in PY23, 3,000 in PY24, 5,000 in PY25-26 (max. 3,000 “alignable” beneficiaries in any base year) High Needs Population ACOs: 500 in PY23, 750 in PY24, 1,200 in PY25, 1,400 in PY26	
Beneficiary alignment	<ul style="list-style-type: none"> • Prospective or preliminary prospective with retrospective reconciliation (elected annually) • Claims-based and voluntary <ul style="list-style-type: none"> ○ Voluntary alignment takes precedence over claims-based 					<ul style="list-style-type: none"> • Prospective • Claims-based and voluntary (may market voluntary alignment) <ul style="list-style-type: none"> ○ Voluntary alignment takes precedence over claims-based ○ Voluntary alignment through MyMedicare.gov takes precedence over Attestation-Based Voluntary Alignment ○ Option to add voluntarily aligned beneficiaries quarterly 	

Beneficiary notification requirements	<p>ACOs must include posted signs in all ACO participant facilities notifying beneficiaries that its providers are participating in MSSP. Each agreement period, ACOs must furnish a written notice to beneficiaries prior to or at the first primary care visit:</p> <ul style="list-style-type: none"> For ACOs under preliminary prospective assignment—send to all FFS beneficiaries prior to or at the first primary care visit during the first performance year that the beneficiary is seen by an ACO participant. For ACOs under prospective assignment—send to all assigned beneficiaries prior to or at the first primary care visit. <p>Within 180 days of providing the notice or at the next primary care visit, ACOs must follow-up with beneficiaries and offer a meaningful opportunity to ask questions and engage with an ACO representative.</p>						<p>Each performance year, ACOs must send CMS-drafted and/or approved letters to all prospectively aligned patients by the date specified by CMS.</p>	
Quality								
Measures	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Scoring	<p>GPRO Web Interface (WI) reporting will sunset after PY 2024. Now through PY 2024, ACOs may report WI, eCQMs/MIPS CQMs, or both (those reporting both will receive the higher of the two scores). The WI will no longer be a reporting option for PY 2025 or later.</p> <ul style="list-style-type: none"> WI reporting: 10 total measures (7 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) eCQMs/MIPS CQMs: 6 total measures (3 clinical quality measures, 2 administrative claims measures, CAHPS for MIPS) <p><i>Note: CMS may suppress certain measures in certain performance years</i> NAACOS remains concerned with the timeline and strategy to shift to all payer/eCQM reporting and the NAACOS Digital Quality Measurement Task Force has provided recommendations to CMS on this issue.</p>						<ul style="list-style-type: none"> Standard & New Entrant ACOs: assessed on 4 measures (3 administrative claims measures and the ACO CAHPS Survey) High Needs ACOs: Timely Follow-Up measure is replaced with Days at Home for Patients with Complex, Chronic Conditions 	
EHR use	<p>In order to earn maximum shared saving, an ACO must meet or exceed the 30th percentile among all MIPS quality performance category scores in 2021-2023 and meet or exceed the 40th percentile each year after. ACOs that do not meet this threshold may share in a portion of savings by achieving a quality performance score equivalent to the 10th percentile (individual measure performance benchmark) or higher on at least one outcome measure. The ACO's final sharing rate would be scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score, which includes any health equity bonus points.</p>						<ul style="list-style-type: none"> 2% benchmark withhold can be earned back through quality scores Total Quality Score (0-100%) = initial quality score adjusted for continuous improvement/sustained exceptional performance (CI/SE) and health equity data reporting (HEDR) Highest performers eligible for a bonus 	
Compliance and Waivers								
Compliance programs	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
Monitoring efforts	<p>ACO must have a compliance plan that meets the requirements of 42 C.F.R. § 425.300, including: a designated compliance official who is not legal counsel to the ACO; anonymous reporting of suspected compliance violations, both by ACO members, employees and contractors regarding internal ACO matters and to law enforcement where the law may be violated; and compliance training.</p> <p>CMS monitors and assesses the performance of ACOs, their ACO participants, and ACO providers/suppliers through:</p> <ul style="list-style-type: none"> Analysis of financial and quality data reported by the ACO as well as aggregate annual and quarterly reports Analysis of any beneficiary/provider complaints Audits (i.e., analysis of claims, chart review, beneficiary survey reviews, coding audits, on-site compliance reviews) 						<p>ACOs must document that at least 75% of Participant Providers that are eligible clinicians use Certified EHR Technology (CEHRT)</p> <p>In addition to MSSP monitoring, CMS will monitor REACH ACOs for:</p> <ul style="list-style-type: none"> Beneficiaries being shifted to MA Excessive risk score growth/ inappropriate coding practices Service use over time <p>Full list of monitoring efforts</p>	

Available waivers	Not applicable	<ul style="list-style-type: none"> • SNF 3-day Rule—Waives 3-day inpatient stay requirement prior to SNF admission. CMS waives 3-star quality rating requirement for providers under swing bed arrangements. • Telehealth—Waives typical geographic restrictions count patients’ homes as originating sites. <i>(Only available to ACOs under prospective assignment)</i> 	<ul style="list-style-type: none"> • SNF 3-day Rule—SNF must be Participant or Preferred Provider and have quality rating of 3+ stars • Telehealth—Same as MSSP • Home visits – care management and post-discharge • Chronic Disease Management Reward Program • Provision of home health services to beneficiaries not “homebound” • Nurse Practitioner Services Benefit • Hospice Benefit— Waive requirement to give up curative care <i>(**only for Global)</i> 					
Allowable beneficiary incentives	Not applicable	<p>Beneficiary Incentive Program —Allows ACOs to provide a limited “cash equivalent” incentive to eligible beneficiaries who receive qualifying primary care services. May not be limited to a subset of beneficiaries or services.</p> <p>In-kind incentives — There must be a reasonable connection between items/services and beneficiary’s medical care; must be preventive care items/services or advance a clinical goal of the beneficiary; must not be a Medicare-covered item/service</p>	<ul style="list-style-type: none"> • Cost sharing support for Part B services tailored to specific categories of services and/or beneficiaries • In-kind items or services—may include home blood pressure monitors, vouchers for OTC medications, transportation vouchers, wellness programs, etc. 					
Policies to promote health equity	<p>Health equity quality adjustment: Beginning PY2023, CMS will award up to 10 bonus points to the quality performance score for ACOs delivering high quality care to underserved populations. Bonus points are only available to ACOs reporting eCQMs/MIPS CQMs. Additional details on the bonus calculation can be found on p. 14-15 here.</p> <p>Advance Investment Payments (AIPs): Beginning PY2024, CMS will provide advance shared savings payments to new, inexperienced, low revenue ACOs, modeled after the ACO Investment Model (AIM). AIPs will consist of a one-time upfront payment \$250,000 and quarterly payment calculated per beneficiary over the first 2 years of an ACO’s agreement period. ACOs will be able to apply for AIPs as part of the MSSP application cycle. More information can be found on p. 9-12 here.</p>		<ul style="list-style-type: none"> • Health Equity Plan requirement • Health equity benchmark adjustment • Requirement to collect and report beneficiary-reported demographic and SDOH data • Application scores include ACOs’ demonstrated ability to provide high quality care to underserved communities 					
Additional Resources								
NAACOS resources	MSSP Basic Level A	MSSP Basic Level B	MSSP Basic Level C	MSSP Basic Level D	MSSP Basic Level E	MSSP Enhanced	REACH Professional	REACH Global
CMS resources	Shared Savings Program webpage , Information for ACOs , Information for Providers , Program Guidance & Specifications , Program Data , MSSP News						NAACOS ACO REACH webpage , Summary of REACH Financial Specifications , REACH FAQs , REACH Model webpage , Model Factsheet , Financial operating guide , Quality measurement methodology , Provider management guide	

Appendix C – Policy Appendix Policies Recommended for Reaffirmation

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 ensures 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; Reaffirmation: I-17; Reaffirmation: A-19)

Patient Information and Choice H-373.998

Our AMA supports the following principles:

1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

(BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation: A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT 16, I-94; BOT Rep. 36, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmte., A-96; Reaffirmation: I-96; Reaffirmation: A-97; Reaffirmed: Rules & Credentials Cmte., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation: A-99; Reaffirmation: A-00; Reaffirmation: I-00; Reaffirmation: A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation: A-07;

Reaffirmation: A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation: I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmation: A-17; Reaffirmed: Res. 108, A-17; Reaffirmation: A-19; Reaffirmed in lieu of: Res. 112, A-19)

Effects of Hospital Integrated System Accountable Care Organizations H-160.892

Our AMA encourages studies into the effect of hospital integrated system Accountable Care Organizations' (ACOs) ability to generate savings and the effect of these ACOs on medical staffs and potential consolidation of medical practices.

Health Care Reform Physician Payment Models D-385.963

1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (e.g., antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.

10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity. (BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21)

The Structure and Function of Interprofessional Health Care Teams H-160.912

1. Our AMA defines 'team-based health care' as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care.
2. Our AMA will advocate that the physician leader of a physician-led interprofessional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform.
3. Our AMA will advocate that all members of a physician-led interprofessional health care team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure and the discretion of the physician team leader in order to most effectively provide quality patient care.
4. Our AMA adopts the following principles to guide physician leaders of health care teams:
 - a. Focus the team on patient and family-centered care.
 - b. Make clear the team's mission, vision and values.
 - c. Direct and/or engage in collaboration with team members on patient care.
 - d. Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
 - e. Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources.
 - f. Encourage adherence to best practice protocols that team members are expected to follow.
 - g. Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
 - h. Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
 - i. Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group or network.
 - j. Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
 - k. Review measures of 'population health' periodically when the team is responsible for the care of a defined group.
5. Our AMA encourages independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks or other networks of independent providers.
6. Our AMA will advocate that the structure, governance and compensation of the team should be aligned to optimize the performance of the team leader and team members.
(Joint CME-CMS Report., I-12; Reaffirmation: I-13; Reaffirmed: CMS Rep. 1, I-15; Reaffirmed: BOT Action in Response to Referred for Decision: Res. 718, A-17)

Alternative Payment Models and Vulnerable Populations D-385.952

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, reductions in health care disparities, and functional improvements, if appropriate; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care.

(CMS Rep. 10, A-19; Modified: Rep. 04, A-23; Reaffirmation: Res. 111, A-23)