

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Bundled Payments and Medically Necessary Care
(Resolution 111-A-22)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which asked the American Medical Association (AMA) to 1) advocate that coverage rules for Medicaid “episodes of care” be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary care with a report back to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional improvement be a key target outcome for bundled payments.

The Council’s review of the literature on select Medicare bundled payment models and Medicaid episodes of care found that lower extremity joint replacement (LEJR) bundles, and some perinatal episodes of care, have produced the most—but still modest—savings without compromising care quality. Because the evidence is clear that the savings accrued under LEJR episodes has been due to decreased spending on skilled nursing and inpatient rehabilitation facilities, some physicians have questioned whether patient access to medically necessary care, including institutional post-acute care, could potentially be limited. The Council believes that performance metrics measuring key patient-centered outcomes, including functional improvements after orthopedic and other procedures, are important and necessary checks on the risk that some models may underserve patients. Because the AMA already has extensive policy on alternative payment models (APMs), we recommend amending Policies H-390.849[2, 3] and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific to bundled/episode-based payments.

To address other concerns and obstacles under bundled/episode-based payment models, the Council recommends reaffirmation of Policy H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which outlines goals to be pursued as part of physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, provide adequate and predictable resources, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue to work with national medical specialty societies and state medical associations to educate physicians on APMs. The Council believes that well-designed, patient-centered bundled payment models can improve care quality and patient outcomes in ways that also lower growth in health care spending. Designing these models to work effectively for patients, physicians, and payers remains challenging, and ongoing refinements to models may be needed to ensure optimal patient outcomes as these initiatives continue to expand.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 04-A-23

Subject: Bundled Payments and Medically Necessary Care
(Resolution 111-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee A

1 At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which was
2 cosponsored by the American Academy of Physical Medicine and Rehabilitation and the Ohio
3 delegations. Resolution 111-A-22 asked the American Medical Association (AMA) to 1) advocate
4 that coverage rules for Medicaid “episodes of care” be carefully reviewed to ensure that they do not
5 incentivize limiting medically necessary services for patients to allow better reimbursement for
6 recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary
7 care with a report back to explore the unintended long-term consequences on health care
8 expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional
9 improvement be a key target outcome for bundled payments.

10
11 The Board of Trustees assigned this item to the Council on Medical Service for a report back to the
12 House of Delegates. This report adds to the body of reports developed by the Council on alternative
13 payment models (APMs) by providing background information specific to bundled/episode-based
14 payment models, summarizing the literature on prominent Medicare and Medicaid models,
15 reviewing relevant AMA policy and advocacy, and making policy recommendations.

16
17 **BACKGROUND**

18
19 Bundled or episode-based payments are a type of APM in which a single comprehensive payment
20 amount covers services delivered by multiple providers during an episode of care. An episode of
21 care is the care delivery process for a certain condition or procedure delivered within a defined
22 period of time. State Medicaid programs use the term episodes of care to describe payment models
23 in which a single bundled payment is made for services associated with the treatment of a condition
24 or procedure. The models aim to lessen variations in cost and quality by incentivizing providers
25 (e.g., physicians, hospitals, post-acute care facilities, and others providing services during the
26 episode) to work together and manage costs without compromising care quality. Providers able to
27 keep costs below a risk-adjusted target price for an episode may share in any savings and,
28 conversely, those exceeding that threshold may incur financial penalties. Savings can be generated
29 if, as is often the case, the target price is a discount of what has historically been paid, or if lower-
30 cost facilities and providers are utilized during the episode. To guard against underserving patients,
31 some models impose limits on gainsharing payments and/or require that certain quality metrics be
32 met.

33
34 Medicare, state Medicaid programs, and many private insurers have adopted bundled or episode-
35 based payment models to varying degrees with perinatal and joint replacement models increasingly
36 prevalent across multiple payers. Although Medicare has administered bundled payments for many
37 years, provisions in the Affordable Care Act (ACA) accelerated their use, along with other APMs,

1 by establishing the Center for Medicare & Medicaid Innovation (CMMI) and authorizing it to
2 develop and test new payment models without the need for Congressional approval. In 2015, the
3 Department of Health and Human Services announced national goals for transitioning to value-
4 based medicine and APMs; the same year, Congress passed the Medicare Access and CHIP
5 Reauthorization Act (MACRA), which among other things established incentive payments for
6 physicians to participate in advanced APMs. Centers for Medicare & Medicaid Services (CMS)
7 and a handful of states continue to experiment with episode-based payment approaches, such as
8 lengthier and more inclusive episodes and those that span multiple providers and/or sites of service.
9 Importantly, there is substantial variance among bundled/episode payment designs, with larger and
10 more widely implemented models including Medicare’s Bundled Payments for Care Improvement
11 (BPCI) Advanced initiative and the Comprehensive Care for Joint Replacement (CJR) model.
12

13 Medicare bundles have informed some Medicaid episodes of care although states have generally
14 adapted APMs to suit the unique needs of their Medicaid enrollees and health care in their states.¹
15 Notably, state Medicaid programs and Medicaid providers are at various stages of implementation
16 of value-based payment reforms and, to address ongoing budget pressures, many states have
17 pursued APMs to reduce cost growth in Medicaid while improving care quality. Because 70
18 percent of Medicaid enrollees are enrolled in managed care,² states often use contracting strategies
19 with managed care organizations (MCOs) to leverage the use of value-based payments, including
20 episodes of care. For example, more than half of states (20 of 37) that contract with MCOs to
21 manage care delivered to Medicaid enrollees require those plans to make a certain percentage of
22 provider payments through APMs, while some states require MCOs to adopt specific models.
23 Several states use financial incentives—and/or penalties—to compel MCOs to pursue value-based
24 payment models. To date, the use of episode-based payments has generally been limited to those
25 states that prescriptively define and require such models, including for joint replacement and
26 perinatal episodes of care.³ In a 2021 Kaiser Family Foundation survey, eight states (CO, NM, NY,
27 OH, PA, TN, VT, and VA) reported implementing episodes of care in Medicaid, although this
28 number changes as states implement new models while sunseting others.⁴
29

30 Most, but not all, bundled payment models are voluntary; the CJR initiative, which is mandatory in
31 certain areas and voluntary in others, and Medicaid models in some states, are exceptions. Beyond
32 that, bundled payment initiatives differ from each other in terms of duration, payment rules, and the
33 types of services included. Episodes can range from shorter durations to lengthier periods, as for
34 perinatal models that span the prenatal through postpartum periods. Although payments for
35 episodes of care can be determined prospectively or based on fee-for-service with retrospective
36 adjustments, most of the models discussed in this report adjust payments retrospectively.
37 Additionally, add-on payments covering high-cost or outlier cases may be made available to
38 varying degrees, depending on the model design. With respect to outliers, Policy H-385.907
39 advocates that bundled payments should recognize the differences in patients’ needs and payment
40 amounts should be risk stratified to reflect patients who need more resource-intensive services. The
41 menu of services paid for in a bundle also varies significantly across models and affects the types
42 of providers that participate. Notably, the CJR model includes most Part A and Part B services,
43 except for hospice and a few other carve-outs, while other models pay for a narrower set of
44 services.
45

46 Physician participation in bundled payment models has increased steadily over the past decade, as
47 evidenced by data from the AMA’s Physician Practice Benchmark Surveys, which are nationally
48 representative samples of non-federal physicians who provide care to patients at least 20
49 hours per week. According to recent Benchmark surveys, 32.0 percent of physicians were in
50 practices involved in bundled payments in 2012. This increased to 34.8 percent in 2016 and topped
51 40 percent in 2020 and 2022 for a cumulative increase of eight percentage points. Additionally, in

1 2022, an average of 10 percent of practice revenue (at the physician level) came from bundled
 2 payments.⁵

3
 4 The main obstacles to effective bundled payments are accurately defining care episodes, pricing the
 5 bundles, and ensuring adequate payment for care provided by all team members across all sites of
 6 service. Physicians have expressed concerns regarding both the financial arrangements and
 7 administrative burdens incurred, including the degree of financial risk required to participate, the
 8 potential for financial strain if the fixed payment amount does not accurately reflect the costs of the
 9 episode, the potential for decreased payments, and administrative hurdles, especially when
 10 participating in more than one APM. Additional concerns include high dropout rates among
 11 hospitals participating in some models, the potential for some models to become mandatory, and
 12 the ability of small physician practices to participate. In the Whereas clauses, the authors of
 13 Resolution 111-A-22 highlighted concerns about the occurrence of unrelated—and costly—events
 14 during a care episode, increased expenses for complex patients, the need for skilled nursing care by
 15 some patients, and possible incentives to lessen costs by decreasing patient access to services they
 16 may need.

17
 18 Defining what is related and unrelated to a bundle can be problematic with episode models, yet
 19 decisions about covered services are critical to ensuring appropriate payment. Care for unrelated
 20 conditions and procedures that takes place within the duration of an episode can be costly and
 21 potentially increase spending beyond the target price of the bundle. Importantly, the AMA
 22 maintains that APMs should be designed by physicians or with significant input from physicians in
 23 part so they can influence decisions about covered services and advocate that care for unrelated
 24 events (e.g., cataract surgery during a 90-day lower extremity joint replacement (LEJR) episode)
 25 not be paid for out of the bundled payment. The AMA also advocates that financial risk
 26 requirements be limited to costs that physicians participating in an APM are able to influence or
 27 control.

28
 29 An additional shortcoming of many of the larger Medicare bundled payment models is that they
 30 start with a hospitalization for a procedure. If, for example, episodes began with an evaluation for
 31 hip, knee, or back pain, or other condition, there would be more opportunities to save money and
 32 improve quality by, for example, engaging in patient-physician shared decision making strategies
 33 that could potentially prevent hospitalizations and procedures altogether. Specific to Medicaid,
 34 staffing, resource, and leadership capacity to develop and implement new models can be major
 35 obstacles to implementing payment initiatives and, for this reason, state Medicaid directors have
 36 asked CMS to provide upfront resources for states to engage in delivery system and payment
 37 reforms.⁶ Additionally, risk thresholds may dissuade some Medicaid providers, especially those
 38 practicing in states with particularly low payment rates, from participating in episode-based
 39 payment models if they feel they cannot take on financial risk. Importantly, Medicaid enrollees
 40 may have complex care needs and/or experience inequities in social determinants of health—such
 41 as housing instability, food insecurity, or lack of transportation—that impact their care and health
 42 outcomes. They also face unique barriers to care and may churn in and out of Medicaid, which
 43 could lead some Medicaid providers to believe they will be disproportionately penalized under
 44 APMs without sufficient risk adjustment.

45
 46 Many of these obstacles have been addressed in previous reports and policy development by the
 47 Council on Medical Service. [Council on Medical Service Report 9-A-16](#) established foundational
 48 policy on physician-focused APMs while [Council on Medical Service Report 10-A-17](#) focused on
 49 reducing some of the barriers to participating in these models and the need for changes to risk
 50 adjustment systems, attribution methods, and performance target setting. AMA policy established
 51 by [Council on Medical Service Report 10-A-19](#) addressed concerns raised by many that physicians

1 serving people who are sicker or experiencing poverty are disproportionately penalized by APMs.
2 [Council on Medical Service Report 3-I-19](#) established new policy on improving risk adjustment in
3 APMs, including that risk stratification systems should use fair and accurate payments based on
4 patient characteristics, and that risk adjustment systems should use fair and accurate outlier
5 payments if spending on an individual patient exceeds a predefined threshold. Concerns about
6 APMs, and AMA advocacy to improve upon value-based payment models, were also discussed in
7 [Council on Medical Service Report 2-A-22](#), which focused on prospective payment model best
8 practices for independent private practice.
9

10 EVIDENCE OF EFFECTIVENESS

11 *Select Medicare Bundled Payment Models*

12
13
14 Bundled/episode-based payments have been implemented for numerous surgical procedures and
15 medical conditions and remain a leading value-based payment reform in Medicare. Lacking the
16 capacity to thoroughly study the impact of all Medicare bundled payment models implemented
17 over the years, the Council reviewed independent evaluations of the larger CMS initiatives and
18 more recent analyses in the literature examining the impact of multiple bundles on Medicare
19 spending, quality of care, and unintended consequences. Information on a unique episode program
20 for non-hospital physicians developed as part of Maryland's statewide CMMI initiative is also
21 provided.
22

23 *BPCI*: One of the largest Medicare models was the voluntary BPCI initiative—four model designs
24 that offered episode-based payments to over 1,000 hospitals, physicians, and post-acute care
25 providers for 48 different clinical episodes over five years (2013-2018).⁷ Consistent with previous
26 findings, the final BPCI evaluation showed that the initiative reduced Medicare spending per
27 episode due primarily to declines in institutional post-acute care utilization and decreases in the
28 number of skilled nursing facility (SNF) days for those that needed SNF care. However, after
29 accounting for reconciliation payments to eligible providers, BPCI did not increase net Medicare
30 savings; instead, the initiative resulted in net increased Medicare spending beyond what it was
31 estimated to be in absence of the model.⁸ Evaluations further demonstrated that BPCI generally did
32 not affect quality of care as measured by emergency department visits, mortality, and hospital
33 readmissions. The evidence was mixed and included both positive and negative associations
34 between BPCI models and patient functioning,⁹ and fewer BPCI patients reported the highest level
35 of satisfaction with their care.¹⁰ Importantly, two studies analyzing outcomes of high-risk patients
36 found that participation in BPCI did not adversely impact their quality of care.^{11,12}
37

38 *BPCI Advanced*: Building on the experiences and lessons learned from BPCI, the BPCI Advanced
39 initiative—which includes bundles with one risk track and a 90-day duration—was launched in
40 2018 and has been extended to run through 2025. BPCI Advanced links performance on select
41 quality metrics to incentive payments and qualifies as an Advanced APM. Accordingly,
42 participating physicians who meet certain cost thresholds may be eligible for a five percent APM
43 incentive payment. Participation in BPCI Advanced is currently voluntary and notably widespread,
44 with 1,295 hospitals and physician groups participating in years one and two (2018 and 2019) and
45 more than 2,000 participating in year three (2020).¹³ CMS continues to use results from its
46 independent evaluations to refine the initiative, which reduced episode payments overall in 2018
47 and 2019 and produced greater savings (\$1,353 per episode) for surgical episodes than for medical
48 episodes (\$564 per episode).¹⁴ After accounting for reconciliation payments made to BPCI
49 Advanced providers in 2018 and 2019, the independent evaluator found that the initiative resulted
50 in net Medicare savings for surgical episodes and net increased Medicare spending for medical
51 episodes with an overall increase in Medicare spending of \$65.7 million.¹⁵ Consistent with BPCI

1 and other bundles, episode savings were primarily attributed to lower payments to post-acute care
2 sites, including SNFs and inpatient rehabilitation facilities. Importantly, quality of care was not
3 adversely impacted; in fact, BPCI Advanced has been found by the evaluators to reduce
4 readmissions for surgical episodes and to not worsen mortality rates.¹⁶ A separate study of BPCI
5 Advanced, published in 2022, also found the initiative to be associated with a net increase in
6 Medicare spending because bonuses paid to eligible hospitals exceeded episode payment
7 reductions.¹⁷ This study further found that hospitals caring for historically marginalized
8 populations received large bonuses under BPCI Advanced, possibly due to initial episode target
9 pricing, which was subsequently adjusted by CMS.¹⁸

10
11 *CJR*: The CJR model pays for care episodes that extend through 90 days after discharge from both
12 inpatient and outpatient settings for some of the most common surgeries among Medicare
13 patients—hip, knee, and, more recently, ankle replacements, also referred to as LEJR.¹⁹ CJR began
14 in 2016 and has been mandatory since 2017 for hospitals in 34 geographic areas where spending
15 had been historically high.²⁰ Over CJR’s first four years, payments across LEJR episodes in CJR’s
16 mandatory areas were 5.2 percent lower than the baseline, with payments averaging \$1,511 less per
17 episode. An independent evaluation estimated small net savings for the Medicare program in
18 earlier years but was unable to conclude definitively that Medicare realized net savings over the
19 first four years of the initiative. Over the four-year period, independent evaluators estimated that,
20 after accounting for reconciliation payments, net savings ranged from a possible \$15.3 million
21 more in Medicare spending to \$167.2 million in savings.²¹ Similar to other surgical bundles,
22 changes in post-acute care utilization drove the decrease in average episode payments, as fewer
23 patients were discharged to SNFs and rehabilitation facilities, and patients who went to SNFs spent
24 fewer days there. When compared to the control group, a larger proportion of CJR patients were
25 discharged to home health agencies, which cost significantly less than institutional post-acute
26 care.²² CJR patient care quality, as measured by unplanned readmissions, emergency department
27 use, and mortality rates, was maintained over the four-year period. Furthermore, patients in the
28 CJR and control groups reported similar functional status gains, pain levels, and overall
29 satisfaction, although some CJR patients reported that they required more caregiving help at home
30 and CJR hip replacement patients reported less improvement on three of eight functional status
31 measures.²³ In terms of unintended consequences, evaluators identified a decrease in patient
32 complexity that could indicate some level of risk selection but no evidence of increased LEJR
33 volume.²⁴ Although a *New England Journal of Medicine* study of CJR’s first two years did not find
34 adverse effects on complications, hospital readmissions, or mortality, it did not look at functional
35 status, pain, and patient satisfaction indicators. This study examined whether the CJR program
36 incentivizes hospitals to 1) treat healthier rather than sicker patients (risk selection); and/or 2)
37 reduce the use of SNF and inpatient rehabilitation. With regard to risk selection, the study noted
38 inconsistent evidence in previous studies and no changes in patient selection in the current study
39 other than some evidence that fewer disabled patients underwent procedures.²⁵ Because CJR did
40 not negatively affect complications, readmissions, or mortality, the study authors concluded that
41 hospitals may have correctly identified patients who could be appropriately discharged home with
42 home health instead of being referred to institutional post-acute settings.²⁶

43
44 A systemic review of CMS’s Acute Care Episode Demonstration (a three-year bundled payment
45 model for inpatient cardiac and orthopedic surgeries), BPCI, and CJR initiatives found no
46 associations between these Medicare models and 1) quality of care—as measured by readmissions,
47 emergency department visits, and mortality—and 2) unintended consequences, such as increased
48 utilization or risk selection.²⁷ This review further found that, in six out of 16 studies that evaluated
49 spending, bundled payments significantly decreased episode costs; importantly, these six studies
50 focused on orthopedic surgery and four of the six looked at LEJR episodes. Other clinical or
51 medical episodes were not found to be associated with episode savings.²⁸ A separate review of 16

1 Medicare bundled payment initiatives similarly found that Medicare spending decreased for LEJR
 2 episodes but not for most other bundled payment models unless provider fees were heavily
 3 discounted.²⁹ This review found limited evidence of risk avoidance across models although the
 4 evidence was mixed.³⁰ The authors highlighted the association between bundled payments and
 5 post-acute care spending, with payments and service intensity more likely to decrease under
 6 bundles that included post-acute care services in the bundle and increased post-acute care
 7 utilization in models that did not include post-acute care services in the bundle. Like other studies,
 8 no association was found between bundled payments and increased episode volume.³¹

9
 10 *Episode Programs in Maryland:* Within its Total Cost of Care All-Payer Model, Maryland has
 11 several CMMI-approved advanced payment initiatives specific to that state, including the Episode
 12 Quality Improvement Program (EQIP) launched in 2022 for specialist physicians in Medicare.³²
 13 This program provides opportunities for more non-hospital providers to participate in bundles
 14 relevant to a range of specialties, including gastroenterology, cardiology, and orthopedics, which
 15 were implemented in year one, as well as additional episodes that have been rolled out since. As of
 16 January 2023, 43 medical specialties were represented in 45 episodes available under EQIP.³³

17
 18 *Select Medicaid Episodes of Care*

19
 20 Although Medicaid programs employ a range of value-based payment programs, including
 21 episodes of care for various conditions and procedures, they have not been as high profile as some
 22 Medicare-focused models. Furthermore, while there is a wealth of published studies of Medicare
 23 bundled payment initiatives, the research literature is less robust for Medicaid models and not all
 24 states implementing episodes of care make cost and performance data publicly available.
 25 Accordingly, the Council reviewed available data from select states that were early adopters of
 26 episodes of care, including Tennessee, Ohio, and Arkansas, as well as a Medicaid and CHIP
 27 Payment and Access Commission (MACPAC) analysis of perinatal episodes implemented across
 28 three states.

29
 30 *Perinatal:* Because Medicaid covers nearly half (42 percent in 2020) of all births in the U.S.,³⁴
 31 several states have implemented episode-based payments for perinatal care. A 2021 MACPAC
 32 analysis reviewed perinatal episodes of care implemented in Arkansas, Colorado, and Tennessee.
 33 Although the Arkansas and Tennessee models were generally viewed positively in terms of
 34 reducing cost variations, Arkansas sunset its model, which had been mandatory, in 2021, due in
 35 part to administrative burdens on providers and diminishing returns as cost variations narrowed
 36 over time. The Tennessee and Arkansas models reduced costs per episode but produced mixed
 37 results on quality measures.³⁵ Because the Colorado model began later, in 2020, with only a few
 38 participants at the start, data on its impact on episode costs was not available at the time this report
 39 was written. Although high-risk pregnancies were excluded from episode-based payments in
 40 Arkansas and Tennessee, the Colorado model, which is voluntary, includes some high-risk patients,
 41 including those with substance use disorders. Importantly, while certain quality measures are
 42 tracked by states, there is no published evidence on the impact of perinatal episodes of care on
 43 maternal health or birth outcomes. Moreover, incentives are generally not tied to key metrics
 44 related to reductions in maternal morbidity and mortality, or impact on health disparities.³⁶

45
 46 *Tennessee:* Aside from its perinatal model, Tennessee's Medicaid program, known as TennCare,
 47 has administered close to 50 episodes of care since 2013. TennCare reported that, in 2018, 22 of
 48 the 27 episodes of care tied to incentive payments saved the state an estimated \$38.3 million. The
 49 five that did not show savings were for acute percutaneous coronary intervention, non-acute
 50 percutaneous coronary intervention, gastrointestinal hemorrhage, bariatric surgery, and human
 51 immunodeficiency virus episodes, which the state described as low volume, making savings more

1 difficult to achieve. Episodes producing the most savings in 2018 included the perinatal model
2 (\$13.5 million in savings), respiratory infection episode (\$6.8 million), and the asthma acute
3 exacerbation episode (\$4.2 million).³⁷ Quality of care, as measured by certain performance metrics,
4 was mostly maintained or improved except for low-volume episodes in which quality metric
5 performance declined.³⁸ Because TennCare waived all episodes of care incentives through 2021
6 due to the Covid-19 pandemic, more recent evaluation data was not available for review.

7
8 *Ohio:* Ohio's Department of Medicaid, which has administered 43 episodes of care since 2015,
9 similarly suspended its episodes of care incentives between 2020 and 2022 due to Covid-19's
10 impact on the state's providers. Data from 2019 showed that Ohio's episodes of care covered more
11 than 1.5 million patients that year, or 51 percent of the state's Medicaid enrollees.³⁹ From 2013 to
12 2019, Ohio participated in CMMI's State Innovation Model (SIM) initiative, which helped
13 facilitate the design and launch of the state's episodes of care as well as its comprehensive primary
14 care program. Results from the first two years of Ohio's episodes of care program were generally
15 positive and showed reductions in average episode costs overall with no adverse effects on care
16 quality. For the nine episodes linked to incentives in 2017 (asthma exacerbation, chronic
17 obstructive pulmonary disease exacerbation, perinatal, cholecystectomy, upper respiratory
18 infection, gastrointestinal bleed, urinary tract infection, colonoscopy, and
19 esophagogastroduodenoscopy), average non-risk-adjusted spending decreased by 0.9 percent
20 annually, saving an estimated \$31.8-\$92.2 million.⁴⁰ That same year, providers received \$4 million
21 in positive incentives and were accountable for \$4 million in negative incentives.⁴¹ In its final SIM
22 report issued in 2019, the Ohio Department of Medicaid identified several factors that were key to
23 the successful design and implementation of its episodes of care, including ongoing provider
24 engagement, addressing provider challenges, streamlining reporting burdens, engaging private
25 insurers in the state, facilitating consistency across public and private health plans, and aligning
26 episodes of care with population health priorities. The episodes of care initiative further benefited
27 from strong leadership in the state, a dedicated innovation team, and alignment with federal
28 models. In 2019, Ohio's episodes of care model was approved as an advanced APM.⁴²

29
30 *Arkansas:* Support from the federal SIM initiative also helped Arkansas develop new payment
31 models and refine and expand episodes of care that were first implemented by the state's Medicaid
32 program in 2011.⁴³ By the end of the SIM initiative in 2016, Arkansas had produced 14 episodes of
33 care that were mandatory for Medicaid providers and voluntary for the state's two private payers.⁴⁴
34 Challenges early on ranged from a degree of provider hesitation and pushback to evidence that
35 coding had been used by some providers to avoid triggering certain episodes. The state reported
36 that average costs for attention-deficit/hyperactivity disorder and joint replacement episodes had
37 decreased significantly while the costs of other episodes, and episodes of care overall, remained
38 relatively constant.⁴⁵ One of the most prevalent models in Arkansas, for upper respiratory tract
39 infections (URIs), showed significant quality improvements after two years, including greater
40 reductions in antibiotic use and improvements in appropriate care for children, relative to a
41 comparison group. However, emergency department visits increased during that time span and
42 some physicians reported in focus groups using alternate coding to avoid triggering an episode.⁴⁶
43 Between 2011 and 2014, URI-related professional and outpatient spending increased while
44 spending on prescription drugs (antibiotics and others) did not change. Over the same time period,
45 the state's perinatal episode was found to decrease emergency department visits but increase
46 inpatient hospital utilization and, importantly, perinatal expenditures declined, and improvements
47 were made across most quality metrics.⁴⁷ A 2020 analysis of perinatal and URI episodes of care in
48 Arkansas concluded that: linking incentives to performance metrics may help improve quality of
49 care; episodes of care may successfully discourage the overuse of services; and unintended
50 consequences are possible, including episode avoidance through coding, a shift of services to
51 outside of the episode, and increased emergency department use.⁴⁸

1 A study of Arkansas' perinatal episode that included privately insured patients found that spending
2 decreased 3.8 percent when compared to nearby states, with savings due primarily to decreased
3 inpatient care prices.⁴⁹ Notably, although some states implementing episodes of care involve
4 commercial payers in their program design and implementation, fewer published analyses have
5 assessed the impact of bundled/episode-based payments among commercially insured patients or
6 across multiple payers. Accordingly, much less is known about the impact of commercial models
7 on spending and care quality. A 2022 meta-analysis looking at various value-based care models in
8 the commercial sector, including nine studies of bundled/episode-based payments, found mixed
9 results on spending and quality but cited significant savings incurred under UnitedHealthcare's
10 cancer bundle.⁵⁰ A recent study of the use of bundled payments for certain surgical procedures
11 among self-insured employers found considerable reductions in episode prices.⁵¹ As more research
12 becomes available and models are refined, increased alignment of bundled/episode-based payments
13 across Medicare, Medicaid, and private insurers may help expand successful models and align
14 quality reporting.

15

16 **AMA POLICY**

17

18 The AMA has an abundance of policies addressing persistent concerns with value-based payment
19 and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849). Under Policy D-385.963,
20 the AMA works with CMS and other payers on evolving payment reforms and ensuring sufficient
21 payments so that patients and families have access to care coordination supports that they need to
22 achieve optimal outcomes. Policy H-385.913 supports goals that should be pursued as part of an
23 APM, including that models be designed by physicians or with significant input from physicians,
24 provide flexibility to physicians to deliver the care their patients need, provide adequate and
25 predictable resources to support the services physician practices need to deliver to patients (and
26 include mechanisms for updating payment amounts), limit physician accountability to aspects of
27 spending and quality that they can reasonably influence, and avoid placing physician practices at
28 substantial financial risk. Policy H-385.913 also directs the AMA to continue to educate physicians
29 about APMs and provide educational resources and support. Policy H-385.908 urges CMS to limit
30 financial risk requirements to costs that physicians participating in an APM have the ability to
31 influence or control and directs the AMA to work with stakeholders to improve risk adjustment
32 systems, attribution methods, and performance target setting. Policy H-390.849 advocates for
33 physician payment reforms that: promote improved patient access to high-quality, cost-effective
34 care; are designed with input from physicians; ensure that physicians have an appropriate level of
35 authority over bonus or shared-savings distributions; and include ongoing evaluations to ensure the
36 reforms are improving patient care and increasing value.

37

38 Policy H-390.849 also opposes bundling of payments in ways that limit care or otherwise interfere
39 with a patient's ability to provide high quality care, while Policy H-385.913 supports the provision
40 of flexibility under APMs so that physicians can deliver the care patients need. Policy H-385.908
41 focuses on reducing barriers to APMs, including limiting financial risk requirements to costs that
42 physicians can control and working with stakeholders to improve attribution methods, risk
43 adjustment systems, and performance target setting. Under Policy H-70.949, the AMA will take
44 steps to ensure that public and private payers do not bundle services inappropriately; Policy
45 D-390.961 directs the AMA to work with appropriate officials to ensure that bundled payments, if
46 implemented, do not lead to hospital-controlled payments to physicians. Additional policy on
47 physician-focused payment reforms includes Policies D-390.953, H-390.844, H-450.931, and
48 H-450.961. Policy H-450.931 directs the AMA to help physician practices address concerns about
49 APMs and harmonize key components of APMs across multiple payers, including performance
50 measures.

1 Improving risk adjustment across payment models is addressed by Policies H-385.907 and
 2 H-285.957, and D-385.952, which also support linking quality measures and payments to outcomes
 3 specific to high-risk populations and reductions in health care disparities. Policy
 4 H-385.907 supports: 1) risk stratification systems that use fair and accurate payments based on
 5 patient characteristics, including socioeconomic factors; 2) risk adjustment systems that use fair
 6 and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and
 7 accurate payments for external price changes beyond the physician’s control; 3) risk adjustment
 8 systems that use risk corridors using fair and accurate payment if spending on all patients exceeds a
 9 pre-defined percentage above the payments; 4) accountability measures that exclude from risk
 10 adjustment methodologies any services that the physician does not deliver, order, or otherwise have
 11 the ability to influence; and 5) risk adjustment mechanisms that allow for flexibility to account for
 12 changes in science and practice. Policy H-165.837 advocates for protecting the patient-physician
 13 relationship in the context of bundled payments and affirms the obligation of physicians to
 14 prioritize patient care above financial interests.

15

16 AMA ADVOCACY

17

18 Many of the concerns about bundled/episode-based payment models have previously been
 19 addressed by AMA policy and advocacy on [payment reform](#) and [APMs](#). Key characteristics of
 20 value-based care, including that new models and incentives must be tailored to the distinct
 21 characteristics of different specialties and practice settings, were also incorporated into the
 22 [Medicare payment system principles](#) crafted by the AMA in collaboration with 120 other physician
 23 and health care organizations. The AMA has worked diligently over the years to improve MACRA
 24 and advance the transition to value-based care and now leads the charge to reform Medicare’s
 25 payment system to increase physician payment stability, reduce burnout, and improve the financial
 26 viability of physician practices. Although the Consolidated Appropriations Act of 2023 extended
 27 the five percent advanced APM incentive payment for 12 months, the AMA is advocating that it be
 28 extended for additional years.

29

30 The AMA continues to encourage and enable physician participation in physician-focused APMs,
 31 including bundled/episode-based payments. The AMA believes that well-designed, patient-
 32 centered APMs can provide significant opportunities to improve the quality and outcomes of
 33 patients’ care in ways that also lower growth in health care spending. However, the AMA
 34 maintains that physicians must be involved in the design of APMs to ensure that models
 35 successfully remove certain barriers and do not require physicians to be accountable for spending
 36 or outcomes they cannot control. The AMA continues to carefully examine APMs that are
 37 proposed by CMS and provide feedback to the agency regarding needed modifications, including
 38 when APMs impose unreasonable requirements on physicians or require them to take on excessive
 39 financial risk. Because the AMA believes that APMs are significantly improved when physicians
 40 are directly and actively involved in their design, the AMA continually advocates for consideration
 41 of physician input on models and approval of APMs that have been designed by physicians.

42

43 The AMA works closely with national medical specialty societies to review proposed APMs,
 44 recommend model improvements, and comment on regulations governing APMs. A more recent
 45 example is the AMA’s advocacy focused on Medicare’s proposed Radiation Oncology (RO)
 46 Model, a bundled payment for cancer patients receiving radiotherapy, which the AMA urged be
 47 delayed so that CMS could work with radiation oncology specialty societies to redesign some of
 48 the model’s key features.⁵² The RO Model that CMS had previously developed could have had
 49 serious unintended consequences for patients because practices would have been mandated to
 50 participate and take steep payment cuts. Accordingly, the AMA expressed general support for the
 51 creation of a bundled payment model for radiation oncology but advocated that several changes be

1 made to CMS’s proposal, namely that payments be stratified based on patients’ clinical
 2 characteristics, adjusted to account for the higher costs of delivering services in rural areas, and
 3 adjusted annually to reflect changes in evidence, technology, and inflation.⁵³ The AMA has further
 4 urged CMS to conduct a limited scale test of the RO Model on a voluntary basis rather than
 5 mandating participation in an untested model.

6
 7 In 2015, the AMA recommended numerous changes to the proposed CJR model and urged CMS to
 8 make participation voluntary and available to physicians in all localities. Among other
 9 modifications to its original design, the AMA recommended that payments be risk-adjusted based
 10 on patients’ functional status and other characteristics that affect the types of post-acute care they
 11 need so that physicians could assign patients to one of several acuity/risk levels and receive higher
 12 payments for higher-risk patients.⁵⁴ Additional advocacy on CJR and other episode-based payment
 13 models has repeatedly urged CMS to incorporate input from relevant national medical specialty
 14 societies in model design and revisions; listen to affected specialty societies that have experience
 15 with the different risks facing patients treated under the models; allow voluntary participation;
 16 begin episodes at the time of diagnoses of a condition instead of at hospital admission; and ensure
 17 that payment is adequate and predictable while limiting physicians’ accountability to costs within
 18 their control. More recent AMA advocacy with CMS on episode-based payment models in
 19 Medicare included support for bundled payments for office-based management of patients with
 20 substance use disorders and bundled payments for chronic pain management.

21
 22 To be successful, the AMA believes a physician-focused APM needs three key components:

- 23
 24 1. Flexibility for physicians to deliver the most appropriate services to meet patients’ needs;
- 25 2. Adequate payments to support the costs physicians incur in delivering high-quality care;
- 26 and
- 27 3. Accountability by physicians for delivering high-quality services and avoiding unnecessary
- 28 services, but without penalties for things that physicians cannot control.
- 29

30 The AMA has held educational seminars about APMs for physicians and organized several
 31 workshops in which physicians have shared their experiences in designing and implementing
 32 APMs. Physicians who want to learn more about episodes of care and other APMs are encouraged
 33 to read the following AMA resources: [Evaluating Medicaid Value-Based Care Models](#), [Evaluating](#)
 34 [Bundled or Episode-Based Contracts](#), and [Medicare Alternative Payment Models](#).

35
 36 DISCUSSION

37
 38 Although the concerns highlighted in referred Resolution 111-A-22 focused primarily on Medicaid
 39 episodes of care, the Council reviewed available research on both Medicaid and Medicare bundled
 40 payment models. Evidence in the literature suggests that certain Medicare bundles may contain
 41 overall costs more effectively than fee-for-service payment but, after accounting for provider
 42 bonuses, aside from joint replacement models, most have not produced net Medicare savings.
 43 Additionally, although studies have been mixed and vary across initiatives, most bundled payment
 44 models have neither significantly improved nor worsened quality of care.⁵⁵ The Council found that
 45 LEJR bundles, and some perinatal episodes of care, have produced the most—but still modest—
 46 savings. LEJR episode savings have been driven by reductions in institutional post-acute care (e.g.,
 47 SNFs and inpatient rehabilitation facilities) spending while hospital pricing contributed to
 48 reductions in perinatal episode spending. The Council was unable to locate published studies
 49 analyzing the impact of bundled/episode-based payment models on physician payment; however,
 50 we reviewed several studies looking at other possible unintended consequences of these models.
 51 For example, studies have found some evidence of risk selection across certain Medicare bundles,

1 although the evidence has been mixed, and no evidence of increased episode volume, which had
2 been an early concern among some stakeholders. A study of episodes of care in Arkansas revealed
3 other possible unintended consequences, including episode avoidance through coding, a shift of
4 some services outside of the bundles, and increased emergency department use.

5
6 Because the evidence is clear that the savings accrued under LEJR episodes has been due to
7 decreased spending on SNFs and inpatient rehabilitation facilities, some physicians have
8 questioned whether patient access to medically necessary care, including SNF services, could
9 potentially be limited. The Council believes that performance metrics measuring key patient-
10 centered outcomes, including functional improvements after orthopedic and other procedures, are
11 important and necessary checks on the risk that some models may underserve patients. Because the
12 AMA already has extensive policy on APMs, we recommend amending Policies H-390.849[2, 3]
13 and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific
14 to bundled/episode-based payments.

15
16 Although evidence across models is limited, high-risk patients have not been found to be adversely
17 impacted under the BPCI initiative; more research is needed on how historically marginalized
18 patients fare, in terms of outcomes, under a broader range of episodes. One study we reviewed
19 found that hospitals serving historically marginalized individuals performed well, and received
20 large bonuses, under BPCI Advanced; however, more studies are needed to ensure that
21 implementation of episode-based models is meaningfully supporting equity goals. The Council
22 previously addressed concerns about the impact of APMs on high-risk populations and points to
23 Policy D-385.952, which we recommend amending. To address other concerns and obstacles under
24 bundled/episode-based payment models, the Council recommends reaffirmation of Policy
25 H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which
26 outlines goals to be pursued as part of physician-focused APMs—including that models be
27 designed by physicians or with significant input from physicians, provide flexibility to physicians
28 to deliver the care patients need, provide adequate and predictable resources, and avoid placing
29 physician practices at substantial financial risk—and directs the AMA to continue to work with
30 national medical specialty societies and state medical associations to educate physicians on APMs.

31
32 As previously noted, one of the frustrations with episode-based payment models concerns the
33 definition of related or unrelated services. For example, since some LEJR models include most
34 Medicare Part A and Part B services, payment for seemingly unrelated procedures (e.g., eye, skin,
35 or sinus surgeries) completed within 90 days of a joint replacement may be paid for out of the
36 bundled payment. AMA policy addresses this concern by advocating that physician accountability
37 be limited to aspects of spending and quality that they can reasonably influence or control. Notably,
38 the services covered under joint replacement models can vary significantly across payers so that
39 services included in a state Medicaid model may differ from CJR's list of covered services.

40
41 Although the Council discussed the need for bundled payment models to clearly define the services
42 included and allow mechanisms for shifting unrelated services outside of the bundle, we believe
43 this is best addressed at the design stage, with meaningful physician involvement, as highlighted by
44 Policy H-385.913. The Council encourages physicians interested in participating in bundled
45 payment models to determine ahead of time which services and Current Procedural Terminology
46 codes are included and not included in an episode, and to review the AMA's [Evaluating Bundled or
47 Episode-Based Contracts](#) for more information. Finally, the Council believes well-designed,
48 patient-centered bundled payment models can improve care quality and patient outcomes in ways
49 that also lower growth in health care spending. Designing these models to work effectively for
50 patients, physicians, and payers remains challenging, and ongoing refinements to models may be
51 needed to ensure optimal patient outcomes as these initiatives continue to expand.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 111-A-22, and that the remainder of the report be filed:

5
6 1. That our American Medical Association (AMA) amend Policy H-390.849[2, 3] by addition
7 and deletion to read as follows:

8
9 2. Our AMA opposes bundling of payments in ways that limit medically necessary care,
10 including institutional post-acute care, or otherwise interfere with a physician's ability to
11 provide high quality care to patients.

12 3. Our AMA supports payment methodologies that redistribute Medicare payments among
13 providers based on outcomes (including functional improvements, if appropriate), quality
14 and risk-adjustment measures only if measures are scientifically valid, ~~verifiable, accurate,~~
15 ~~and based on current data~~ reliable, and consistent with national medical specialty society-
16 developed clinical guidelines/standards. (Modify HOD Policy)

17
18 2. That our AMA amend Policy D-385.952[1, 2] by addition and deletion to read as follows:

19
20 Our AMA: (1) supports alternative payment models (APMs) that link quality measures and
21 payments to outcomes specific to vulnerable and high-risk populations, ~~and~~ reductions in
22 health care disparities, and functional improvements, if appropriate; (2) will continue to
23 encourage the development and implementation of physician-focused APMs that provide
24 services to improve the health of vulnerable and high-risk populations and safeguard
25 patient access to medically necessary care, including institutional post-acute care. (Modify
26 HOD Policy)

27
28 3. That our AMA reaffirm Policy H-385.907, which supports risk stratification systems that
29 use fair and accurate payments based on patient characteristics, including socioeconomic
30 factors; risk adjustment systems that use fair and accurate outlier payments if spending on
31 a patient exceeds a pre-defined threshold, and fair and accurate payments for external price
32 changes beyond the physician's control; and accountability measures that exclude from
33 risk adjustment methodologies any services that the physician does not deliver, order, or
34 otherwise have the ability to influence. (Reaffirm HOD Policy)

35
36 4. That our AMA reaffirm Policy H-385.913, which outlines goals for physician-focused
37 APMs—including that models be designed by physicians or with significant input from
38 physicians, provide flexibility to physicians to deliver the care patients need, limit
39 physician accountability to aspects of spending and quality that they can reasonably
40 influence, and avoid placing physician practices at substantial financial risk—and directs
41 the AMA to continue working with national medical specialty societies and state medical
42 associations to educate physicians on APMs. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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APPENDIX

Policies Recommended for Reaffirmation and Amendment

Improving Risk Adjustment in Alternative Payment Models H-385.907

Our AMA supports: (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications; (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost; (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19; Reaffirmed: CMS Rep. 2, A-22)

Physician-Focused Alternative Payment Models H-385.913

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
 - A. Be designed by physicians or with significant input and involvement by physicians;
 - B. Provide flexibility to physicians to deliver the care their patients need;
 - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
 - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
 - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
 - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
 - G. Avoid placing physician practices at substantial financial risk;
 - H. Minimize administrative burdens on physician practices; and
 - I. Be feasible for physicians in every specialty and for practices of every size to participate in.
3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
 - A. Identify leading health conditions or procedures in a practice;
 - B. Identify barriers in the current payment system;
 - C. Identify potential solutions to reduce spending through improved care;
 - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
 - E. Define services to be covered under an APM;
 - F. Identify measures of the aspects of utilization and spending that physicians can control;
 - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
 - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
 - I. Identify mechanisms for ensuring adequacy of payment; and
 - J. Seek support from other physicians, physician groups, and patients.

4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
 - A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
 - B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
 - C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
 - D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
 - E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. ([CMS Rep. 09, A-16](#); [Reaffirmed: CMS Rep. 10, A-17](#); [Reaffirmed: CMS Rep. 10, A-19](#); Reaffirmed: BOT Rep. 13, I-20; [Reaffirmed: CMS Rep. 2, A-22](#))

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 and reductions in health care disparities; (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 (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (CMS Rep. 10, A-19)

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
 - a) promote improved patient access to high-quality, cost-effective care;
 - b) be designed with input from the physician community;
 - c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
 - d) not require budget neutrality within Medicare Part B;
 - e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
 - f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
 - g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
 - h) use adequate risk adjustment methodologies;
 - i) incorporate incentives large enough to merit additional investments by physicians;
 - j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
 - k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
 - l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and

m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. 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.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22)