

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports, 1–10, were presented by Robert E. Hertzka, MD, Chair:

1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2006 AMA HOUSE POLICIES

Reference committee hearing: see report of [Reference Committee A](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to re-establish it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.
- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.
- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.
- For each recommendation, the Council provides a succinct but cogent justification for the recommendation.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

RECOMMENDATION

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

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated.

Appendix - Recommended Actions on 2006 Socioeconomic Policies

Policy #	Policy Title	Recommended Action and Rationale
H-35.971	Diagnosis of Disease and Diagnostic Interpretation of Tests Constitutes Practice of Medicine to be Performed by or Under the Supervision of Licensed Physicians	Retain. Still relevant.
H-40.972	CHAMPUS Balance Billing Requirements	Rescind. Superseded by Policies H-40.969 and D-40.991.
H-70.918	Medicare Evaluation and Management Medical Decision Making Guidelines	Retain. Still relevant.
H-70.958	Modify Medicare ICD-9 “Fifth Digit Coding” Requirements	Retain-in-part with change in title to reflect the replacement of ICD-9 with ICD-10 has 7 characters and the format is different. Modify as follows: The AMA will: (1) request that CMS ensure that its

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		Medicare carriers fully understand and implement the distinction between coding to the “highest level of specificity” within a code category, and that coding for the condition(s) to the “highest degree of certainty” for that visit. For this purpose, symptoms, signs, abnormal test results or other reason for the visit are appropriate and acceptable diagnoses; and (2) will use all appropriate vehicles to communicate to physicians the correct method to report ICD-10-CM codes to describe diagnoses and other reasons for the physician-patient encounter; and for dealing with claim denials for 5th digit specificity.
H-70.960	Documentation Requirements for Physician Care Plan Oversight	Retain. Still relevant.
H-125.983	Changes in Drug Formularies and Copays	Rescind. Superseded by Policy H-125.979.
H-125.987	Prepaid Prescription Plans Medication Substitution	Rescind. Superseded by Policies H-125.991, H-125.984, and H-125.993.
H-155.970	Cost-Cutting Decisions by Third Party Payers	Retain. Still relevant.
H-160.937	The Promotion of Quality Telemedicine	Retain-in-part. Change “Essentials and Standards” to “Accreditation Criteria” in (4).
H-160.966	Market Forces on Medical Practice	Retain. Still relevant.
H-160.978	The Mentally Ill Homeless	Retain. Still relevant.
H-165.851	Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance	Retain-in-part. Modify by deleting (1) as it is superseded by Policies H-165.920, H-165.865, and H-165.855.
H-165.887	Development of Health Care Priorities	Retain. Still relevant.
H-180.968	Third Party Payer Credentialing	Retain. Still relevant.
H-185.971	Health Insurance Policy Information	Rescind. Superseded by H-320.968.
H-200.972	Primary Care Physicians in the Inner City	Retain. Still relevant.
H-200.998	Tax Credit to Disadvantaged Area Medical Practices	Retain. Still relevant.
H-215.965	Hospital Visitation Privileges for GLBT Patients	Retain. Despite HHS policy prohibiting discrimination and requiring hospitals to provide visitation rights to domestic partners without requiring documentation of those relationships, there continue to be cases where same-sex couples face discrimination in hospital visitation.
H-215.966	Evaluating Advertising	Retain. Still relevant.
H-215.975	Uniform Standards for Not-For-Profit and For-Profit Hospitals	Retain. Still relevant.
H-220.938	JCAHO Adherence to its Own Standards	Retain-in-part. Modify by combining with D-225.992, which is recommended for rescission, as follows: The AMA Board of Trustees directs its Commissioners to The Joint Commission the JCAHO to strongly advocate that the JCAHO The Joint Commission: (1) consistently enforce its standards regarding unilateral amendment of medical staff bylaws; (2) <u>continue to cite hospitals for unilateral amendment of medical staff bylaws, rules and regulations, and that hospitals found to have made unilateral changes to medical staff bylaws be cited for a serious (Type 1) violation of JCAHO standards</u> which may lead to loss of accreditation if the violation is not rectified within a specified timeframe; and (3) <u>cite hospitals for including provisions in their corporate bylaws that allow for the unilateral amendment of medical staff</u>

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		<u>bylaws, rules and regulations, when state statutes do not require the governing body of the hospital to have such authority.</u>
H-220.975	Medical Staff Comment on JCAHO “Field Review of Proposed Standards”	Retain with change in title to reflect new name of The Joint Commission as follows: Medical Staff Comment on TJC JCAHO “Field Review of Proposed Standards”
H-220.976	Bylaws Approval Time Limit	Retain-in-part to reflect the new name of The Joint Commission as follows: The AMA supports including a standard in the JCAHO <u>The Joint Commission Accreditation Manual for Hospitals</u> requiring that initial medical staff bylaws and subsequent amendments be approved or disapproved by the hospital governing body within a reasonable period of time specified in the medical staff bylaws and, if the governing body fails to act within the time specified, the proposed changes should be deemed adopted.
H-220.977	Chief Executive Officer at Medical Staff Executive Session <u>Committee</u>	Retain-in-part. Change title and modify as follows: The AMA reaffirms its support for amending JCAHO Medical Staff Standard 1.40 <u>The Joint Commission Medical Staff Standard MS.02.01.01, Element of Performance 2</u> , to read as follows: “That the Chief Executive Officer of the hospital or his or her designee may be invited to attend meetings of the Executive Committee of the medical staff.”
H-220.978	Hospital Medical Staff Representation on the Hospital Governing Body	Retain-in-part. Modify as follows: The AMA supports amending the governing body chapter of the JCAHO “Accreditation Manual for Hospitals” <u>The Joint Commission Leadership Standard LD.01.03.01</u> to provide for representation at all meetings of the governing body, with vote by one or more medical staff members nominated and elected by the medical staff, consistent with applicable state law.
H-225.965	Activities of the Joint Commission on Accreditation of Healthcare Organizations and a Single Signature to Document the Validity of the Contents of the Medical Record	Retain with change in title to reflect the new name of The Joint Commission: Activities of the Joint Commission on Accreditation of Healthcare Organizations <u>The Joint Commission</u> and a Single Signature to Document the Validity of the Contents of the Medical Record
H-225.984	Hospital Corporate Bylaws	Retain. Still relevant.
H-225.986	Physician Economic Incentive Program	Retain. Still relevant.
H-230.963	Limitations of Membership on Multiple Hospital Medical Staffs	Retain. Still relevant.
H-230.965	Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators	Retain. Still relevant.
H-230.984	Peer Review of Performance of Hospital Medical Staff Physicians	Retain. Still relevant.
H-230.997	Recertification and Hospital or Health Plan Network Privileges	Retain. Still relevant.
H-235.968	Physician Review of Medical Staff Activities	Retain. Still relevant.
H-235.985	Medical Executive Committee Composition	Retain. Still relevant.
H-260.964	Reimbursement for Clinical Lab Work	Retain. Still relevant.
H-260.998	Laboratory Services Contracted by a Physician	Retain. Still relevant.

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H-275.942	AMA Physician Profiles	Rescind. Superseded by Policies D-275.989 and D-275.994.
H-280.951	Quality of Care in Nursing Homes Nursing Staff Level	Retain-in-part. Clarify title. Modify policy to read as follows: H-280.951 Quality of Care <u>and Staffing</u> in Nursing Homes Nursing Staffing Level Our AMA will support the policy that staffing levels in nursing homes should appropriately address: (1) the acuity of the patient population; (2) the functional level of the patient and the services provided; (3) the existence of shortages for certain types of staff in some geographic locations and temporary shortages due to events such as employee illness or termination; and (4) the quality, education, and training of staff. (Sub. Res. 109, A-06)
H-280.953	Physician Visits Under Medicare Skilled Nursing Facility Prospective Payment System	Retain-in-part. Modify to reflect new name of The Joint Commission as follows: Our AMA will: (1) work with the CMS and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) <u>The Joint Commission (TJC)</u> to ensure that physician visits to nursing homes and skilled nursing facilities be based on the physician's determination of appropriate care for each patient; (2) work with CMS to ensure that its Medicare carriers implement these policies in a uniform way; and (3) advocate that physician assessments necessary to comply with both the prospective payment system (PPS) as well as JCAHO <u>TJC</u> requirements be recognized and reimbursed.
H-280.979	Adequate Physician Reimbursement for Long-Term Care	Retain. Still relevant.
H-285.941	Managed Care Consensus Bill	Retain. Still relevant.
H-285.950	Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services	Retain. Still relevant.
H-285.951	Financial Incentives Utilized in the Management of Medical Care	Retain. Still relevant.
H-285.957	Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts	Retain-in-part. Modify policy to read as follows: H-285.957 Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts The AMA will work with the American Academy of Pediatrics and other <u>interested</u> medical organizations in urging state Medicaid programs and other third party payers to assure the inclusion of risk adjustment mechanisms in capitation rates paid to physicians providing care to chronically ill children and adults enrolled in managed care plans. (Sub. Res. 128, A-96; Reaffirmed: CMS Rep. 8, A-06)
H-285.967	Distribution of Premiums Collected by Managed Care Companies	Retain. Still relevant.
H-285.971	Population Based Practices in Managed Care Systems	Retain. Still relevant.
H-285.983	Organized Medical Staffs in Medical Delivery Systems	Retain. Still relevant.
H-285.994	Managed Care	Rescind. Accomplished with AMA strategic focus

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		on physician satisfaction and practice sustainability, including RAND research on burdens associated with modern practice and the development of related AMA resources.
H-285.996	Due Process in the Managed Care Environment	Rescind. Accomplished with AMA model legislation for due process with respect to exchanges, third party payers, and health plans, as called for in Policy H-285.946.
H-285.997	Managed Care	Rescind. Superseded by more recent AMA Policies H-180.967, H-230.971, and H-285.991 on economic credentialing and selective contracting.
H-290.972	Health Savings Accounts in the Medicaid Program	<p>Retain-in-part. Health Opportunity Accounts no longer exist. Modify policy to read as follows:</p> <p>H-290.972 Health Savings Accounts in the Medicaid Program</p> <p>1. Our AMA encourages state medical associations to assist in the design, monitoring, and evaluation of state Health Opportunity Account (HOA) demonstrations. 2. It is the policy of our AMA that states offering Medicaid beneficiaries HOAs or similar coverage modeled after Health Savings Accounts (HSAs) should adhere to the following principles: (a) Make beneficiary participation voluntary; (b) Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible; (c) Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health; (d) Set deductibles at 100% of account contributions, but no higher; (e) Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits; (f) Allow the deductible limits for families to be the lower of either the individual or family combined deductible; (g) Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits; (h) Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages; (i) Encourage HOA <u>HSA</u> enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care; (j) Prohibit use of HOA <u>HSA</u> funds for non-medical purposes, but consider allowing HOA <u>HSA</u> balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage; (k) Monitor the impact on utilization and beneficiary financial burden; (l) Test broadening of eligibility to include currently ineligible beneficiary groups; and (m) Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to</p>

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		obtain payment from the insurer or account custodian. (CMS Rep. 1, I-06)
H-290.973	Medicaid Citizenship Documentation Interim Final Rule	Retain-in-part. CMS issued a rule with the opportunity for public comment to modify the policy (42 CFR 435.407) to be consistent with the AMA's position. Modify policy to read as follows: H-290.973 Medicaid Citizenship Documentation Interim Final Rule Our AMA strongly urges the Centers for Medicare and Medicaid Services to amend 42 CFR 435.407 (a) to specify <u>advocates</u> that the a state Medicaid agency's record of payment for the birth of an individual in a US hospital is satisfactory documentary evidence of both identity and citizenship. (Res. 702, I-06)
H-315.972	HIPAA Business Association Contracting, Domestic and Foreign, and Foreign Outsourcing	Retain. Still relevant.
H-315.979	Electronic Data Interchange Status Report	Retain. Still relevant.
H-320.953	Definitions of "Screening" and "Medical Necessity"	Retain. Still relevant.
H-320.954	Post-Partum Hospital Stay and Nurse Home Visits	Retain. Still relevant.
H-320.985	Economic Discharge Order for Utilization Review Committee Denial	Retain. Still relevant.
H-320.987	Second Opinions When Required by Carrier	Retain. Still relevant.
H-320.989	Third Party Utilization Review Programs	Retain. Still relevant.
H-320.990	Standardization of Mandatory Second Surgical Opinion Programs	Retain. Still relevant.
H-320.991	Hospital Preadmission Review/Certification	Retain. Still relevant.
H-330.899	Medicare Pharmaceutical Benefit	Retain. Although Medicare Part D, the Medicare prescription drug benefit, went into effect in 2006, this policy provides important guidelines for Part D.
H-330.934	Sharing Demographic Medicare Data with Other Public Entities by CMS	Retain. Still relevant.
H-330.937	Local Medical Policy of Medical Payers	Retain. Still relevant.
H-340.913	Peer Review by Actively Practicing Physicians	Retain. Still relevant.
H-345.980	Advocating for Reform in Payment of Mental Health and Addiction Services	Retain-in-part. Replace "addiction" with "substance use disorder." Modify policy to read as follows: H-345.980 Advocating for Reform in Payment of Mental Health and Addiction <u>Substance Use Disorder</u> Services Our AMA will <u>advocates</u> that funding levels for public sector mental health and addiction substance use disorder <u>substance use disorder</u> services not be decreased in the face of governmental budgetary pressures, especially because private sector payment systems are not in place to provide accessibility and affordability for mental health and addiction substance use disorder <u>substance use disorder</u> services to our citizens. (Res. 205, A-06)
H-360.986	Professional Nurse Staffing in Hospitals	Retain. Still relevant.
H-375.964	IOM Report on QIO Program	Retain. Still relevant.
H-385.924	Support for State Medical Association Economic Research, Development and Planning	Retain. Still relevant.
H-385.953	Medicare Coronary Artery Bypass and Cataract Surgery Demonstrations: Status Report	Rescind. Superseded by AMA Policy H-285.991 addressing contracting.
H-385.991	Balance Billing	Retain. Still relevant.
H-390.854	Freedom of Choice	Retain. Still relevant.

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H-390.866	DRGs for Physician Pay	Rescind. Outdated due to payment reform initiatives.
H-390.898	Equity in Medicare Payment Levels	Retain-in-part. Modify as follows: Our AMA: (1) adopts as a major legislative priority for 1994 the adequate funding of the Medicare program; and (2) supports the initiation of legislation to prevent any further reduction of the current Medicare limiting charges (140 percent for evaluation and management services, 125 percent for all other services).
H-390.977	Reimbursement for Diagnostic Studies Identified as Surgical Procedures	Retain. Still relevant.
H-400.953	Update on RBRVS	Rescind. Accomplished with RUC's annual submission to CMS of all components of the RBRVS.
H-400.991	Guidelines for the Resource-Based Relative Value Scale	Retain. Still relevant.
H-405.993	Median Physician Income	Retain. Still relevant.
H-406.995	Research Related to the Collection, Use and Release of Physician-Specific Health Care Data	Rescind. Superseded by AMA Policies H-406.996 and H-406.990 on the collection, use and release of physician-specific data.
H-406.999	Goal of Health Care Data Collection	Retain. Still relevant.
H-410.961	Adding a Disclaimer to Clinical Practice Guidelines	Retain. Still relevant.
H-410.970	Use of Practice Parameters	Retain. Still relevant.
H-410.997	Practice Parameters and Review Criteria	Retain. Still relevant.
H-450.943	Effects of Pay-for-Performance on Minority Health Disparities	Retain. Still relevant.
H-465.981	Enhancing Rural Physician Practices	Retain. Still relevant.
H-475.991	Postoperative Care – Responsibility and Reimbursement	Retain. Still relevant.
H-475.994	Mandated Outpatient Surgery	Rescind. Policies D-240.994 and H-285.954 support physician decision-making on choice of service sites.
H-475.996	Revision of AMA Surgical Screening Criteria	Retain. Still relevant.
H-475.997	Same-Day Admission for Elective Surgery	Retain. Still relevant.
D-60.980	Emergency Medical Services for Children (EMSC) Program	Retain-in-part. The AMA continues to support Emergency Medical Services for Children reauthorization legislation. Modify policy to read as follows: D-60.980 Emergency Medical Services for Children (EMSC) Program Our AMA will (1) reaffirm <u>recognizes</u> the importance of Emergency Medical Services for Children (EMSC); (2) advocates for full funding for the EMSC program in Congress; and (3) advocates for <u>continuous</u> passage of EMSC reauthorization legislation in Congress. (Res. 213, A-06)
D-70.957	Fixed Reimbursement to Physicians for Laboratory Services	Retain. Still relevant.
D-70.958	Blended Payments	Retain. Still relevant.
D-70.961	CMS New Definition of Consultation	Rescind. Directive accomplished. The AMA, together with other organizations, developed extensive recommendations for CMS' consultation policy. A letter for widespread sign-on was drafted and sent to CMS to propose changes to the prohibition of split-shared billing and the definition

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		of transfer of care as it pertains to consults and documentation.
D-70.964	Time Based Codes for Counseling and Education	Rescind. Directive accomplished.
D-70.979	Preservation of Five Levels of Evaluation and Management Services	Retain (1) and rescind (2) as the study has been completed. D-70.979 Preservation of Five Levels of Evaluation and Management Services Our AMA will (1) communicate to the Centers for Medicare and Medicaid Services (CMS) and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level; and (2) study the issue of five levels of E&M Coding for the purpose of maintaining a plurality of levels in order to preserve coding flexibility and appropriate payment. (Sub. Res. 804, I-01; Reaffirmation A-06; Reaffirmed in lieu of Res. 823, I-06)
D-125.993	Medicare Part D Guidelines	Retain. Still relevant.
D-155.995	Containing Catastrophic Care Costs	Retain. Still relevant.
D-165.951	Participation in Citizens' Health Care Working Group	Rescind. No longer relevant. On September 29, 2006, The Citizens' Health Care Working Group sent its final recommendations to Congress and the President. The AMA participated in the Health Care Coverage for the Uninsured working group, which also completed its work.
D-165.970	Medical Care for Patients with Low Incomes	Rescind. Superseded by Policies H-165.855 and D-165.966.
D-185.989	Expanding Health Insurance Coverage to the Uninsured: 2007 and Beyond	Rescind. Directive accomplished, with the presentation to the House of Delegates of CMS Report 2-I-07, "Health Insurance Coverage of High-Risk Patients," and CMS Report 5-I-07, "Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions."
D-190.980	Problems Encountered with WebMD and Other Clearinghouses	Rescind. Superseded by AMA Policies D-406.993, H-406.996, and H-406.990 on Medicare claims data release and policy on the use of physician-specific data.
D-200.989	Incentive Programs to Improve Access to Health Care Services in Underserved Areas	Rescind. Superseded by Policy D-200.980.
D-220.975	JCAHO Transparency	Retain-in-part. Modify as follows: JCAHO <u>TJC</u> Transparency 1. Our AMA Commissioners to <u>The Joint Commission (TJC)</u> the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will be asked to advocate for a truly open and transparent comment process for all proposed changes to JCAHO <u>TJC</u> standards. 2. It is AMA policy that: (a) all proposed changes to JCAHO <u>TJC</u> standards resulting from field reviews be published along with clearly stated rationale(s) for each proposed change; (b) all proposed changes to JCAHO <u>TJC</u> standards be published along with clearly stated identities of entity(ies) external to JCAHO <u>TJC</u> that suggested the proposed changes to JCAHO <u>TJC</u> ; (c) all proposed changes to JCAHO <u>TJC</u> standards that are modified by JCAHO <u>TJC</u> as a result of comments received must provide clearly stated rationale(s) for each modified proposal, to

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		include a clear and thorough analysis of the comment or comments upon which the modification(s) was based; and (d) all proposed changes to JCAHO TJC standards that are adopted as final by JCAHO TJC be published along with a clear and thorough analysis of all the field review. 3. Our AMA will ask that the new system for proposed changes to JCAHO standards be fully implemented during calendar year 2007.
D-220.976	The Relationship Between the Joint Commission on Accreditation of Healthcare Organizations and Physicians	Retain-in-part. Modify to reflect the new name of The Joint Commission as follows: The Relationship Between the Joint Commission on Accreditation of Healthcare Organizations and Physicians Our AMA will: (1) communicate to <u>The Joint Commission (TJC)</u> the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) the concern regarding the unintended consequences of TJC/JCAHO's standards, and methods of communicating those standards to physicians; (2) advocate with <u>TJC</u> JCAHO for direct communication to physicians' organizations about standards to be adopted or modified, with at least six months available for open commentary and feedback; (3) advocate that this communication be timely and that it occur in print media as well as through e-mail; (4) advocate that <u>TJC</u> JCAHO accreditation standards be made available to any licensed physician without hindrance; (5) advocate that <u>TJC</u> JCAHO establish a process for any physician to provide feedback about <u>TJC</u> JCAHO programs that affect that physician's practice; and (6) require that AMA <u>TJC</u> JCAHO Commissioners meet with the Organized Medical Staff Section Governing Council to review <u>TJC</u> JCAHO standards no less than twice per year.
D-220.977	Joint Commission on Accreditation of Healthcare Organizations - Evidence-Based Recommendations	Retain-in-part. Modify to reflect the new name for The Joint Commission as follows: <u>The Joint Commission on Accreditation of Healthcare Organizations - Evidence-Based Recommendations</u> Our AMA will: (1) work with the <u>The Joint Commission on Accreditation of Healthcare Organizations</u> to investigate the provision of a cost analysis for each new requirement; and (2) request that JCAHO TJC provide an evidence-based evaluation to justify the expenditures for the recommendations it makes.
D-220.978	JCAHO Establishment of a Certification Program for Services Provided in the Physician Office Setting Related to the Treatment of Chronic Kidney Disease	Rescind. Directive accomplished.
D-225.992	Unilateral Medical Staff Bylaw Amendments	Rescind. Combine with H-220.938 (<i>see above</i>).
D-230.988	Fiduciary Credentialing	Retain. Combine with D-285.970 as follows: Our AMA will: (1) continues to encourage physicians who have experienced what they believe to be inappropriate hospital de-credentialing to contact their state medical association and the

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		Litigation Center of the AMA and the State Medical Societies; and (2) explore the feasibility of participating in legal action designed to address arbitrary and abusive economic profiling of physicians.
D-240.998	Outpatient Prospective Payment System	Rescind. The AMA continues to work with CMS to ensure that payments for outpatient procedures are based on reliable data, as called for in Policy H-330.925.
D-275.970	Needle Electromyography	Retain. Still relevant.
D-285.970	Arbitrary and Abusive Economic Profiling	Combined with D-230.988 (<i>see above</i>).
D-285.974	Possible Anti-Competitive and Ethical Implications of Integrated Health System Referral Expectations	Retain. Still relevant.
D-290.984	State Plan Amendments for Medicaid and Medicaid Task Force	Retain-in-part. The Medicaid Task Force has been disbanded and model state legislation has been developed. Modify policy to read as follows: D-290.984 State Plan Amendments for Medicaid and Medicaid Task Force Our AMA will: (1) promote mechanisms that provide the opportunity for public comment and legislative oversight prior to submission of the State Plan Amendments (SPAs) to the Centers for Medicare and Medicaid Services, including the development of model state legislation, as appropriate ; and (2) serve as a repository of information relating to the outcomes of SPAs in different states, disseminate such information and educate physicians about the impact of proposed changes to Medicaid via SPAs. (Sub. Res. 701, I-06)
D-315.982	AMA's Prescribing Data Restriction Program Opt-Out Policy	Rescind. Directive accomplished.
D-315.983	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	Retain. Still relevant.
D-320.993	Insurance Coverage Appeals	Retain-in-part. Modify the beginning of the policy as follows: "Our AMA will: (1) continue to update and promote the AMA Campaign to Promote Independent External Review and AMA Campaign to Preserve Physicians' Role in Medical Necessity Determinations and support . . . " Various AMA activities have replaced these formal campaigns.
D-330.931	Adequate Formularies for Dual Eligible Patients Under Medicare Part D	Rescind. Directive accomplished. The members of the AMA Part D Workgroup continue to meet and discuss Part D issues as they arise.
D-330.934	Informed Consent and Interpretive Guidelines	Rescind. Directive accomplished. The AMA worked with other organizations, such as ACS, AAMC and AHA to draft a completely revised set of acceptable informed consent Guidelines to give to CMS to replace those currently in place. The AMA requested that CMS immediately withdraw those portions of the Interpretive Guidelines that are most burdensome and unworkable for physicians, such as naming practitioners performing the procedures or "important aspects of the

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		procedures,” as well as naming “significant tasks” that will be conducted by practitioners other than the lead physician/surgeon; and a signature of a professional witnessing the consent.
D-330.935	Promoting the Utilization of New and Old Medicare Preventive Services Benefits	Retain-in-part. Rescind (4). Medicare G codes have been replaced and the CPT codes are valued.
D-330.936	Precertification for FDA-Approved Prescription Medications	Rescind. Superseded by Policy D-330.933.
D-330.942	Coverage of Benzodiazepines and Substance Use Disorder Medications in the Medicare Part D Benefit	Rescind. No longer relevant, given the enactment of federal mental health parity legislation.
D-335.987	Erroneous Guidelines by Medicare Carriers and Waiver of Audit and Refund Penalties	Retain. Still relevant.
D-375.990	Legal Protections for Medical Peer Review	Rescind. Superseded by H-375.962 Legal Protections for Peer Review.
D-390.974	Modes of Participation in Medicare and Their Impact on the Patient, the Physician, and the US Congress	Retain. Still relevant.
D-390.977	Medicare’s Sustainable Growth Rate Formula and Pay-for-Performance	Rescind. Directive accomplished. Part B pool assessment no longer relevant post-SGR.
D-390.985	Medicare Balance Billing	Retain-in-part. Section (2) directive accomplished. Modify as follows: D-390.985 Medicare Balance Billing Our AMA will (4) work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate; and (2) evaluate the potential impact of the Medicare burden on its members in order to save health care for all Americans if the federal government denies the right to balance bill Medicare patients.
D-390.990	Medicare Physician Payment Schedule Formula	Rescind. Directive accomplished.
D-435.977	Closed Claims Database	Rescind. Directive accomplished. The AMA shared BOT Report 12-A-06 with national medical specialty societies and encouraged the development of closed claims databases where appropriate. The report was also shared and discussed with officials at the Agency for Healthcare Research and Quality.
D-440.955	Insurance Coverage for HPV Vaccine	Retain. Still relevant.
D-450.974	Ambulatory Care Quality Alliance	Rescind. Directive accomplished.

2. AFFORDABLE CARE ACT MEDICAID EXPANSION

Reference committee hearing: see report of [Reference Committee A](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies H-165.855, H-290.965, H-290.966 and D-290.976

At the 2015 Annual Meeting, the House of Delegates adopted Policy D-290.976 which states:

That our American Medical Association (AMA) use all available data to study the issues surrounding the expansion of Medicaid to tens of millions of low-income adults as specified by the Affordable Care Act (ACA) to evaluate to the best extent possible (a) the level of health care access available to those who are part of the Medicaid expansion population (b) the quality of health care services provided to those who are part of the Medicaid expansion population (c) the adequacy of provider payments for those services rendered to those in the Medicaid expansion population, and (d) the ramifications of the ACA’s Medicaid expansion to the health

care system as a whole, including but not limited to the possibilities of increased health care cost-shifting and increased emergency room use.

The Board of Trustees assigned the requested study to the Council on Medical Service for a report back to the House of Delegates at the 2016 Annual Meeting. This report provides background on the ACA Medicaid expansion; summarizes research on the impact of the Medicaid expansion on access to health care, quality of health care, adequacy of provider payments, and ramifications to the health care system as a whole; summarizes AMA policy and advocacy efforts; discusses avenues to address the impacts of Medicaid expansion; and provides policy recommendations.

For its study, the Council consulted with data analysts and policy experts from a range of perspectives. The Council notes that data on the Medicaid expansion is just now becoming available. Due to normal discrepancies in survey designs and research methods, the data are not yet conclusive on the impact of Medicaid expansion on access to care, quality of care, physician payment or the ramifications on the health care system. In addition, state Medicaid expansion designs are subject to change on an annual basis and according to the state's political climate. As such, this report includes examples of state Medicaid expansions that are current as of the writing of this report.

BACKGROUND

The US spent \$3 trillion on health care in 2014, of which 16.4 percent, or \$495.8 billion, was spent on Medicaid. The Medicaid expansion increased health care spending by 11 percent from 2013-2014, and its share of health care spending increased from 15.5 to 16.4 percent.¹ As of February 2016, the ACA has resulted in an estimated 20 million uninsured individuals obtaining health insurance. Approximately 14 million obtained health insurance through Medicaid and the Children's Health Insurance Program, and 12.7 million through the health insurance marketplace. The total number is greater than the net gain in health insurance (20 million) because of changes in health insurance status.² The Congressional Budget Office (CBO) estimates that Medicaid expansion will cost the federal government \$64 billion in 2016 and increase to \$134 billion by 2026. The CBO predicts that the program will cover 11 million beneficiaries in 2016 and about 15 million in 2026 as a result of the Medicaid expansion.³ Even with these coverage gains, approximately three million uninsured adults in non-expansion states fall into the "coverage gap" of earning too much to qualify for Medicaid in their states, but too little (i.e., less than 100 percent of the federal poverty level) to qualify for subsidies to purchase health insurance through the health insurance marketplace.^{4,5}

States have chosen to expand Medicaid in various ways, which has resulted in vastly different patient access experiences and physician participation rates. Following are two diverse examples.

Arkansas

Arkansas' Medicaid expansion program, the Arkansas Health Care Independence Program, is commonly known as the "private option." The state took an alternative approach to Medicaid expansion by using Medicaid funding to provide premium assistance to nondisabled beneficiaries to allow them to purchase private coverage through the health insurance marketplace. With Medicaid beneficiaries insured by private insurers, physicians are paid exchange rates, experience quick payment turn-around and minimal administrative hassles. Between 2013 and 2014, Arkansas' private option reduced the state's uninsured rate from 27.5 percent to 15.6 percent, increased the number of carriers offering marketplace plans, decreased uncompensated care costs by 55 percent and saved the state \$30.8 million.⁶ The most recent data available from 2013 reported that 89.8 percent of office-based physicians in Arkansas accepted new Medicaid patients.⁷ The majority of physicians reportedly still participate in the program.

California

California's Medicaid program, Medi-Cal, expanded through the Affordable Care Act's traditional Medicaid expansion program. The program's enrollment increased by about 4 million from 2014 through 2015, which was more than expected, primarily due to the expansion. In 2015, about 12 million California residents, or one-third of the state's population, received health care through Medi-Cal. The majority of Medi-Cal beneficiaries, approximately 10.3 million, are enrolled in managed care.⁸ In 2016, the state further expanded eligibility to undocumented children.⁹ While expanding Medicaid, the state began implementing payment reductions to Medi-Cal providers. The higher-than-expected enrollment in Medi-Cal along with decreasing provider payments has caused

immense access to care issues. The most recent data available from 2013 reported that only 54.2 percent of office-based physicians in California accepted new Medicaid patients.¹⁰ It is unclear how many physicians currently participate in the program. When the federal government's financing of the Medicaid expansion decreases from 100 percent to 95 percent in 2017, it is estimated that California's five percent share of the cost will be \$385 million every six months.¹¹

At the time this report was written, 31 states and the District of Columbia have expanded Medicaid under the ACA with most having done so through their existing Medicaid programs. Six states (AR, IA, IN, MI, MT and NH) have been awarded and are implementing a Section 1115 Demonstration, or "Medicaid waiver" from the US Department of Health and Human Services (HHS). Medicaid waivers give states flexibility to design, demonstrate and evaluate policy approaches such as expanding eligibility to individuals who are not otherwise Medicaid eligible; providing services not typically covered by Medicaid; or using innovative service delivery systems that improve care, increase efficiency, and reduce costs.¹² Many experts believe that states that decide to expand Medicaid in the future will do so through a Medicaid waiver.

ACCESS TO HEALTH CARE

Evidence on the impact of Medicaid expansion on access to care is mixed. Obtaining health insurance does not necessarily ensure better access to health care,¹³ although recent research has shown improved access in expansion states relative to non-expansion states. Adults with chronic conditions in two expansion states (Arkansas and Kentucky) experienced an 11.6 percent increase in receiving consistent care to manage their conditions compared to a non-expansion state (Texas). Furthermore, unmet health care needs due to costs declined 10.5 percent in the two expansion states.¹⁴ In Michigan, appointment availability increased six percent for new Medicaid patients compared to availability before the expansion and wait times remained stable, at one to two weeks.¹⁵ Additionally, the Government Accountability Office recently reported that some expansion states have increased behavioral health care treatment availability compared to non-expansion states.¹⁶

Despite some gains, ensuring access to health care remains an enduring challenge for Medicaid programs regardless of a state's decision to expand Medicaid. Two 2014 HHS Office of Inspector General (OIG) reports evaluated the adequacy of access to care for Medicaid managed care beneficiaries. One report found that approximately 50 percent of providers were either not participating in the health plan at the location listed by the health plan or not accepting new patients enrolled in the plan. In addition, wait times for routine appointments were on average two weeks for 50 percent of providers and as much as four weeks or more for 28 percent of providers.¹⁷ The other OIG report found that state standards for access to care varied widely, ranging from requiring one primary care provider for every 100 enrollees to one primary care provider for every 2,500 enrollees.¹⁸

To improve provider availability, OIG recommended that the Centers for Medicare & Medicaid Services (CMS) work with states to: (1) assess the number of providers offering appointments and improve the accuracy of plan information; (2) ensure that plans' networks adequately meet the needs of their Medicaid managed care enrollees; and (3) ensure that plans are complying with existing state standards and assess whether additional standards are needed.

To improve state standards for access to care, OIG recommended that CMS work with states to: (1) strengthen its oversight of state standards and ensure that states develop access standards for primary care providers and high-demand specialists; (2) strengthen its oversight of states' methods to assess plan compliance and ensure that states conduct direct tests (e.g., by calling physicians) of access standards; (3) improve states' efforts to identify violations of access standards; and (4) provide technical assistance and share effective practices.

CMS issued the final rule, "*Medicaid Program: Methods for Assuring Access to Covered Medicaid Services*," in November 2015 that addresses many issues identified by the OIG.¹⁹ The final rule mandates that states develop an access monitoring review plan by July 1, 2016, and update it annually. Of note, states must provide a comment period before submitting the plan to CMS. Every three years, states must conduct a separate analysis, by provider type and site of service, for each of the following core services: primary care, specialty, behavioral health care, pre- and post-natal obstetrics (including labor and delivery), and home health. States must include any additional services for which the state or CMS has received a significantly higher than usual volume of access complaints.

The final rule also mandates that states develop mechanisms for ongoing beneficiary and provider input via hotlines, surveys, ombudsmen, reviews of grievance and appeals data, or other equivalent mechanisms. States must promptly respond to public input with appropriate investigation and maintain a record of data on how the state responded. The record must be available to CMS upon request. When deficiencies in access to care are identified, the state has 90 days to submit a corrective action plan with specific steps and timelines to address those issues.

The final rule only requires access monitoring review plans for services provided by the state Medicaid fee-for-service model, not for Medicaid services provided by managed care organizations, which include about 70 percent of Medicaid patients, or through state waiver programs. In a January 2016 comment letter, as outlined in the advocacy section of this report, the AMA advocated for standardized access standards across all Medicaid delivery systems.

Primary Care Medical Homes/Patient Centered Medical Homes

The Council notes that states have been able to address access concerns, such as with the primary care medical home (PCMH) model either through or independent of an ACA Medicaid expansion program. The ACA created options for states to implement Medicaid health homes or Medicaid PCMHs. As of January 2015, 43 states and the District of Columbia had implemented some type of medical home program for their Medicaid beneficiaries.²⁰ While North Carolina is not a Medicaid expansion state, Community Care of North Carolina (CCNC) has been successful in using the PCMH model to provide access to quality care for 1.3 million of the state's Medicaid beneficiaries. The Oregon Health Plan, a Medicaid expansion program, provides health care for Medicaid beneficiaries through Coordinated Care Organizations (CCOs) delivering care through Patient-Centered Primary Care Homes (PCPCHs). Enrollment in Oregon's PCPCHs has increased more than 70 percent from 2013 to 2015 due to the state's Medicaid expansion.²¹

Specialty Care

A national comparison of typical payments for general surgeons found that there are wide variations in Medicaid payments between states for the same procedures.²² Inadequate payment and administrative burdens for physicians are key barriers to accessing specialty care for Medicaid beneficiaries. One study reviewed six innovative models that are successfully delivering appropriate and efficient specialty care to Medicaid beneficiaries. The strategies these models use are implementing telemedicine for specialty consultations, training primary care physicians to manage certain specialty needs and enhancing coordination among primary care providers and specialists through the use of "access coordinators." These models include collaboration between hospitals, primary care and specialty physicians, community health centers and Medicaid agencies.²³

QUALITY OF HEALTH CARE

Research conclusions on the quality and outcomes of primary and specialty care services for Medicaid expansion beneficiaries are mixed, highlighting the need for additional study.

For primary care services, one study found that 59 percent of primary care providers reported no change in their ability to provide high-quality care to their Medicaid patients a year after the expansion.²⁴ Kentucky's Medicaid expansion resulted in more than a 100 percent increase for breast and colon cancer screenings and physical exams, and an 88 percent increase for cervical cancer screenings.²⁵ Adults with diabetes in Ohio's MetroHealth Care Plus waiver program improved more than 13 percent on the diabetes composite standard than members of the uninsured comparison group.²⁶ A comparison of three expansion states to neighboring non-expansion states found that Medicaid expansion was significantly associated with a reduction in mortality.²⁷

From 2008 to 2009, the Oregon Health Insurance Experiment used random selection to offer a limited amount of uninsured low-income adults health insurance through Medicaid. The researchers concluded that Medicaid coverage increased emergency use by 40 percent, decreased rates of depression and improved feelings of financial security. The study did not find statistically significant improvements in measures of physical health outcomes, specifically blood pressure, cholesterol, or glycated hemoglobin levels. While the study was able to take advantage of random selection, the authors acknowledge limitations in the generalizability of the study's conclusions since it covered a short period of time, the sample size was small and the population covered was relatively homogenous (disproportionately white and urban-dwelling).^{28, 29, 30}

For specialty care, one evaluation of the quality of cancer care by source of health insurance has concluded that there are significant disparities in cancer survival and quality of care among individuals having different sources of health insurance, with some of the greatest deficiencies in care found among Medicaid beneficiaries.³¹ Another study found that Medicaid beneficiaries had a higher rate of mortality when undergoing major surgical operations.³² Researchers acknowledge that Medicaid beneficiaries tend to be diagnosed at a later stage and have worse overall survival rates compared to privately insured individuals.^{33, 34} Contributing to poorer outcomes may be a lack of access to high-volume centers for complex surgical procedures.³⁵ The literature recognizes the need for additional studies to determine factors that could account for poorer outcomes for Medicaid beneficiaries compared to privately insured individuals.

When analyzing the quality of care provided by Medicaid, factors such as the severity and length of illnesses, complexity of coexisting illnesses, stage at diagnoses, inconsistencies in obtaining health care, degree of access to high-quality care, level of health literacy, and availability of social supports should all be taken into consideration. The complexity of the Medicaid population requires extensive, longitudinal and risk-adjusted research to determine the program's impact on quality of care.

ADEQUACY OF PROVIDER PAYMENTS

Section 1902(a)(30)(A) of the Social Security Act, also known as the “equal access” provision of Medicaid, requires that states have procedures in place to ensure that provider payment rates are “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” It recognizes that “without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program.”

In the past, Medicaid providers have sued state Medicaid agencies to enforce the equal access requirement. However, in March 2015, the Supreme Court ruled in *Armstrong v. Exceptional Child Center Inc.*, that the Medicaid statute does not provide a private right of action for providers to enforce state compliance in federal court. The Court ruled that enforcement of the law falls to CMS.

In a January 2016 comment letter to CMS on the final rule, *Methods for Assuring Access to Covered Medicaid Services*,³⁶ as outlined in the Advocacy section of this report, the AMA emphasized that it is incumbent upon CMS to aggressively protect beneficiaries' access to care and ensure that physicians receive fair and adequate payment, especially given the *Armstrong v. Exceptional Child Center Inc.*, ruling. Specifically, the AMA advocated that CMS should provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can access necessary services in a timely manner. The AMA also advocated that CMS should create a mechanism for providers to challenge payment rates directly to CMS.

Increased physician payments

The ACA increased Medicaid primary care payment rates to be equal to Medicare rates for 2013 and 2014 to encourage more primary care physicians to participate in Medicaid and increase access to care. Even though the federally funded increase was temporary, it encouraged some states to continue paying at the higher rate. For 2016, 13 states have kept primary care rates at 100 percent of Medicare rates and 11 states have increased Medicaid rates to be closer to Medicare levels.

With respect to the Medicaid expansion, some states are experiencing decreases in expenses for state-funded health care services for low-income residents, which is resulting in budget savings available for other purposes. For example, Medicaid expansion in New Jersey has resulted in a 44.3 percent drop in uncompensated care costs since 2013, which saved the state \$453 million.³⁷ As a result of the savings, the 2016 New Jersey Governor's budget called for a redirection of a portion of the existing uncompensated care costs (\$15 million state share/\$45 million total) to physician payments in the state's Medicaid expansion program, NJ FamilyCare. A recent memo to New Jersey physicians explained that the redistribution of health care funding is intended to support a continuing effort by the Division of Medical Assistance and Health Services to encourage physician participation in the NJ FamilyCare program, expand beneficiaries' use of primary care services and reduce episodic non-emergent emergency department (ED) visits.³⁸ The increased payment rate went into effect on January 1, 2016.

RAMIFICATIONS TO THE HEALTH CARE SYSTEM

Many states report Medicaid enrollment has surpassed expectations. The uninsured rate has decreased 52.5 percent in expansion states and 30.6 percent in non-expansion states.³⁹ Expansion states are experiencing a greater increase in health care sector employment than non-expansion states.⁴⁰ Hospitals in expansion states report decreased uncompensated care costs and increased revenues,⁴¹ whereas rural hospitals in non-expansion states are becoming financially vulnerable since they are not benefiting from federal Medicaid funds to offset uncompensated care costs.⁴² Expansion states have experienced decreased expenses for state-funded health care services for low-income residents, such as behavioral health care services, hospitalizations for incarcerated individuals, and uncompensated care, and also experienced increased revenue from expansion funding.⁴³ States are increasingly enrolling their Medicaid populations in managed care to reduce financial risk, outsource administration, and allow for a more predictable state expense. Some health insurers are experiencing higher-than-expected revenues due to an increase in Medicaid enrollees.⁴⁴ There is limited empirical evidence of additional cost-shifting prior to or since Medicaid expansion.⁴⁵

Regarding ED use, research conclusions on the impact of the Medicaid expansion have been mixed. One Portland-area study concluded that ED use increased by about 40 percent from 2008-2009 for newly enrolled Medicaid beneficiaries,⁴⁶ while a state-wide study found that ED use decreased by about 23 percent from 2011-2015 for Medicaid beneficiaries enrolled in Oregon's Medicaid expansion program, attributed in part to the use of ED navigators.⁴⁷ An American College of Emergency Physicians (ACEP) member poll suggests that Medicaid expansion is associated with an increase in ED use,⁴⁸ although a National Center for Health Statistics survey did not find a significant change in the percentage of Medicaid beneficiaries using the ED or the frequency of their use between 2013 and 2014.⁴⁹

A Washington state-wide program, "ER is for Emergencies," was developed in 2012 by a coalition of stakeholders including ACEP's Washington Chapter, the Washington State Medical Association, the Washington State Hospital Association and the Washington State Health Care Authority. Medicaid ED use decreased by about 10 percent in the first year of the program resulting in a savings of approximately \$34 million. The program attributes its success to implementing the following best practices: using electronic health information; providing patient education; identifying frequent ED users and developing patient care plans; following statewide standards for prescribing opioids; monitoring prescriptions; and using feedback information.⁵⁰

PREVIOUS COUNCIL REPORTS

The Council addressed access to health care for patients with low incomes in Council Report 1-I-03, "Medical Care for Patients with Low Incomes" and Council Report 1-A-12, "Medicaid Financing Reform," which established and updated Policy H-165.855, respectively. The Council notes that some states with Medicaid waivers are experimenting with implementing components of Policy H-165.855, which include encouraging state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance; assuring continuity of care; using presumptive eligibility; allowing for retroactive coverage; offering a choice of coverage; and continuing to provide some non-medical benefits for at least a transitional period of time, such as non-emergency medical transportation.

In addition, the Council addressed Medicaid expansion alternatives in Council Report 5-I-14, "Medicaid Expansion Options and Alternatives," which established Policy H-290.966 encouraging the development of coverage options, including through state waivers, for adults in non-expansion states who do not qualify for either Medicaid or exchange subsidies. The policy also urged CMS to review Medicaid expansion waiver requests in a timely manner and to exercise broad authority in approving such waivers. The report also highlighted the variety of waivers that were being considered at that time.

AMA POLICY

In general, AMA policy supports a preference for using Medicaid funds to purchase private health insurance with income-adjusted premiums and minimal, if any, copays, rather than public sector expansion (Policies H-165.920, H-165.855 and H-290.982). AMA policy encourages the development of coverage options, notably through state waiver demonstrations, for low income adults living between their state's Medicaid income eligibility and 138% FPL (Policies H-290.966, H-165.855; D-165.966, H-290.987 and D-290.979) and advocates for coverage that

allows individual choice of health plans and benefits (Policies H-165.845, H-165.855, H-290.985, H-165.852, H-290.972 and H-290.984). The AMA supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions for use in subsidizing private health insurance coverage for the uninsured (Policy H-160.923).

AMA Policy H-165.855 supports continuous eligibility, presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person sought medical care. For enrollees subsidized through the exchange, the AMA advocates that plans be required to notify physicians of their patients' grace period status upon an eligibility verification (Policy H-185.938). The AMA supports improvements in Medicaid that will reduce administrative burdens (Policy D-290.979).

Long-standing AMA policy advocates that Medicaid should pay physicians at minimum 100 percent of Medicare rates (Policies H-385.921 and H-290.976) and supports reinstatement of Medicaid primary care payments that are equal to Medicare rates (Policy D-290.977). Key elements of an adequate network are outlined in Policy H-285.908 and health plans should educate enrollees on the continuum of available health care services and the appropriate use of the ED (Policies H-130.970 and H-290.985).

AMA ADVOCACY

The AMA continues to advocate for access to care and adequate physician payment in the Medicaid program.

Access to Medicaid Services

In July 2011 and January 2016, the AMA submitted comment letters⁵¹ on the proposed and final rule, *Methods for Assuring Access to Covered Medicaid Services*.⁵² The final rule requires states to submit to CMS an access monitoring review plan to document that provider payment rates are sufficient to enlist enough providers to serve the Medicaid population. The AMA advocated for the following:

- States should be required by CMS to use uniform data elements, such as cost studies as part of their access review plan.
- States should use consistent standards to measure access to care regardless of whether care is provided on a fee-for-service basis, through a managed care entity or by a waiver program.
- CMS should provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can access necessary services in a timely manner.
- CMS should create a mechanism for providers to challenge payment rates directly to CMS.
- CMS should develop a rule for assuring access to covered Medicaid services for Medicaid managed care plans as expeditiously as possible.

Medicaid Managed Care

In July 2015, the AMA submitted a comment letter⁵³ on the proposed rule, *Medicaid Managed Care*,⁵⁴ which advocated for the following:

- State regulators should be established as the primary enforcer of network adequacy requirements.
- Managed care entities should be required to publish their provider selection standards.
- Provider directories should provide comprehensive, accurate and up-to-date information; paper forms should be updated monthly and electronic versions within three days.
- CMS should require all states to impose a minimum medical loss ratio of 85 percent and require managed care plans to remit a portion of their capitation payment if they do not comply.
- Physician payment rates should be based on realistic costs of care and should be an essential element of the capitation rate-setting process.
- As part of their access review, CMS should require states to submit cost studies, physician payment rates, the number of physicians accepting new Medicaid patients, and an analysis of access in Medicaid compared to those in private group plans and Medicare, and to make the information publicly available.
- CMS should ensure standardization and harmonization of quality measures and methodologies across reporting programs to reduce administrative burdens and simplify compliance.

The final rule, *Medicaid Managed Care*, was released in April 2016, and requires states to create network adequacy standards for private Medicaid plans; applies a medical loss ratio standard of at least 85 percent to Medicaid managed care plans; and provides the opportunity to expand access to behavioral health care by easing restrictions on reimbursements at certain facilities for short-term stays. CMS will develop a quality rating system for private Medicaid and CHIP plans. In addition, CMS will prohibit states from making certain supplemental payments to hospitals and other providers that serve Medicaid managed care enrollees. Instead, states and Medicaid plans must transition to a payment structure linked to delivered services or quality of care.

DISCUSSION

The Council has reviewed a wide range of research on the impact of Medicaid expansion on access to care, quality of care, physician payment and the health care system as a whole. Throughout the course of its study, the Council experienced a constant influx of new and emerging research, and met with experts regarding Medicaid and the Medicaid expansion.

The Council remains concerned about the current and projected federal costs of Medicaid expansion, which the Congressional Budget Office has estimated at \$64 billion in 2016 and \$134 billion by 2026. Given the enormous monetary investment in Medicaid expansion, it is unclear if the resulting level of access to health care is due to characteristics of the previously uninsured patient population or the Medicaid program's delivery system. Research conclusions on the quality and outcomes of primary and specialty care services for Medicaid expansion beneficiaries are mixed, highlighting the need for additional study. Furthermore, since access to care and adequate physician payment are intrinsically linked, mechanisms to ensure adequate provider payment need to be developed. As such, the Council presents recommendations to improve the provision of health care services through Medicaid expansion programs.

Access to Care

Results of states that have expanded Medicaid vary widely, although compared to other states, Arkansas' expansion model has been successful in providing access to quality care, and adequate provider payment. It has also had a positive impact on the health care industry as a whole by reducing the uninsured rate, increasing choice of coverage through marketplace plans, and decreasing physician and hospital uncompensated care costs. It is highly consistent with AMA Policy H-165.855, which encourages state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance. The policy also encourages states to support a Medicaid Physician Advisory Committee to evaluate and monitor access to care in the state Medicaid program. Accordingly, the Council recommends that Policy H-165.855 be reaffirmed.

Despite the early stage of data collection, the Council is concerned about the level of access to quality care for patients in the Medicaid program, which coincides with low physician payment rates. To encourage states to take responsibility for providing access to quality care to their Medicaid populations, the Council recommends reaffirming Policy H-290.966, which advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on state Medicaid web sites.

CMS requires that states develop an access monitoring review plan by July 1, 2016, and update it annually. States must provide a comment period before the review plan goes into effect and develop mechanisms to receive ongoing provider input. The Council recommends that state medical associations participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.

An access monitoring review plan does not apply to Medicaid services provided by managed care organizations, which include about 70 percent of Medicaid patients, or through state waiver programs. It is only required for services provided by the state Medicaid fee-for-service model. The Council recommends that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.

The HHS OIG's reports evaluating the adequacy of access to care for Medicaid managed care beneficiaries concluded that the findings demonstrate a significant vulnerability in provider availability and raise serious questions about the ability of plans, states and CMS to ensure that access to care standards are met. The Council

concur with these concerns and recommends that the AMA support efforts to monitor CMS' progress on the OIG's recommendations to improve access to care for Medicaid beneficiaries.

Poor access to specialty care is a serious barrier for Medicaid patients. The Council recommends that CMS ensure that mechanisms are in place to provide robust access to specialty care for Medicaid beneficiaries.

Quality of Care

Comprehensive research is needed to determine the quality of care that Medicaid beneficiaries are receiving through Medicaid expansion programs. The Council recommends that independent researchers perform longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.

Physician Payment

Physician practices cannot remain economically viable if they lose money on the care they provide. The Council recommends that adequate physician payment should be an explicit objective of state Medicaid expansion programs.

Some states are reporting significant budget savings and increased revenue as a result of their Medicaid expansions. The Council believes that physician payment rates should be considered in any redistribution of funds in Medicaid expansion states experiencing budget savings in order to encourage physician participation and increase patient access to care.

Access to care and adequate physician payment are intrinsically linked. The Council recommends that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can access necessary services in a timely manner. In addition, CMS should develop a mechanism for physicians to challenge payment rates directly to CMS.

Medicaid Expansion Funding

For states that choose to expand Medicaid eligibility in the future under the ACA, the Council suggests extending to states the three years of 100 percent federal funding for Medicaid expansion programs that are implemented beyond 2016.

To address state concerns that the federal government will discontinue the 90 percent contribution for Medicaid expansions after 2020, the Council recommends supporting maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the ACA's Medicaid expansion exists.

Ramifications to the Health Care System

State Medicaid expansion programs are in different stages of development, implementation and assessment. As such, the ramifications these programs are having on the health care system are still becoming apparent. The Council recommends that the AMA support improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.

Regarding ED use, the Council recommends implementing evidenced-based best practices for reducing inappropriate ED use such as employing ED navigators; using electronic health information; providing patient education; identifying frequent ED users; developing care plans; monitoring prescriptions; and using feedback information.

Future AMA Activity

Finally, the Council recommends rescinding Policy D-290.976, which calls for the study that has been accomplished by the development of this report. The Council will continue to study the impact of the Medicaid expansion on access to quality care, the level of provider payment rates and the ramifications on the health care system, and report back to the House of Delegates as necessary.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-165.855, which encourages state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance, and encourages states to support a Medicaid Physician Advisory Committee to evaluate and monitor access to care in the state Medicaid program.
2. That our AMA reaffirm Policy H-290.966, which advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.
3. That our AMA encourage state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
4. That our AMA continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
5. That our AMA support efforts to monitor the progress of the Centers for Medicare & Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
6. That our AMA advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
7. That our AMA support independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
8. That our AMA support adequate physician payment as an explicit objective of state Medicaid expansion programs.
9. That our AMA support increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
10. That our AMA continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
11. That our AMA continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
12. That our AMA support extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
13. That our AMA support maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
14. That our AMA support improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
15. That our AMA support the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
16. That our AMA rescind Policy D-290.976, which requested this report.

REFERENCES

- 1 Centers for Medicare and Medicaid Services. National Health Expenditures. 2014. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>
- 2 Namrata Uberoi, Kenneth Finegold and Emily Gee. Health Insurance Coverage and the Affordable Care Act, 2010-2016. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation. Available at: <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>
- 3 Federal Subsidies for Health Insurance Coverage for People Under 65: 2016-2026. Congressional Budget Office. 2016. Available at: <https://www.cbo.gov/publication/51385>
- 4 Rachel Garfield and Anthony Damico. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update. The Kaiser Commission on Medicaid and the Uninsured. 2016. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8659-04-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid.pdf>
- 5 Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015. Health Reform Monitoring Survey. Urban Institute Health Policy Center. 2015. Available at: <http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.pdf>
- 6 Jocelyn Guyer, Naomi Shine, Manatt Health, MaryBeth Musumeci and Robin Rudowitz. A Look at the Private Option in Arkansas. Kaiser Family Foundation. 2015. Available at: <http://files.kff.org/attachment/issue-brief-a-look-at-the-private-option-in-arkansas>
- 7 Esther Hing, Sandra L. Decker and Eric Jamoom. Acceptance of New Patients with Public and Private Insurance by Office-based Physicians: United State, 2013. United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics Data Brief. 2015. Available at: <http://www.cdc.gov/nchs/data/databriefs/db195.pdf>
- 8 Medi-Cal Managed Care Enrollment Report – February 2016. Available at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptFeb2016.pdf
- 9 Scott Graves. Medi-Cal and the Governor’s Proposed 2015-16 Budget: Health Care Reform Boosts Enrollment and Federal Funding. California Budget and Policy Center. 2015. Available at: <http://calbudgetcenter.org/blog/californias-17-billion-medicaid-question-for-the-feds/>
- 10 Esther Hing, Sandra L. Decker and Eric Jamoom. Acceptance of New Patients with Public and Private Insurance by Office-based Physicians: United State, 2013. United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics Data Brief. 2015. Available at: <http://www.cdc.gov/nchs/data/databriefs/db195.pdf>
- 11 Max Taylor. The 2016-17 Analysis of the Medi-Cal Budget. Legislative Analyst’s Office. 2016. Available at: <http://www.lao.ca.gov/reports/2016/3350/medi-cal-budget-analysis-021116.pdf>
- 12 Status of State Action on the Medicaid Expansion Decision. The Henry J. Kaiser Family Foundation. 2016. Available at: <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>
- 13 Adele Shartzter, Sharon K. Long and Nathaniel Anderson. Access to Care and Affordability Have Improved Following Affordable Care Act Implementation; Problems Remain. Health Affairs. 2015. Available at: <http://content.healthaffairs.org/content/early/2015/12/14/hlthaff.2015.0755.abstract>
- 14 Benjamin D. Sommers, Robert J. Blendon and E. John Orav. Both the ‘Private Option’ and Traditional Medicaid Expansions Improved Access to Care For Low-Income Adults. Health Affairs. 2016. Available at: <http://content.healthaffairs.org/content/35/1/96.full.pdf>
- 15 Elyse N. Reamer et al., Primary Care Appointment Availability For New Medicaid Patients Increased After Medicaid Expansion in Michigan. Health Affairs. 2015. Available at: <http://content.healthaffairs.org/content/early/2015/07/15/hlthaff.2014.1425.full.pdf>
- 16 United States Government Accountability Office. Behavioral Health. Options for Low-Income Adults to Receive Treatment in Selected States. 2015. Available at: <http://www.gao.gov/assets/680/670893.pdf>
- 17 Access to Care: Provider Availability in Medicaid Managed Care. Department of Health and Human Services. Office of Inspector General. 2014. Available at: <http://oig.hhs.gov/oei/reports/oei-02-13-00670.pdf>
- 18 Department of Health and Human Services. Office of Inspector General. State Standards for Access to Care in Medicaid Managed Care. 2014. Available at: <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>
- 19 Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program. Fed. Reg. 80,211 (November 2, 2015) Final Rule.
- 20 National Academy for State Health Policy. State Delivery System and Payment Reform Map. Available at: <http://nashp.org/state-delivery-system-payment-reform-map/>
- 21 K. John McConnell. Oregon’s Medicaid Coordinated Care Organizations. Journal of the American Medical Association. 2016. Available at: <http://jama.jamanetwork.com/article.aspx?articleid=2490523>
- 22 Charles D. Mabry, Lori A. Gurien, Samuel D. Smith and Steven C. Mehl. Are Surgeons Being Paid Fairly by Medicaid? A National Comparison of Typical Payments for General Surgeons. Journal of the American College of Surgeons. 2015. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/26916127>

- 23 Laurie E. Felland, Amanda E. Lechner and Anna Sommers. Improving Access to Specialty Care for Medicaid Patients. The Commonwealth Fund. 2013. Available at: http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/jun/1691_felland_improving_access_specialty_care_medicaid_v2.pdf
- 24 The Kaiser Family Foundation and The Commonwealth Fund. Experiences and Attitudes of Primary Care Providers Under the First Year of ACA Coverage Expansion. 2015. Available at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/jun/1823_kaiser_commonwealth_primary_care_survey_ib.pdf
- 25 Families USA. Kentucky's Medicaid Expansion Yields Coverage and Access to Important Preventive Care. 2015. Available at: <http://familiesusa.org/blog/2015/08/kentuckys-medicaid-expansion-yields-coverage-and-access-important-preventive-care>
- 26 Randall D. Cebul, Thomas E. Love, Douglas Einstadter, Alice S. Petrusis and John R. Corlett. MetroHealth Care Plus: Effects of a Prepared Safety Net on Quality of Care in a Medicaid Expansion Population. Health Affairs. 2015. Available at: <http://content.healthaffairs.org/content/34/7/1121.full.pdf>
- 27 Benjamin D. Sommers, Katherine Baicker and Arnold M. Epstein. Mortality and Access to Care among Adults after State Medicaid Expansions. The New England Journal of Medicine. 2012. Available at: <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1202099>
- 28 Sarah L. Taubman, Heidi L. Allen, Bill J. Wright, Katherine Baicker and Amy N. Finkelstein. Medicaid Increases Emergency Department Use: Evidence from Oregon's Health Insurance Experiment. Science. 2014. Available at: <http://science.sciencemag.org/content/343/6168/263>
- 29 Mira Bernstein, Joseph P. Newhouse and Heidi L. Allen. The Oregon Health Insurance Experiment: Evidence from the First Year. Quarterly Journal of Economics. 2012. <http://www.nber.org/papers/w17190>
- 30 Katherine Baicker et al., The Oregon Experiment – Effects of Medicaid on Clinical Outcomes. The New England Journal of Medicine. 2013. Available at: <http://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321>
- 31 Arti Parikh-Patel, Cyllene R Morris, Robert Martinsen & Kenneth W. Kizer. Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance. University of California, Davis Institute for Population Health Improvement. 2015. Available at: <http://escholarship.org/uc/item/8xc078vj>
- 32 Damien J. LaOar, et al. Primary Payer Status Affects Mortality for Major Surgical Operations. Annals of Surgery. 2010. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3071622/pdf/nihms279555.pdf>
- 33 Plascak, J.J., Fisher, J.L. and Paskett, E.D. Primary care physician supply, insurance type and late-stage cancer diagnosis. American Journal of Preventive Medicine. 2015. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/25441233>
- 34 Alexander A. Parikh, Jamie Robinson, Victor M. Zaydfudim, David Penson and Martin A. Whiteside. The Effects of Health Insurance Status on the Treatment and Outcomes of Patients with Colorectal Cancer. Journal of Surgical Oncology. 2014. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/24810008>
- 35 Restricted Breast Cancer Surgery Facilities for Medicaid Recipients. New York State Department of Health. Available at: https://www.health.ny.gov/health_care/medicaid/quality/surgery/cancer/breast/
- 36 Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program. Fed. Reg. 80,211 (November 2, 2015) Final Rule.
- 37 New Jersey Department of Public Health. Calendar Year 2014. Report of Documented Charity Care. Office of Health Care Financing. 2015. Available at: http://www.state.nj.us/health/charitycare/documents/cc_report2014.pdf
- 38 NJ Memo to physicians. Available at: <https://www.njmmis.com/downloadDocuments/25-15.pdf>
- 39 Urban Institute. Health Reform Monitoring Survey. 2015. Available at: <http://hrms.urban.org/briefs/Gains-in-Health-Insurance-Coverage-under-the-ACA-as-of-March-2015.html>
- 40 Fitch Ratings. Health Care Jobs Grew Faster in Medicaid Expansion States. 2015. Available at: https://www.fitchratings.com/gws/en/fitchwire/fitchwirearticle/Healthcare-Jobs-Grew?pr_id=980053&cm_sp=homepage--FitchWire--Fitch:%20Healthcare%20Jobs%20Grew?20Faster%20in%20ACA%20Expansion%20States
- 41 The Health System Haves and Have Nots of ACA Expansion. Pricewaterhouse Coopers. 2014. Available at: <https://www.pwc.com/us/en/health-industries/health-research-institute/assets/pwc-hri-medicaid-report-final.pdf>
- 42 Kristin L. Reiter, Marissa Noles and George H. Pink. Uncompensated Care Burden May Mean Financial Vulnerability For Rural Hospitals In States That Did Not Expand Medicaid. Health Affairs. 2015. Available at: <http://content.healthaffairs.org/content/34/10/1721.full.pdf>
- 43 Deborah Bachrach, Patricia Boozang, and Dori Glanz. States Expanding Medicaid See Significant Budget Savings and Revenue Gains. State Health Reform Assistance Network. 2015. Available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf419097
- 44 Emily Berry. Mining for Medicaid Gold: Health Plans' Latest Profit Strategy. 2010. <http://www.amednews.com/article/20101206/business/312069965/4/>
- 45 Austin B. Frakt. How Much Do Hospitals Cost Shift? A Review of the Evidence. The Milbank Quarterly. 2011. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/>
- 46 Sarah L. Taubman, Heidi L. Allen, Bill J. Wright, Katherine Baicker and Amy N. Finkelstein. Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment. Science. 2014. Available at: <http://www.sciencemag.org/content/343/6168/263.short>

- 47 Oregon Health Authority Office of Health Analytics. Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update. 2016. Available at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>
- 48 2015 ACEP Poll Affordable Care Act Research Results. American College of Emergency Physicians. Marketing General. 2015. Available at: <http://newsroom.acep.org/2015-05-04-ER-Visits-Continue-to-Rise-Since-Implementation-of-Affordable-Care-Act>
- 49 Renee M. Gindi, Lindsey I. Black and Robin Cohen. US Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics. Reason for Emergency Room Use Among US Adults Aged 18-64: National Health Interview Survey, 2013 and 2014. 2016. Available at: <http://www.cdc.gov/nchs/data/nhsr/nhsr090.pdf>
- 50 Stephen H. Anderson and Nathan Schlicher. Seven Best Practices to Reduce Emergency Department Misuse. American College of Emergency Physicians. 2014. Available at: <http://www.acepnow.com/article/7-best-practices-reduce-emergency-department-misuse/>
- 51 American Medical Association. Comment letters to the Centers for Medicare and Medicaid Services on the proposed and final rules, *Methods for Assuring Access to Covered Medicaid Services*. 2011 and 2016. Available at: <http://www.ama-assn.org/resources/doc/washington/x-pub/ama-letter-to-cms-medicare-access-rule-04jan2016.pdf>
- 52 Medicaid Program; Request for Information (RFI) – Data Metrics and Alternative Processes for Access to Care in the Medicaid Program. Fed. Reg. 80,211 (November 2, 2015) Final Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27696.pdf>
- 53 American Medical Association. Comment letter to the Centers for Medicare and Medicaid Services on the proposed rule, *Medicaid Managed Care*. 2015. Available at: <http://www.ama-assn.org/resources/doc/washington/x-pub/medicaid-chip-proposed-rule-letter-to-cms-27july2015.pdf>
- 54 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability. Fed. Reg. 80,104 (Monday, June 1, 2015) Proposed Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf>

3. PAID SICK LEAVE (RESOLUTION 202-A-15)

Reference committee hearing: see report of [Reference Committee A](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-420.979 and H-440.823

At the American Medical Association's (AMA) 2015 Annual Meeting, the House of Delegates referred Resolution 202-A-15, "Measuring the Effect of Paid Sick Leave on Health Care Outcomes," submitted by the Medical Student Section. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2016 Annual Meeting. Resolution 202-A-15 asked:

That our AMA recognize the positive impact of paid sick leave on health and support legislation that offers paid sick leave; and that our AMA work with appropriate entities to build on the current body of evidence by studying the health and economic impacts of newly enacted paid sick leave legislation.

This report discusses government efforts on paid sick leave policies, provides examples of the public health impact of paid sick leave on communities, outlines possible financing structures, discusses the employer and employee perspectives, and recommends policy to encourage the adoption of paid sick leave policies.

BACKGROUND

Lack of paid sick leave can have a health impact on individual workers and the public health. Approximately 40 percent of private-sector workers in the US do not have paid sick time, and the lack of paid sick leave is more pronounced among those employed in low-wage jobs. Highlighting the need for paid sick leave is the changing structure of the family.¹ Dual-earning households have increased significantly. Additionally, the fraction of children

living with a single parent has increased. Taken together, these societal shifts increasingly challenge workers to juggle both family and work.

The US is the only industrialized nation without a federal family-leave law that guarantees workers may receive pay while taking time to care for themselves and their families. Through the Family and Medical Leave Act, current federal law mandates that companies provide leave, but does not require that it be paid.

Workers lose pay and may risk workplace discipline or job loss when they take sick time. Low-income and minority families disproportionately bear the economic hardship and negative health impacts of not having access to paid sick leave.² Low wage workers are typically least able to afford an interruption of income.^{3,4} Access is particularly low among Hispanics, less educated workers, and low wage workers.⁵ For example, about 60 percent of non-Hispanic whites have access to paid sick days while only about 38 percent of Hispanics have this access.⁶ Level of educational attainment also plays a role in access to paid sick leave. About 54 percent of workers with some college have access while only about 22 percent of workers with no degree have access to paid sick leave.⁷ Further, 83 percent of workers making \$65,000 or more annually have access to paid sick leave while 28 percent of workers making up to \$20,000 annually have access.⁸ This lack of access exacerbates inequality between groups where there is not only a wage gap but also a benefits gap.⁹

It is important to note that not all paid leave is paid sick leave. Various employers choose to grant paid leave differently due to varying benefit designs. Paid sick leave provisions vary for private and public employees and generally there are few leave requirements for private employers. More than half of all companies offer employees paid time off at the employee's discretion instead of a set number of paid sick days in addition to any paid vacation time, a benefit design that may be particularly preferable for healthy workers. Employees with discretionary paid time off days may enjoy the flexibility versus having employers control their paid time off. The Council notes that paid personal time off would have the same benefits for balancing work and family as paid sick days.

GOVERNMENT EFFORTS

Currently, four states and 20 cities have paid-leave laws. In 2006, San Francisco became the first locality in the nation to guarantee workers access to earned paid sick leave, including time off to care for children, parents, grandparents, spouses, domestic partners, and siblings. Subsequently, in 2008, Washington, DC passed a paid sick leave standard requiring all employers to provide each employee with an amount of paid sick leave depending on the employer's size. And in 2011, Connecticut became the first state to pass statewide legislation mandating paid sick leave. Defining who is covered under the law and the rate at which sick leave is accrued varies by state and locality. For example, in Connecticut, hourly workers in certain occupations are covered if they work for a business with 50 or more employees, and employees accrue one hour of paid sick time for every 40 hours worked with a maximum accrual of 40 hours.¹⁰ Conversely, California chooses to cover all employees working in California for 30 or more days a year after commencement of employment. Employees in California accrue one hour of paid sick time for every 30 hours worked and can accrue a maximum of 48 hours.¹¹

Supporting paid sick leave is a major initiative pursued by the Obama Administration. In fall 2014, the Administration announced its support for the Healthy Families Act, which would allow millions of working Americans to earn up to seven days of paid sick leave each year.¹² Workers could use their acquired days for either themselves or to care for a sick family member.¹³ Identical bills have been introduced in both the House and Senate in 2015 and referred to committees.¹⁴ Also, in 2015, President Obama issued an executive order requiring federal contractors to offer their employees up to seven days of paid sick leave per year.¹⁵ The action will provide coverage for as many as 300,000 workers whose jobs do not currently provide paid sick leave and many others with limited time-off benefits.¹⁶ The order will take effect in 2017.¹⁷

PAID SICK LEAVE IMPACTS ON PUBLIC HEALTH

Lack of paid sick leave can have substantial adverse effects on public health, including the spread of infectious disease and obstacles to preventive care.¹⁸ Research on the impact of paid sick leave policies has demonstrated benefits to employers, workers, families, and communities.¹⁹ Paid sick leave creates safer work environments and reduced spread of contagion.^{20,21}

Children in low-income families are more likely to have health problems than children living in higher income families.²² Further, workers without paid sick days are more likely to work sick and are more likely to delay needed medical care, which can lead to prolonged illness and worsen otherwise minor health issues.²³

There is growing evidence supporting the positive public health impact of paid sick leave, stemming from a national health impact assessment.²⁴ The assessment found evidence that the policy would result in more workers taking needed leave from work to recover from illness, receive preventive care, and care for ill children.²⁵ These actions would reduce transmission of influenza in the community, foodborne disease in restaurants, and gastrointestinal infections in health care facilities.²⁶ Ultimately, the authors of the assessment concluded that the best available public health evidence demonstrates that paid sick leave would have significant and beneficial public health impacts.²⁷

Paid sick leave has been shown to aid children's health.²⁸ Studies show that children recover faster from illness when cared for by a parent.²⁹ The presence of a parent shortens a child's hospital stay by 31 percent.³⁰ When parents have access to paid sick days, they are able to take their children to well-child visits and to receive immunizations.³¹ A 2010 survey of San Francisco employees supports this assessment and found that parents with sick days were more than 20 percent less likely to send a child with a contagious disease to school, consequently reducing disease transmission and generating public health benefits for the community.³² Access to paid sick leave allows working parents to balance both their jobs and their children's health while ensuring the family's economic security. The Council notes that paid personal time off would have the same benefits of balancing work and family.

The 2009 H1N1 flu pandemic highlighted the need for paid sick days. The US Centers for Disease Control and Prevention (CDC) estimated that, during the 2009 H1N1 outbreak, about 7 million additional individuals were infected and 1,500 deaths occurred due to contagious employees who did not stay home from work to recover.^{33,34} Lack of a paid sick leave workplace policy was correlated with a higher incidence of influenza-like illness, and an estimated 5 million additional cases were attributed to the absence of workplace policies like paid sick leave.³⁵ Further, the CDC estimates that the annual flu season constitutes a \$10.4 billion loss to companies in direct costs for hospitalizations and outpatient visits.³⁶ Proponents of paid sick leave policies state that workplaces are healthier and more productive when workers who become sick are able to stay home without losing pay.

EMPLOYER CONSIDERATIONS

Employers and employer groups are concerned that the costs of providing paid sick leave would be significant and correspond with negative impacts on the economy including stifled job growth.³⁷ Some employers provide disability leave, typically through an insurance program that compensates employees for their time off; however, this is an employer benefit generally not offered to low income employees. Many parties agree with the goal of increasing the number of employers providing paid sick leave, but the debate lies in how employers provide this paid time off. Employers underscore the key distinction between policies that incentivize paid leave and those that mandate paid leave. Paid leave policies may burden and negatively impact employer operations, such as independent physician practices, and generally employers react more positively when they are incentivized to take specific action. Additionally, many employers provide paid leave through policies such as paid personal time off or flexible work schedules, which are policy flexibilities that may help ease the employer burden of providing leave.

FINANCING PAID SICK LEAVE

In three of the states mandating paid sick leave, programs are successfully funded by employee payroll contributions and provide benefits equivalent to 100 percent of a worker's base salary. Other localities with existing programs that provide infrastructure for paid sick leave generally fund these programs through employee payroll deductions and provide partial wage replacement.

The Obama Administration has not only supported paid sick leave policies but also advocated funding these policies. In calling on Congress to pass the Healthy Families Act, President Obama's fiscal year 2016 budget request included more than \$2.2 billion to create an incentive fund to help states pay for family leave programs and an additional \$35 million in grants for states that are building infrastructure to launch such programs.³⁸ The Department of Labor has already awarded \$500,000 to several states and DC to fund studies on the feasibility of implementing paid leave.³⁹

There is a growing body of evidence that paid sick leave has a limited effect on employers. The senior vice president for policy at the San Francisco Chamber of Commerce called the employer impact of San Francisco's paid sick leave ordinance "minimal."⁴⁰ Three years after the law's implementation, 70 percent of employers reported no impact on profitability, and two-thirds of the employers expressed support for the law.⁴¹ Similar support is evidenced in New York City, Connecticut, and Washington, DC where reports of administrative burden were minimal, and localities have reported decreased employee turnover and improved employee productivity and morale.⁴²

RELEVANT AMA POLICY

The general concept of mandatory paid sick leave is potentially inconsistent with current AMA Policy H-420.979, which supports voluntary employer policies that provide employees with reasonable job security and continued availability of health plan benefits in the event that leave by an employee becomes necessary due to documented medical conditions. This policy further states that such employer policies should provide for a reasonable period of either paid or unpaid medical leave to care for oneself, including maternity leave, care for a member of the employee's immediate family, or adoption or for foster care leading to an adoption. The Council notes that this policy concerns medical leave, which generally is considered an extended absence, as distinguished from sick days.

However, AMA policy is consistent with required paid sick leave for medical students, residents, and physicians. Policy H-405.960 directs the AMA to urge medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate or encourage the development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement. Additionally, policy supports resident and fellow family and medical leave including fringe benefits and a minimum of six weeks paid leave per year for residents and fellows for all purposes including family, vacation, and sick leave (Policies H-310.929, H-310.912, H-310.908).

DISCUSSION

The Council recognizes the myriad socioeconomic issues involved with paid sick leave. Lack of paid sick leave overwhelmingly affects those individuals least able to afford an interruption of income.⁴³ There are significant disparities in access to paid leave among workers with different educational attainment and between Hispanics and non-Hispanics.⁴⁴

Many families lack the benefits to meet the evolving needs of today's families. Flexible paid sick leave can be used to care for not only children but also parents. There are 44 million unpaid eldercare providers in the US who experience loss of wages and risk losing job-related benefits like health insurance.⁴⁵ Policies such as paid sick leave, paid time off, and flexible work schedules allow employees to take care of sick elderly parents such as taking them to doctor's appointments and making housing arrangements.⁴⁶

The Council recognizes the dual nature of paid sick leave as both a public health and an employer issue. The Council finds a growing body of evidence supporting the conclusion that lack of access to paid sick leave is a public health issue that can result in delayed screenings, diagnoses, and treatment. Concurrently, the Council expresses concerns regarding the appropriateness of endorsing a sick leave mandate on the nation's businesses. Access to paid sick leave is a widely shared goal. However, various stakeholders disagree on how best to provide employees access to sick leave, and various employers choose to provide such leave in varying ways through ad hoc policies like scheduling flexibility, location adjustments, or policies such as paid personal time off. Accordingly, the Council believes that any policy on this topic should be flexible and account for various employer policies that in effect provide access to paid sick leave.

The Council understands employer concerns that providing paid sick leave has the potential to harm the economic sustainability of businesses. While most localities with paid sick leave policies have demonstrated little to no negative impact on business operations and prosperity, the Council recognizes that providing paid leave may be unduly burdensome to some employers. In such instances, the Council supports employers providing unpaid time off to mitigate the financial burden of providing paid time off.

The Council recognizes that paid sick leave increasingly is garnering employer and legislative attention and understands that studies continue to be released on the effects of varying paid sick leave policies. As such, moving forward, the Council will continue to monitor evolving approaches for providing discretionary paid time off.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 202-A-15 and that the remainder of the report be filed:

1. That our American Medical Association reaffirm Policy H-420.979 supporting voluntary employer policies that provide employees with job security and continued availability of health plan benefits in the event leave becomes necessary due to medical conditions.
2. That our AMA recognize the public health benefits of paid sick leave and other discretionary paid time off.
3. That our AMA support employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member.
4. That our AMA support employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

REFERENCES

- 1 The Executive Office of the President, Council of Economic Advisers. (June 2014). The Economics of Paid and Unpaid Leave. Available at https://www.whitehouse.gov/sites/default/files/docs/leave_report_final.pdf.
- 2 Lisa Clemans-Cope, PhD, Cynthia D. Perry, PhD, Genevieve M. Kenney, PhD, Jennifer E. Pelletier, BA, Matthew S. Pantell, BA. The Urban Institute. Available at <http://pediatrics.aappublications.org/content/pediatrics/122/2/e480.full.pdf>.
- 3 *Id.*
- 4 Stephen Brobeck. Understanding the Emergency Savings Needs of Low- and Moderate-Income Households: a Survey-Based Analysis of Impacts, Causes, and Remedies. Consumer Federation of America. Available at http://consumerfed.org/wp-content/uploads/2010/08/Emergency_Savings_Survey_Analysis_Nov_2008.pdf.
- 5 The Executive Office of the President, *supra* note 1.
- 6 American Center for Progress. Latinos Least Likely to Have Paid Leave or Workplace Flexibility. Available at <https://www.americanprogress.org/issues/labor/report/2012/11/20/45394/latinos-least-likely-to-have-paid-leave-or-workplace-flexibility/>.
- 7 Clemans-Cope, *supra* note 2.
- 8 Institute for Women's Policy Research. Paid Sick Days Access in the US: Differences by Race/Ethnicity, Occupation, Earnings, and Work Schedule. Available at http://www.iwpr.org/publications/pubs/paid-sick-days-access-in-the-united-states-differences-by-race-ethnicity-occupation-earnings-and-work-schedule/at_download/file.
- 9 The Executive Office of the President, *supra* note 1.
- 10 Think NC First. Family Matters: How Paid Sick Leave Pays Off for Working Families. Available at <http://www.thinkncfirst.org/research/family-matters-how-paid-leave-pays-off-for-working-families>.
- 11 *Id.*
- 12 The Health Families Act. National Partnership for Women & Families. February 2015. Available at <http://www.nationalpartnership.org/research-library/work-family/psd/the-healthy-families-act-fact-sheet.pdf>.
- 13 *Id.*
- 14 S. 497 Healthy Families Act. Available at <https://www.congress.gov/bill/114th-congress/senate-bill/497/related-bills>.
- 15 The Executive Office of the President, Council of Economic Advisers. (September 2015). Establishing Paid Sick Leave for Federal Contractors. Available at <https://www.whitehouse.gov/the-press-office/2015/09/08/executive-order-establishing-paid-sick-leave-federal-contractors>.
- 16 The Executive Office of the President. Fact Sheet: Helping Middle-Class Families Get Ahead by Expanding Paid Sick Leave. (September 2015). Available at <https://www.whitehouse.gov/the-press-office/2015/09/07/fact-sheet-helping-middle-class-families-get-ahead-expanding-paid-sick>.
- 17 *Id.*
- 18 American Public Health Association. Support for Paid Sick Leave and Family Leave Policies. Available at <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/16/11/05/support-for-paid-sick-leave-and-family-leave-policies>.
- 19 Williams, Claudia, Susan Andrzejewski, and Jeffrey Hayes. 2013. Valuing Good Health in Newark: The Costs and Benefits of Earned Sick Time. IWPR Publication No. B324. Washington, DC: Institute for Women's Policy Research. Available at <http://www.iwpr.org/publications/pubs/valuing-good-health-in-newark-the-costs-and-benefits-of-earned-sick-time>.

- 20 Lovell, Vicky. 2003. No Time to Be Sick: Why Everyone Suffers When Workers Don't have Paid Sick Leave. IWPR Publication No. B242. Washington, DC: Institute for Women's Policy Research. Available at <http://www.iwpr.org/publications/pubs/no-time-to-be-sickwhy-everyone-suffers-when-workers-don2019t-have-paid-sick-leave>.
- 21 Goetzel, Ron Z., Stacey R. Long, Ronald J. Ozminkowski, Kevin Hawkins, Shaohung Wang, and Wendy Lynch. 2004. "Health, Absence, Disability, and Presenteeism Cost Estimates of Certain Physical and Mental Health Conditions Affecting U.S. Employers." *Journal of Occupational and Environmental Medicine* 46 (April): 398-412.
- 22 Clemans-Cope, *supra* note 2.
- 23 Miller, K., Williams, C. & Yi, Y. (2011). Paid Sick Days and Health: Cost Savings from Reduced Emergency Department Visits. Institute for Women's Policy Research Publication.
- 24 American Public Health Association, *supra* note 12.
- 25 Cook WK, Heller J, Bhatia R, Farhang L. A Health Impact Assessment of the Healthy Families Act of 2009. Available at: http://www.nationalpartnership.org/site/DocServer/WF_PSD_HFA_HealthImpactAssessment_HIA_090611.pdf?docID=5101.
- 26 *Id.*
- 27 *Id.*
- 28 Paid Sick Days Benefit Children's Health. National Partnership for Women & Families. Available at <http://www.nationalpartnership.org/research-library/work-family/psd/paid-sick-days-benefit-childrens-health.pdf>.
- 29 *Id.*
- 30 Heymann, J. (2001). *The Widening Gap: Why America's Working Families Are in Jeopardy—and What Can Be Done About It*. New York, NY: Basic Books.
- 31 *Id.*
- 32 Paid Sick Days Improve Our Public Health, National Partnership for Women & Families (2013). Available at <http://www.nationalpartnership.org/research-library/work-family/psd/paid-sick-days-improve-our-public-health.pdf>.
- 33 Drago R, Miller K. Sick at Work: Infected Employees in the Workplace during the H1N1 Epidemic. Available at <http://www.iwpr.org/publications/pubs/sick-at-work-infected-employees-in-the-workplace-during-the-h1n1-pandemic>.
- 34 US Centers for Disease Control and Prevention. Updated CDC estimates of 2009 H1N1 influenza cases, hospitalizations and deaths in the United States, April 2009–April 10, 2010. Available at www.cdc.gov/h1n1flu/estimates_2009_h1n1.htm.
- 35 Kumar S, Quinn SC, Kim KH, Daniel LH, Freimuth VS. The Impact of Workplace Policies and Other Social Factors on Self-Reported Influenza-Like Illness Incidence during the 2009 H1N1 Pandemic. *Am J Public Health*. 2012;102(1):134–140.
- 36 Centers for Disease Control and Prevention. Seasonal Flu Vaccine: A Toolkit for Businesses and Employers. Available at http://www.cdc.gov/flu/pdf/business/Toolkit_Seasonal_Flu_For_Businesses_and_Employers.pdf.
- 37 Family and Medical Insurance Leave Act of 2013 discussion draft. Available at <http://www.nationalpartnership.org/research-library/work-family/paid-leave/family-act-draft.pdf>.
- 38 US Department of Labor. DOL Factsheet: Paid Family and Medical Leave. Available at <http://www.dol.gov/wb/PaidLeave/PaidLeave.htm>.
- 39 *Id.*
- 40 Rachel L. Swarns. Despite Business Fears, Sick-Day Laws Like New York's Work Well Elsewhere. *New York Times*. Available at http://www.nytimes.com/2014/01/27/nyregion/despite-business-fears-sick-day-laws-like-new-yorks-work-well-elsewhere.html?_r=0.
- 41 Paid Sick Days: Low Cost, High Reward for Workers, Employers and Communities. National Partnership for Women & Families. Available at <http://www.nationalpartnership.org/research-library/work-family/psd/paid-sick-days-low-cost-high-reward.pdf>.
- 42 *Id.*
- 43 The Executive Office of the President, *supra* note 1.
- 44 *Id.*
- 45 Liz O'Donnell, The Crisis Facing America's Working Daughters. *The Atlantic*. Available at <http://www.theatlantic.com/business/archive/2016/02/working-daughters-eldercare/459249/>.
- 46 Lynn Feinberg, Rita Choula. Understanding the Impact of Family Caregiving on Work. AARP Public Policy Institute. Available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/lc/2012/understanding-impact-family-caregiving-work-AARP-ppi-ltc.pdf.

4. ACCESS TO SELF-ADMINISTERED MEDICATIONS

Reference committee hearing: see report of [Reference Committee A](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED**

See Policies H-120.934, H-120.943, H-120.952, H-120.931, D-120.942 and D-125.997

At the 2015 Annual Meeting, the House of Delegates adopted Policy D-120.942, directing the American Medical Association (AMA) to study the prevalence of medication dispensing and refill restrictions on ophthalmic and other “difficult to dose” medications and the effect they have on patient care when medically necessary refills are denied or delayed due to the arbitrary determination by non-physicians of what actually constitutes a one or three month supply of ophthalmic and other medications. The study directed in Policy D-120.942 was assigned to the Council on Medical Service for a report back at the House of Delegates 2016 Annual Meeting.

This report provides background on self-administered medications, reviews health insurance coverage of self-administered medications, summarizes AMA policy and advocacy efforts, discusses the appropriate avenues for addressing the denial of early refills for difficult to dose medications and presents policy recommendations.

SELF-ADMINISTERED MEDICATIONS

The majority of ophthalmic medications are delivered topically via eye drops, which can create difficulties when patients attempt to self-administer the correct dosage. Patients may lack the manual dexterity to administer their own eye drops, have medical conditions that make it hard to hold the bottle steady, have poor hand-eye coordination and/or suffer from poor eyesight.

An estimated 57 percent of patients regularly administer more than one drop at a time.¹ When waste occurs and prescriptions run out before the refill date, patients have experienced denials for early refills by health insurance companies. Patients who are concerned about running out of eye drops may take less than the prescribed daily dose to make the prescription last longer and/or experience a lapse in medication until their health insurance company allows the next refill. Without continuous access to prescription eye drops, patients with glaucoma and other degenerative or inflammatory eye diseases risk further degeneration or vision loss.

INSURANCE COVERAGE

Medicare Part D pharmacy benefit management (PBM) companies and commercial health insurance companies typically impose strict limits on the frequency of medication refills. The American Academy of Ophthalmology (AAO) has advocated for access to necessary medications for chronic glaucoma treatment. In 2009, working with other eye health organizations, the AAO began recommending that prescription eye drop refill policies should be more flexible. As a result, Medicare Part D drug plans now allow an override of the refill limits when patients request a refill of their eye drop prescription at 70 percent of the predicted days of use, e.g., at day 21 for a 30-day supply. In addition, physicians can request authorization for earlier refills.

Advocacy at the state level has also been effective. As of July 2015, 18 state ophthalmology societies, in partnership with the AAO, have been successful in working with their state legislators to pass legislation allowing patients with commercial drug plans to refill their eye drop medications prior to the prescription refill date.

RELEVANT AMA POLICY AND ADVOCACY

The AMA opposes PBM companies’ interference in the provision of medical care by physicians (Policies D-125.997 and H-125.986[4]). As expressed in Policy H-120.943, health plans should define a one month’s supply of medication as a minimum of 31 days and a three month’s supply as a minimum of 93 days so that patients have an adequate supply of their prescription medication. Prescription refills should provide the appropriate number of doses for the time period specified by a patient’s physician. Policy H-120.952 opposes limitations on the legitimate, clinically appropriate refill of patient prescriptions, such as restricting the refill date or imposing less than a 90-day supply of a prescription refill for chronic conditions.

The AMA is working with the National Association of Insurance Commissioners to revise its model bill on PBMs to encourage greater transparency of their activities and greater deference to physicians' clinical judgment in utilization management appeals and exceptions.

DISCUSSION

The request for the AMA to study the prevalence of medication dispensing and refill restrictions on ophthalmic medications does not appear necessary or within the AMA's purview. It is clear that advocacy efforts by the appropriate specialty societies have improved Medicare coverage policies and is improving state coverage policies in a manner supported by the intent of Resolution 504-A-15 (Policy D-120.942).

Another element of the requested study was to determine the effect on patient care when medically necessary refills are denied or delayed. The impact on patient care, such as risking further degeneration of a patient's illness and interfering in the patient-physician relationship, has been clearly enumerated and detailed by the AAO.

In response to the request to also study other "difficult to dose" medications, the Council recommends that the AMA support legislation that prohibits health insurance and PBM companies from denying early prescription refills for solutions, ointments, gels, creams, nasal sprays and other formulations that are difficult and/or imprecise to self-administer and therefore may be completely used prior to their refill date. One exception should be for controlled substances as there could be valid reasons to deny an early refill.

The Council believes that organizations with clinical expertise on the medical conditions that necessitate prescriptions for solutions, ointments, gels, creams, nasal sprays, and other formulations that are difficult and/or imprecise to self-administer should lead advocacy efforts to increase access to these medications. As the AAO is already addressing the concerns raised in Policy D-120.942, the Council recommends that the AMA support and encourage interested national medical specialty societies and other stakeholders to continue to advocate on the state level and work with health insurance and PBM companies to re-evaluate their refill policies on medications that are difficult and/or imprecise to self-administer to allow for early refills as needed.

The Council recommends reaffirming Policies D-125.997, H-120.952 and H-120.943, which oppose both the interference by PBM companies into the practice of medicine and restrictions on prescription refills, and support an adequate supply of prescription medications.

Finally, the Council recommends rescinding Policy D-120.942, which calls for the study that has been accomplished by the development of this report.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support legislation that prohibits health insurance and pharmacy benefit management (PBM) companies from denying early prescription refills for solutions, ointments, gels, creams, nasal sprays, and other formulations that are difficult and/or imprecise to self-administer.
2. That our AMA support and encourage interested national medical specialty societies and other stakeholders to continue to advocate on the state level and work with health insurance and PBM companies to re-evaluate their refill policies on medications that are difficult and/or imprecise to self-administer to allow for early refills as needed.
3. That our AMA reaffirm Policies D-125.997, H-120.952 and H-120.943, which oppose both the interference by PBM companies into the practice of medicine and restrictions on prescription refills, and support an adequate supply of prescription medications.
4. That our AMA rescind D-120.942, which requested this report.

REFERENCE

- 1 American Academy of Ophthalmology and American Glaucoma Society Joint Statement on Glaucoma Eye Drop Availability. 2014. Available at: <http://www.aao.org/clinical-statement/aao-ags-statement-on-glaucoma-eye-drop-availability>

5. VIRTUAL SUPERVISION OF “INCIDENT TO” SERVICES (RESOLUTION 713-A-15)

Reference committee hearing: see report of [Reference Committee G](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED**

See Policy H-330.880

At the 2015 Annual Meeting, the House of Delegates referred Resolution 713, “Include Telemedicine in the Definition of Direct Supervision,” which was sponsored by the New Mexico Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2016 Annual Meeting. Resolution 713-A-15 asked:

That our American Medical Association (AMA) request that the Centers for Medicare & Medicaid Services update its direct supervision requirements to change the definition of direct supervision to include supervision via real-time telemedicine-based visual and audio interaction, rendered in accordance with applicable federal and state laws and regulations.

This report outlines the requirements of the various levels of physician supervision, highlights developments in “incident to” billing requirements included in the 2016 Medicare Physician Payment Schedule final rule, summarizes relevant AMA policy, and presents policy recommendations.

LEVELS OF PHYSICIAN SUPERVISION

Physicians can provide varying levels of supervision of services and procedures furnished by non-physician practitioners and employees. “Personal supervision” has been defined by the Centers for Medicare & Medicaid Services (CMS) as requiring physicians to be in the room during the provision of the service or procedure. “General supervision” means that the physician does not need to be in the room during the provision of the service or procedure; however, the service or procedure must be performed under the physician’s overall direction and control.¹

Resolution 713-A-15 asked that our AMA request that CMS update its direct supervision requirements to include supervision via real-time telemedicine-based visual and audio interaction. After debate in the reference committee hearing and on the floor of the House of Delegates, it was clarified that the sponsor of Resolution 713-A-15 supported the amended language offered by the reference committee. As such, the sponsor of Resolution 713-A-15 supports revising the direct supervision requirement for physicians to bill “incident to” to include virtual supervision via real-time visual and audio interaction between the supervising physician and the non-physician providing patient care services, if rendered in accordance with other applicable federal and state laws and regulations.

For services and supplies that are provided in a physician’s office, a patient’s home or other institution excluding a hospital and skilled nursing facility, the Medicare Benefit Policy Manual states that, in order “to be covered incident to the services of a physician or other practitioner, services and supplies must be:

- An integral, although incidental, part of the physician’s professional service;
- Commonly rendered without charge or included in the physician’s bill;
- Of a type that are commonly furnished in physician’s offices or clinics; and
- Furnished by the physician or by auxiliary personnel under the physician’s direct supervision.”¹

While Council on Medical Service Report 8-A-16, also being considered at this meeting, more comprehensively examines the billing of “incident to” services, this report is specifically addressing the requirement by CMS that a

physician must provide direct supervision of “incident to” services. CMS has clarified that direct supervision does not mean that the treating physician or any physician in the physician’s group must be in the same room as the non-physician practitioner providing the service. Rather, a physician must be present in the larger office suite and immediately available to provide assistance and direction during the provision of “incident to” services. In addition, the physician billing “incident to” must have first seen the patient and initiated the course of treatment, and provided subsequent services at a rate that shows active participation in and management of the course of treatment. If services provided by non-physician practitioners do not meet the requirements of “incident to” billing, non-physician practitioners would bill under their own national provider identifier (NPI) number; the payment for most non-physician practitioners (except nurse-midwives and nurse anesthetists) is a percentage (65 to 85 percent) of the physician rate.

There are some differences in supervision requirements depending on the site of care. For those services and supplies that are provided incident to a physician’s service in a physician-directed clinic, several physicians may provide supervision for “incident to” services versus an individual attending physician. There are also some exceptions to the direct supervision requirement for a limited set of services provided to homebound patients in medically underserved areas, and when services provided to homebound patients comprise an integral part of the physician’s professional services to the patient, provided by personnel meeting relevant state requirements. In these exceptions, general physician supervision is required, which means “that the physician need not be physically present at the patient’s place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control.”

In determining whether direct supervision exists, CMS has stated that the availability of the supervising physician by telephone and the presence of the physician somewhere in the institution (beyond the larger office suite) does not meet the direct supervision standard.¹ Therefore, when physicians have offices in institutions including skilled nursing facilities, the “office must be confined to a separately identifiable part of the facility and cannot be construed to extend throughout the entire facility.”² Addressing the requirement for direct supervision that physicians must be immediately available to provide assistance and direction during the provision of “incident to” services, CMS included the following language in its Medicare Benefit Policy Manual addressing hospital services covered under Part B:

Immediate availability requires the immediate physical presence of the supervisory physician or non-physician practitioner. CMS has not specifically defined the word “immediate” in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician or non-physician practitioner is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician or non-physician practitioner may not be so physically distant on-campus from the location where hospital/CAH outpatient services are being furnished that he or she could not intervene right away. The hospital or supervisory practitioner must judge the supervisory practitioner’s relative location to ensure that he or she is immediately available. The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure or provide additional orders.³

THE 2016 MEDICARE PHYSICIAN PAYMENT SCHEDULE FINAL RULE

In the 2014 Medicare Physician Payment Schedule (MFS) final rule, CMS set explicit requirements that “incident to” services must be furnished consistent with applicable state law, including state licensure and other requirements for the “auxiliary personnel” providing the services. In the 2016 MFS, CMS modified existing language around its requirement that “the physician or other practitioner who bills for incident to services must also be the physician or other practitioner who directly supervises the auxiliary personnel who provide the incident to services.” The change removed a sentence explaining that the physician supervising the services did not need to be the physician who initiated the patient’s treatment and is overseeing their general care. The AMA and other physician groups argued that this change could be interpreted as prohibiting this practice which is common for certain types of services such as periodic drug injections or infusions where one physician is managing the overall plan of care but another may supervise the provision of individual services during the course of that care. Fortunately, CMS clarified in the MFS that the supervising physician (or practitioner) for a particular incident to service does not have to be the same person who is “treating the patient more broadly” and added clarifying regulatory language to that effect.

RELEVANT AMA POLICY

Policy H-360.988 supports the provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. While the policy stipulates that the supervision of physician assistants in most settings includes the personal presence or participation of the physician, the policy also recognizes that the physician assistant may function apart from the supervising physician in certain practice settings, if permitted by state law. The policy states that such remote function should be approved by the state medical licensing board on an individual basis, and that the approval for remote function should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.

Policy H-160.950, which outlines guidelines for integrated practice of physicians and nurse practitioners, states that physicians are responsible for the supervision of nurse practitioners and other advance practice nurses in all settings, and that at least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner. Policy H-160.947 states that physicians are responsible for the supervision of the physician assistants in all settings, and must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means. Policy H-35.992 states that reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel, and such personnel should be under the supervision of practicing physicians. Policy H-465.986 encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions to identify any modifications needed to allow the most effective use of mid-level practitioners in improving access to care, while assuring appropriate physician direction and supervision of such practitioners. Policy D-390.959 states that our AMA will work with key stakeholders to make general supervision, rather than direct supervision, the requirement for Medicare payment for most, but not all, outpatient therapeutic services.

DISCUSSION

The Council recognizes that payment resulting from "incident to" services can be an important revenue source for physician practices that choose to fulfill the conditions and administrative requirements to do so. That being said, allowing for services provided by non-physician practitioners and employees to be billed incident to a physician's professional services if a physician provides virtual supervision via real-time visual and audio interaction requires additional testing before full implementation. Allowing physicians to provide virtual supervision to meet the direct supervision standard in order to bill "incident to" could enable physicians to receive payment for supervision they already provide via a real-time visual and audio interaction. However, a chief premise of the direct supervision requirement in order to bill "incident to" is that a physician must be immediately available to provide assistance and direction during the provision of the services. In the case of virtual supervision, the capacity for physicians to provide said direction and assistance would be limited, since they would not be physically present.

While the Council is not in support of making the requirements for virtual supervision of "incident to" services more onerous than traditional direct supervision, additional safeguards must in place to ensure patient safety and quality of care in the provision of "incident to" services with virtual supervision, and prevent these services from undergoing serious scrutiny for fraud and abuse. As such, the Council is supportive of CMS initiating pilot programs in the Medicare program to enable virtual supervision of "incident to" services that require direct supervision. The physician billing "incident to" and providing virtual supervision of "incident to" services must otherwise fulfill all other requirements to bill "incident to." Before virtual supervision of "incident to" services can be permitted, the Council believes that physicians providing virtual supervision of "incident to" services should visit the sites in person where patients receive procedures from non-physician practitioners or employees. Also, patients receiving "incident to" services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit. During the course of the encounter, virtual supervision of "incident to" services must require the physician to be connected through real-time audio and video technology with the room in which the "incident to" service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service.

The Council recognizes that virtual supervision of “incident to” services and procedures may not be appropriate for all services and procedures. It is paramount that virtual supervision of “incident to” services follows evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes. The Council notes that national medical specialty societies may have a role in outlining what services and procedures could be safely and effectively overseen with virtual supervision. As such, national medical specialty societies should develop best practices and protocols for virtual supervision of “incident to” services, including specifying which services and procedures would not qualify for this practice.

One of the chief responsibilities of physicians billing “incident to” is to respond to an emergency if it occurs during the provision of “incident to” services, and to take over the provision of the service or procedure if necessary. As physicians virtually supervising “incident to” services would not be physically present to assist in that capacity, the Council believes that physicians providing virtual supervision of “incident to” services must establish protocols for emergency services if needed during the provision of said services. Finally, they must have an agreement with a physician at the site at which “incident to” services are provided, to ensure the provision of immediate assistance.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 713-A-15, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) supports pilot programs in the Medicare program to enable virtual supervision of “incident to” services that require direct supervision if they are developed with specialty society input and abide by the following principles:
 - a) The physician billing “incident to” must fulfill other requirements of direct supervision of “incident to” services, including first seeing the patient and initiating the course of treatment, and providing subsequent services at a rate that shows active participation in and management of the course of treatment.
 - b) The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services.
 - c) Non-physician practitioners and employees providing “incident to” services must follow existing requirements for the provision of “incident to” services, including abiding by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
 - d) The delivery of “incident to” services must be consistent with state scope of practice laws.
 - e) Virtual supervision of “incident to” services must require the supervising physician to be connected through real-time audio and video technology with the room in which the “incident to” service is provided, to ensure that the physician is immediately able to provide assistance and direction during the provision of the service.
 - f) Virtual supervision of “incident to” services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
 - g) Physicians providing virtual supervision of “incident to” services should visit the sites in person where patients receive procedures from non-physician practitioners or employees.
 - h) Physicians providing virtual supervision of “incident to” services must establish protocols for arranging for emergency services, including having an agreement with a physician at the site at which “incident to” services are provided, to ensure the provision of immediate assistance.
 - i) Patients receiving “incident to” services that are virtually supervised must have access to the certification, licensure and/or board certification qualifications of the health care practitioners who are providing and supervising the care in advance of their visit.
 - j) Patients receiving “incident to” services that are virtually supervised must have a choice of provider, as is required for all medical services.
2. That our AMA encourages national medical specialty societies to develop best practices and protocols for virtual supervision of “incident to” services, including specifying which services and procedures would not qualify for this practice.

REFERENCES

- 1 Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Health Services. Revised November 6, 2015. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.
- 2 Centers for Medicare and Medicaid Services. MLN Matters SE0441. "Incident to" Services. April 9, 2013. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>.
- 3 Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered Under Part B. Revised December 18, 2015. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf>.

**6. PHYSICIAN COMMUNICATION AND CARE COORDINATION
DURING PATIENT HOSPITALIZATIONS
(RESOLUTION 714-A-15)**

Reference committee hearing: see report of [Reference Committee G](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED**

See Policies H-225.946, H-225.949H-385.910 and D-160.945

At the American Medical Association's (AMA) 2015 Annual Meeting, the House of Delegates referred Resolution 714-A-15, which was sponsored by the Organized Medical Staff Section (OMSS). Resolution 714-A-15 asked:

That our AMA advocate that hospital admission processes should include: (1) a determination of whether the patient has an existing relationship with a primary care physician; and (2) prompt notification of the patient's primary care physician, where such a relationship is found to exist and where the patient does not object to such notification.

At the 2015 Interim Meeting, the House of Delegates adopted Policy H-225.946, which asks:

1. That our AMA and the Organized Medical Staff Section (OMSS) advocate that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; prompt notification of such actively treating physician(s) where such a relationship exists; notice to the patient that he/she may request admission and treatment by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges. 2. That our AMA and the OMSS advocate that a medical staff incorporate the above principles into medical staff bylaws, rules and regulations. 3. That our AMA request that the AMA Litigation Center be alert for opportunities to challenge and the Advocacy Resource Center study and address the trend of hospitals' use of their employed hospitalists to limit the rights of their non-employed medical staff to admit and treat patients.

The Board of Trustees assigned the third clause of Policy H-225.946 and referred Resolution 714-A-15 to the Council on Medical Service. This report provides background on physician communication and care coordination during patient hospitalizations, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

The goals of referred Resolution 714-A-15 and Policy H-225.946 are to preserve physician-patient relationships; improve communication and collaboration between hospital-based physicians and patients' other treating physicians during hospitalizations; and ensure that appropriately credentialed community physicians can admit and follow their hospitalized patients if they want to do so. Policy H-225.946 is intended to enhance care coordination as well as patient safety, quality, and satisfaction. Suboptimal communication between attending and treating physicians can lead to fragmented care, unnecessary testing and treatment, and potentially more costly hospitalizations or post-

discharge problems. Conversely, good communication among hospital-based and community physicians results in more seamless, high-value care.

Before the advent of hospitalists and growth in the hospital medicine specialty, primary care physicians (PCPs) typically admitted and followed their patients during hospital stays, or took turns covering a practice's hospitalized patients. A recent editorial in the *New England Journal of Medicine* (NEJM) calls the “near disappearance of PCPs from general medical inpatient care” one of the most significant changes in health care delivery in the past 25 years.¹ A number of factors have fueled this transformation, including higher levels of acuity in the acute care setting as well as pressures for efficiencies in both inpatient and outpatient care.² In addition, community physicians who determine that providing inpatient care is not cost-effective or that it interferes with their office-based practice have embraced this change. Referred Resolution 714-A-15 and Policy H-225.946 raise concerns regarding episodic lapses in communication between hospital-based physicians and patients' other treating physicians during patient hospitalizations.

Surveys and observational studies have found that a significant number of PCPs do not know about the hospitalization of their patients, and those patients whose PCPs are unaware of their admission are more likely to report post-discharge problems.^{3,4,5} Hospitalists have reported that community physicians do not always alert them about patients needing hospitalization, or provide limited medical histories on hospitalized patients.⁶ Lack of time, difficulty reaching providers in the other setting, lack of personal relationships among hospital and non-hospital providers, and a lack of routine communication between health systems have been identified as contributors to lapses in communication among hospitalists and PCPs.⁷ In addition, patients may be unable to identify a treating physician upon admission or incorrectly report a non-treating physician to the hospital team. These studies highlight variability in the extent of communication between inpatient and outpatient physicians and the need for two-way exchanges.

Testimony at I-15 described anecdotal instances of hospitals failing to notify non-hospital-based treating physicians that their patients were hospitalized, or preventing physicians from seeing their patients while hospitalized. To carry out the third clause of Policy H-225.946, the Council requested feedback from the Federation to better understand the prevalence of these practices. Nearly all respondents indicated that they had not heard complaints regarding hospitals preventing on-staff, credentialed physicians from seeing their hospitalized patients. Two physicians reported that hospitalists had preferentially notified physicians other than the patient's treating physician about a hospital admission, and that they had been prevented from participating in their patients' hospitalized care. Clinical privileges were not at issue, and these physicians became aware of their patients' hospitalizations only when they were contacted directly by patients or their families. It is important to note that these were isolated incidences specific to particular hospitals.

The Society of Hospital Medicine (SHM), which is the national medical specialty society representing hospitalists, supports as policy an open medical staff and the ability of all credentialed and qualified physicians to admit their patients. Hospitals generally recognize a patient's right to have a PCP promptly notified of his or her admission to the hospital, and a review of hospital policies found that patients are generally informed that their PCP is welcome to communicate with the hospitalist throughout their hospital stay.

Models Promoting Physician Communication and Payment for Interprofessional Consultations

Models designed to bridge the divide between inpatient and outpatient care have been described in the literature. A recent *JAMA Viewpoint* discusses two delivery models in which hospitalists lead team-based care provided to high-risk elderly patients in both inpatient and outpatient settings.⁸ Under the “comprehensive care” and “extensivist” models, a single physician—a hospitalist—is responsible for patients across inpatient and ambulatory sites of care.⁹

A model in which PCPs participate as consultants to hospitalist teams was described in a 2015 NEJM editorial.¹⁰ Barriers to this collaborative inpatient care model include the time burden placed on participating PCPs and payment policies that do not adequately compensate physicians for providing collaborative inpatient care. To this point, the American Academy of Family Physicians has asked Centers for Medicare & Medicaid Services (CMS) and seven of the large private health insurers to revise their payment and coverage policies to “recognize ambulatory primary care physicians as specialists for the purposes of consulting on their hospitalized patients and to allow for payment when a consultation is requested from the patient's PCP by a hospitalist or specialist attending physician.”¹¹ Similarly, the American College of Physicians has recommended that CMS pay for electronic consultations both between

hospitalists and PCPs and specialists and PCPs.¹² In 2014, the CPT Editorial Panel created four CPT codes to describe interprofessional telephone/internet consultative services (CPT Codes 99446-99449); however, Medicare does not currently provide separate payment for these codes. Our AMA strongly supports recognizing these services and establishing Medicare payments to physicians for consulting with each other on patient care. These payments would facilitate collaboration among patients' treating physicians—including PCPs, medical specialists, surgeons and other hospital-based physicians—on care and treatment planning for individual patients, including those who are hospitalized.¹³

Future HIT and Telehealth Solutions

In the future, advances in the fields of health information technology (HIT) and telemedicine will likely ameliorate some of the concerns that are the focus of Resolution 714-A-15 and Policy H-225.946. More widespread use of direct messaging capabilities, such as admit/discharge/transfer (ADT) messaging, will enable hospitals to alert community physicians when one of their patients is hospitalized. Health information exchanges (HIEs) provide the ability for electronic health records (EHRs) to “subscribe” to ADT messaging. However, many barriers remain, including HIE interface costs, EHR capabilities, and HIE networks that are unable to talk to each other. The AMA continues to advocate for interoperability cornerstones, including the need for patient matching, provider directories, more guidance on privacy and security and standardized clinical vocabularies that will make state-of-the-art ADT messaging a reality. Similarly, maturation in the field of telemedicine and ongoing expansion of who may furnish and receive payment for telehealth consults may make virtual hospital visits more standard.

AMA POLICY

The actions requested by Resolution 714-A-15 were largely accomplished by adoption of Policy H-225.946 at the 2015 Interim Meeting. Additional policy recognizes the importance of effective communication between hospitals and referring primary care physicians. Policy D-160.945 directs the AMA to advocate for timely and consistent inpatient and outpatient communications among hospital and hospital-based physicians and the patient's primary care referring physician, including the physician of record, admitting physician, and physician-to-physician, to decrease gaps that may occur in the coordination of care process and improve quality and patient safety. Policy D-160.945 also directs the AMA to explore new mechanisms to facilitate and incentivize communication and transmission of data for timely coordination of care between hospital-based physicians and PCPs.

In addition, the AMA has extensive policy on the voluntary use of hospitalists, including Policies H-225.960 and H-285.964. Policy H-225.960 states that the use of a hospitalist as the physician of record during a hospitalization must be voluntary, and the assignment of responsibility to the hospitalist must be based on the consent of the patient's personal physician and the patient. AMA policy also opposes any hospitalist model that disrupts the patient-physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants (Policy H-285.964). More broadly, the AMA supports free choice by patient and physician (Policy H-330.988).

Medical staffs are encouraged to develop medical staff membership categories for physicians who provide a low-volume or no volume of clinical services in the hospital under Policy H-225.949, which also encourages medical staffs to engage community physicians in hospital activities, including transitions of care initiatives and professional and collegial events.

AMA RESOURCES

The granting of hospital clinical privileges is generally enumerated in hospital medical staff bylaws. The AMA's [Physician's Guide to Medical Staff Organization Bylaws \(Physician's Guide\)](#), a reference manual for drafting or amending medical staff bylaws, includes sample bylaw language on clinical privileges, self-governance and other issues relevant to hospital-medical staff relationships. Free to AMA members, the Physician's Guide describes elements that should be included in any medical staff bylaws.

The AMA worked with the SHM, the American Hospital Association and The Joint Commission to develop Principles for Developing a Sustainable and Successful Hospitalist Program, which are appended to the [Physician's Guide](#). The Principles emphasize shared accountability for patients among hospitalists and community physicians, stating that “both parties must be diligent to assure that key information (medications, test results, follow up

requirements, etc.) is transmitted and acted upon in a clear and timely fashion. During the hospitalization, the hospitalist needs to communicate to the PCP if there are significant changes in the patient's condition; the PCP should be accessible if any new issues arise that may require further input or information."¹⁴

DISCUSSION

The Council concurs that communication and coordination among physicians during patient hospitalizations is essential to the provision of safe, high-quality, and personalized care. This is especially true at a time when a preponderance of hospital care is overseen by the more than 50,000 hospitalists currently practicing in the United States, and as community physicians increasingly choose not to care for their patients in the hospital setting. Accordingly, the Council recommends reaffirming Policy D-160.945, which addresses communication between hospitals and primary care referring physicians, and Policy H-225.949, which encourages engagement of community physicians by medical staffs around care transitions and other activities.

Community physicians who are aware of their patients' hospitalizations are better prepared to provide appropriate post-discharge follow-up. Accordingly, the Council supports universal notification of patient hospitalizations to the physician(s) identified by patients during the admissions process, and recommends modifying Policy H-225.946 to ensure that these notifications are made with appropriate patient consent. The Council further acknowledges that future advances in the fields of HIT and telemedicine, along with more widespread use of ADT, will better enable hospitals to alert community physicians when one of their patients is hospitalized.

The Council believes that hospital-based and community physicians share accountability for the timely exchange of patient information and that communication must be bi-directional. Accordingly, the Council recommends adding two principles to Policy H-225.946. First, the Council recommends that contact information between these physicians be exchanged for routine and urgent situations, so that hospitalists can reach ambulatory providers when needed and vice versa. Second, the Council recommends that, to the extent possible, a patient's PCP or specialty physician relay information back to the inpatient medical team about the patient's medical history, medications, recent testing or other pertinent clinical data. The Council recommends additional minor modifications to further refine Policy H-225.946.

The Council's work on alternative payment models reinforces the notion that the lack of payment for physician consultative services may be undermining communications because physicians are not paid to take the time to talk with each other about the care of hospitalized patients. The Council is aware of alternative delivery models proposed by a variety of national medical specialty societies that incorporate interprofessional consultative services that are not currently compensated under the Medicare program. The Council acknowledges that the AMA has been engaged in advocacy efforts to enable physicians to be paid for these services, and recommends that the AMA continue to advocate for third party payment for interprofessional consultative services related to the care of hospitalized patients.

As directed by Policy H-225.946[3], the Council solicited feedback from the Federation about whether non-employed medical staff are being limited from admitting and treating their hospitalized patients. It is widely agreed that physicians who have admission and treatment privileges at a hospital should be allowed to treat their hospitalized patients to the full extent of their privileges. The Council encourages physicians who believe they are being prevented from doing so to communicate with their patients, the hospital-based physician(s) and the medical staff in an attempt to resolve these cases reasonably. Physicians should also refer to the hospital's medical staff bylaws, which often codify their right to exercise clinical privileges and prohibit infringement of this right. County and state medical associations are additional resources, as is the AMA Litigation Center, which provides physicians with legal expertise and assistance. The Council consulted with the AMA Litigation Center in the development of this report. To date, the Litigation Center has not received any requests seeking to challenge a hospital allegedly limiting the rights of non-employed medical staff members to admit and treat their patients.

The AMA is developing guidance to help medical staffs enact the principles outlined in Policy H-225.946. The Council recommends rescinding the third clause of Policy H-225.946 as this report accomplishes the requested study.

Finally, the Council believes that communication among physicians at the point of discharge is equally critical to well-coordinated, high-value care, and will present a report to the House of Delegates on discharge communications at the 2016 Interim Meeting.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 714-A-15 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-160.945, which directs the AMA to advocate for timely and consistent communication between hospitals and primary care referring physicians, and to explore new mechanisms to facilitate and incentivize this communication.
2. That our AMA reaffirm Policy H-225.949, which encourages medical staffs to engage community physicians in medical staff and hospital activities around issues such as transitions of care.
3. That our AMA modify Policy H-225.946 by addition and deletion to read as follows:
 1. Our AMA ~~and the Organized Medical Staff Section (OMSS)~~ advocate that hospital admission processes should include: a determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician; ~~where the patient does not object,~~ prompt notification of such actively treating physician(s) of the patient's hospitalization and the reason for inpatient admission or observation status where such a relationship exists; to the extent possible, timely communication of the patient's medical history and relevant clinical information by the patient's primary care or specialty physician(s) to the hospital-based physician; notice to the patient that he/she may request admission and treatment by ~~such~~ actively treating physician(s) if the physician has the relevant clinical privileges at the hospital; honoring requests by patients to be treated by their physician(s) of choice; and allowing actively treating physicians to treat to the full extent of their hospital privileges.
 2. Our AMA ~~and the OMSS~~ advocate that a medical staff incorporate the above principles into medical staff bylaws, rules and regulations.
 3. ~~Our AMA will request that the AMA Litigation Center be alert for opportunities to challenge and the Advocacy Resource Center study and address the trend of hospitals' use of their employed hospitalists to limit the rights of their non-employed medical staff to admit and treat patients.~~
4. That our AMA continue to advocate that third party payers establish separate physician payments for interprofessional consultative services related to the care of hospitalized patients.

REFERENCES

- 1 Goroll AH and Hunt DP. Bridging the Hospitalist-Primary Care Divide through Collaborative Care. *New England Journal of Medicine*. January 22, 2015: 372;4. Available online at: <http://www.nejm.org/doi/full/10.1056/NEJMp1411416>.
- 2 Society for Hospital Medicine. Letter to AMA Council on Medical Service. February 11, 2016.
- 3 Lovell, Vicky. 2003. No Time to Be Sick: Why Everyone Suffers When Workers Don't have Paid Sick Leave. IWPR Publication No. B242. Washington, DC: Institute for Women's Policy Research. Available at <http://www.iwpr.org/publications/pubs/no-time-to-be-sickwhy-everyone-suffers-when-workers-don2019t-have-paid-sick-leave>.
- 4 Goetzel, Ron Z., Stacey R. Long, Ronald J. Ozminowski, Kevin Hawkins, Shaohung Wang, and Wendy Lynch. 2004. "Health, Absence, Disability, and Presenteeism Cost Estimates of Certain Physical and Mental Health Conditions Affecting U.S. Employers." *Journal of Occupational and Environmental Medicine* 46 (April): 398-412.
- 5 Lovell, Vicky. 2003. No Time to Be Sick: Why Everyone Suffers When Workers Don't have Paid Sick Leave. IWPR Publication No. B242. Washington, DC: Institute for Women's Policy Research. Available at <http://www.iwpr.org/publications/pubs/no-time-to-be-sickwhy-everyone-suffers-when-workers-don2019t-have-paid-sick-leave>.
- 6 Pham, HH et al. Hospitalists and Care Transitions: The Divorce of Inpatient and Outpatient Care. *Health Affairs*. Vol. 27, No. 5: 1315-1327. September/October 2008.
- 7 Jones CD et al. A Failure to Communicate" A Qualitative Exploration of Care Coordination Between Hospitalists and Primary Care Providers Around Hospitalizations. *Journal of General Internal Medicine*. 30(4): 417-24. 2014.
- 8 Powers BW et al. Delivery Models for High-Risk Older Patients: Back to the Future? *JAMA*. Volume 315, No. 1, January 5, 2016. Available online at: <http://jama.jamanetwork.com/article.aspx?articleid=2480493&resultClick=3>.

- 9 Ibid.
- 10 Goroll, AH and Hunt, DP. Bridging the Hospitalist-Primary Care Divide through Collaborative Care. *New England Journal of Medicine*. January 22, 2015: 372;4. Available online at: <http://www.nejm.org/doi/full/10.1056/NEJMp1411416>.
- 11 American Academy of Family Physicians. Letter to Andy Slavitt, Acting Administrator, Centers for Medicare & Medicaid Services. September 16, 2015.
- 12 American College of Physicians. Comment letter to the Honorable Orrin Hatch, Ron Wyden, Johnny Isakson and Mark Warner on the Senate Finance Committee's Bipartisan Chronic Care Working Group Policy Options document. January 26, 2016.
- 13 American Medical Association. Comment letter to the Centers for Medicare & Medicaid Services on Medicare Program Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016. September 8, 2015. Available online at: <https://download.ama-assn.org/resources/doc/washington/x-pub/physician-fee-schedule-letter-08sept2015.pdf>.
- 14 American Medical Association. Physician's Guide to Medical Staff Organization Bylaws, Sixth Edition. 2015.

7. PRIOR AUTHORIZATION SIMPLIFICATION AND STANDARDIZATION (RESOLUTIONS 705-A-15 AND 712-A-15)

Reference committee hearing: see report of [Reference Committee G](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

*See Policies H-130.970, H-160.906, H-285.998, H-320.944, H-320.961, H-320.968,
D-120.938, D-320.986, D-320.987, D-320.988 and D-330.909*

At the 2015 Annual Meeting, the House of Delegates referred Resolution 705, "Pre-Authorization Simplification and Standardization," sponsored by the Washington Delegation. Resolution 705-A-15 asked:

That our American Medical Association: (1) study and develop best practices recommendations for simplification and timeliness of preauthorization and admission notifications, and report back to the House at the 2015 Interim Meeting, with such recommendations to include timely and binding preauthorization procedures for expensive procedures when requested by a physician or a patient; (2) advocate that NCQA, URAC, and ERISA adopt these recommendations; and (3) study all options including the option for developing a single interactive, browser-based portal for pre-authorization or admission notification and report back to the House at the 2015 Interim Meeting.

At the same meeting, the House also referred Resolution 712, "Increasing Prior Authorization Requirements," submitted by the New Mexico Delegation. Resolution 712-A-15 asked:

(1) That our AMA study the burdens imposed upon physician practices and patients as a result of growing requirements by payers to obtain prior authorization for medications, other forms of treatment, diagnostic procedures and referrals, and include in its study possible solutions such as: (a) Alternative models of quality-based and shared-risk reimbursement that reduce or obviate the need for prior authorization; (b) Reimbursement of physicians for time and resources spent on compliance with prior authorization requirements, taking into consideration recent legal precedent; (c) Whether new CPT codes would need to be developed in order for physicians to bill for reimbursement for time and resources spent on compliance with prior authorization requirements; (d) Regulations or legislation that prohibit retroactive rescission of prior authorization or clawback of reimbursement after prior authorization has been given, provided that information for the prior authorization was not fraudulent; (e) Standardization of formulary formats, including new requirements that formularies be importable into ONC certified electronic health records; (f) Requirements that insurance company practices regarding medication substitution meet accepted standards developed by medical specialty societies for patient safety, efficacy and equivalence; and (g) Requirements that insurance companies not use lack of an FDA indication or designation of a medication as a "high risk" as justification for denial, overriding clinical judgment and accepted standards of care; and (2) That our AMA consider the inclusion of prior authorization requirements in the AMA's Professional Satisfaction and Practice Sustainability strategic focus; and (3) That our AMA consider the development of possible model state legislation that allows physicians to bill payers or benefit managers for the time and resources spent in compliance with prior authorization

requirements, and model state legislation that prohibits retroactive rescission of prior authorization or clawback of reimbursement after prior authorization has been given, provided that information for the prior authorization was not fraudulent.

The Council readily acknowledges the significant problems associated with prior authorization (PA) for both patients and physician practices and agrees with the underlying intent of these resolutions. However, extensive existing American Medical Association (AMA) policy on PA and ongoing AMA advocacy activities already address several of the issues raised by the resolutions. The Council also notes that a few of the recommended actions could have unintended and/or undesirable consequences. Accordingly, this report summarizes existing AMA PA policy related to these resolutions, outlines relevant AMA advocacy activities, and identifies concerns with a few of the recommended activities. This review and analysis allow the Council to provide recommendations that build upon, rather than duplicate, existing or ongoing AMA policies and efforts and avoid inadvertent, unfavorable outcomes.

BACKGROUND

PA requires providers to obtain advance approval from a health plan before service delivery to qualify for payment coverage. PA is often a very manual, time-consuming process that can divert valuable and scarce resources away from direct patient care. The medical literature clearly establishes the time and cost burdens associated with PA on physician practices, although results vary depending on study methodology. An often-cited study by Casalino and colleagues found that physicians spend an average of one hour a week completing PA requirements, while nursing and clerical staff average 13.1 and 6.3 hours per week on PA tasks, respectively.¹ Another study by Morley and colleagues estimated that practices spend \$2,161 to \$3,430 annually per full-time equivalent physician completing PA requirements.² Overall, practices spend nearly \$83,000 annually per physician on interactions with health plans.³ Even more concerning is the negative impact that PA can have on patient care, given the treatment delays associated with health plans' PA requirements. A 2010 AMA survey of 2,400 physicians showed that two-thirds of physicians reported waiting several days to receive PA for drugs, while 10 percent waited more than a week.

Given the negative impact of payers' PA requirements on both patient care and practice efficiency, it is no surprise that existing AMA policy and current advocacy activities address many of the facets of Resolutions 705-A-15 and 712-A-15. PA is a complicated issue that requires a comprehensive advocacy strategy. The referred resolutions, current policy, and ongoing AMA efforts all reflect this broad approach and address a variety of PA-related topics, including research, state legislation, policy reform, process automation, payment for administrative tasks, and issue priority.

ADMINISTRATIVE BURDEN AND PA RESEARCH

AMA policy calls for research that establishes the time burdens of administrative activities such as PA on physician practices (Policies D-330.909 and D-320.988). In response to these directives, the AMA is engaged in several research endeavors seeking to better quantify the time and costs associated with meeting health plans' requirements. The AMA partnered with Dartmouth-Hitchcock in a 2015 joint research project to establish the amount of time that physicians spend on administrative tasks vs. clinical care. Board of Trustees Report 11-A-15 outlined the methodology and research plan for this study, which involved direct observation of physicians in 16 practices across four medical specialties and four geographic regions. At the time that this report was written, AMA and Dartmouth-Hitchcock authors had prepared a manuscript describing the results of this study for submission to a peer-reviewed journal.

The AMA plans an ambitious related project for 2016 that will specifically focus on PA. Through rigorous analysis of claims and clinical data, this study will assess the impact of PA on resource utilization, costs (both for a particular service and overall health care expenditures), and patient outcomes. While health plans endorse PA as a mechanism to control costs, the more holistic analysis proposed for this study may show an overall lack of value for the health care system. The AMA issued a Request for Proposal for this project and will be selecting a research partner by early in the second quarter 2016.

The results of both the AMA/Dartmouth-Hitchcock project and the 2016 PA-specific study may provide valuable information to support future AMA advocacy activities to reduce PA burdens and drive industry interest in exploring alternative and potentially less onerous approaches to resource utilization management. Armed with

quantitative data that clearly establish the health care dollars being wasted on administrative tasks, the AMA can present a strong argument with both legislatures and health plans that PA burdens must immediately be addressed.

STATE LEGISLATIVE ACTIVITY

While most physicians would prefer to see an outright elimination of PA programs, steadily increasing health care costs and the availability of innovative—yet expensive—new therapies that will undoubtedly require PA suggest that this is not an attainable goal for the near future. Instead, AMA advocacy efforts have focused on placing limitations on health plans' PA programs and reducing the impact of these programs on physician practices. State legislation has proven to be one effective avenue for this work, and the AMA works closely with state and specialty medical societies to address PA-related issues through introduction of bills restricting the parameters of utilization management programs. AMA resources offer talking points and model legislation to support medical societies in protecting physicians' interests related to PA requirements. These include the AMA's model bill on PA, the "Ensuring Transparency in Prior Authorization Act," which incorporates various limitations on PA programs called for under AMA policy, including the following points raised by the referred resolutions:

1. *PA response timeliness:* The model bill requires health plans to respond to PA requests in two business days for non-urgent services, one business day for urgent services, and 60 minutes for post evaluation or post-stabilization services following emergency care. The bill also prohibits health plans from requiring PA for emergency health care services. These restrictions are consistent with Policies H-130.970, H-285.998, and H-320.968.
2. *Binding PA decisions:* The AMA model bill prohibits health plans from revoking or restricting a PA for a period of 45 working days from the date the health care provider received the PA, as well as sets the duration of PA validity at one year from the date the health care provider received PA. These provisions mirror Policy H-320.961, which calls for the AMA to support legislation or regulations that would prevent the retrospective denial of payment for any services for which a physician previously obtained PA.
3. *Step therapy limitations:* The bill sets limits on health plans' use of step therapy (programs requiring patients to first try and fail less expensive medications before permitting access to more costly drugs) if such requirements interfere with the physician's clinical judgment or are not in the patient's best interests. This restriction is consistent with Policy D-330.933, which states that the AMA will work to eliminate PAs that undermine a physician's best clinical judgement.
4. *Electronic PA:* The AMA's model PA bill requires health plans to accept and respond to pharmacy PA requests using standard electronic transactions, consistent with Policies H-320.944 and H-160.906.

The AMA is also developing model state legislation to address the accuracy and completeness of the drug formulary data available in electronic health records (EHRs), as referenced in Resolution 712-A-15. The unreliability of the formulary data currently provided in EHRs prevents physicians from determining PA requirements at the point of prescribing and results in significant workflow inefficiencies, as well as delays in patient care. The AMA is researching the magnitude of this problem and plans to include requirements regarding the provision of accurate EHR formulary data to physicians in a future model bill. This activity aligns with Policy H-125.979, which calls on the AMA to work to enable physicians to receive accurate, real-time formulary data at the point of prescribing.

PA BEST PRACTICES, PRINCIPLES, AND ALTERNATIVES

In addition to state legislative advocacy, health plans and their accreditation organizations should be directly approached to improve PA programs. Resolution 705-A-15 asks the AMA to develop best practices for PA and advocate for adoption of these recommendations by health plan accreditation bodies. The existing and extensive AMA policy on PA could easily function as a starting point for a core set of PA best practices to be used in advocacy with health plans and their certification bodies. For example, the issues outlined above and addressed in the AMA's model PA bill, such as PA response timeliness, prohibition of PA for emergency services, and the binding nature of PA decisions, could serve as the basis for the AMA's initial PA best practices.

However, there are undoubtedly other potential best practices that merit inclusion in this list and that warrant further discussion and consideration. Additionally, Resolution 712-A-15 asks the AMA to study alternative models of

quality-based and shared-risk reimbursement that reduce or obviate the need for PA. PA alternatives such as “gold card” programs (under which physicians with a high PA approval rate are excused from PA programs), appropriate use criteria/clinical decision support tools, PA sunset programs (which discontinue PA for services with universally high PA approval rates), and programs granting physicians a certain number of PA waivers per year are currently being explored by health plans. Although these programs are not widely available across all health plans and in all regions of the country, they deserve further discussion and study.

To ensure creation of the most robust and inclusive set of PA practices, as well as to evaluate alternative approaches to resource utilization control, the AMA plans to convene a PA staff workgroup in 2016, which will include representatives from the Federation and patient advocacy groups. The workgroup will be tasked with developing the initial set of PA best practices, starting with existing AMA policy but expanding to other concepts as necessary to ensure maximal protections of patient and physician interests. The workgroup will also evaluate and recommend alternative approaches to utilization management. When finalized, these best practices and recommendations will be shared with health plan accreditation bodies, such as the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC), and the AMA will advocate for the inclusion of these concepts in URAC and NCQA criteria for utilization review programs. These best practices and PA alternatives will also be used in the AMA’s discussions with major national health plans to effect changes in PA programs and encourage pilot use of PA alternative programs.

PA AUTOMATION: STANDARD ELECTRONIC TRANSACTIONS AND PORTALS

Physicians and their staff currently face a very manual PA process. In the AMA’s 2010 physician PA survey, 83 percent of survey respondents indicated that they request PA using faxes, 63 percent reported using a paper form, 35 percent completed PA through a payer website, and 14 percent used an electronic standard transaction either through their practice management system (PMS) or EHR. While it would be preferable to have more current data, all indications suggest that these numbers are still reflective of the manual PA system currently used by most health plans.

Process simplification and automation could significantly reduce the practice burdens associated with PA. As previously noted, Policies H-320.944 and H-160.906 call for the AMA to support streamlining of the PA process through the adoption of standard electronic transactions. The AMA strongly advocates for widespread adoption of standard electronic transactions for PA in a variety of arenas and regularly participates in the standards development organizations charged with creating and maintaining the transactions that support automated pharmacy and medical services PA. The AMA also recently updated its PA Toolkit (available at www.ama-assn.org/go/priorauthorization) to include tips for simplifying the PA process and an overview of the current status of electronic PA implementation.

Resolution 705-A-15 called for the AMA to study the development of a single, interactive, browser-based portal for PA. This request undoubtedly resulted from physician frustrations with the multitude of proprietary Web portals that health plans use to support their current PA processes. These portals burden practices, as each website requires a unique login/password and re-entry of all supporting PA data into the portal. Portals also do not support existing practice workflows, since staff must exit the EHR or PMS to access the health plan website.

While a multi-payer portal could eliminate some of the burdens associated with multiple websites and logins, it would still require physicians and practice staff to exit the EHR or PMS, login to a different system, and manually re-enter data contained in the EHR. In contrast, the standard electronic transactions that the AMA currently favors allow practices to communicate PA-related information in a uniform manner across health plans using the practice’s PMS or EHR and do not require workflow disruption or logging into different systems.

COMPENSATION FOR PA

Along with process automation, payment for the time practices spend on fulfilling PA requests is often discussed as another mechanism to reduce the impact of PA on physicians. Existing AMA policy supports payment of physicians for the time required to complete PAs on behalf of their patients. For example, Policy H-320.968 supports state or federal legislation that would require health plans to compensate physicians for work required to comply with utilization review requirements that are more costly, complex, and time consuming than the completion of standard health insurance claim forms. Policy H-385.951 states that insurers should pay physicians fair compensation for work associated with PAs, including pre-certifications and prior notifications, that reflects the actual time expended

by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.

Available billing codes also support payment for fulfilling PA requirements. Current Procedural Terminology (CPT) code 99080 is to be used for “special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form” and therefore supports physicians billing insurers for administrative tasks such as PA. However, although the tools exist to bill for time spent completing PA requirements, the AMA is unaware of any major health plans that are currently providing payment for PA completion using this code. Assigning a specific payment amount to CPT code 99080 may be challenging, as time and administrative costs likely vary greatly by the specific PA request. Due to the unlikelihood that health plans would agree to pay for PA, the AMA has prioritized other advocacy activities seeking to reduce PA burdens, as outlined above.

PA ISSUE PRIORITY

Due to the high volume of member and Federation questions and concerns, the AMA gives PA-related activities top priority and attention. Although PA is not specifically mentioned in the AMA’s Professional Satisfaction and Practice Sustainability (PS2) strategic focus, reducing administrative hassles such as those associated with PA clearly fit within PS2’s scope of work. Burdensome PA requirements impact both physicians’ enjoyment of their work and practices’ bottom line. The PS2 Group works to better quantify and understand the impact of PA on practices through research activities, such as the 2015 AMA/Dartmouth-Hitchcock administrative burden study. The AMA Advocacy Group joins PS2 in these important efforts and works to reduce the impact of PA on practices through the state legislative activities, automation advocacy, physician education efforts, and collaborative industry work described above. As indicated earlier, PA is a complex issue that requires a multi-pronged advocacy approach. As such, AMA staff from various work units, including PS2, the Advocacy Resource Center, Government Affairs, and Health Policy, regularly collaborate to ensure the most productive approach to addressing the multitude of member concerns on this issue.

DISCUSSION

The Council recognizes the value and importance of an evidence-based advocacy approach, particularly on issues such as PA where physician and health plan interests are not well aligned. Quality data regarding the time and resource burdens associated with PA will support the AMA’s efforts to place restrictions around utilization control programs and minimize burdens for practices. The Council recommends reaffirmation of Policies D-330.909 and D-320.988, the directives are policy which are currently being addressed by the AMA/Dartmouth-Hitchcock administrative burden time study and the 2016 PA research project. The results from these studies, which are targeted for publication in peer-reviewed journals, will inform and support the AMA’s future PA advocacy activities.

A review of existing policy and ongoing AMA activities indicates that the state legislative work recommended by Resolution 712-A-15 is already being accomplished. The AMA’s model PA bill addresses many of the concerns outlined in both resolutions, including timely PA responses, prohibition of PA for emergency services, the binding nature of PA decisions, limitations in pharmacy step therapy programs, and requirements for electronic PA. The AMA also is further evaluating current issues surrounding the accuracy of formulary data in EHRs and the ability of physicians to discern PA requirements at the point of prescribing. Given the high level of PA state legislative activity that aligns with existing AMA policies, the Council recommends reaffirmation of policies addressing PA response timeliness, finality of PA decisions, and PA automation and creating new policy to address the intrusion of step therapy programs on physicians’ clinical decision-making and patients’ health needs.

The Council recognizes the importance of advocacy with health plans and their accreditation organizations regarding PA policies. A set of PA best practices based on, but not limited to, existing AMA PA policy would serve as a valuable tool in discussions with payers and their certification bodies. Additionally, alternatives to PA, including “gold card” programs and appropriate use criteria, should be explored and piloted as means to reduce administrative practice burdens. The impact of the health care industry’s movement from a fee-for-service model to value-based systems on the use of PA programs should also be assessed. The Council supports the AMA’s plans to create a Federation staff workgroup tasked with developing a set of PA best practices and alternative resource

management approaches and recommends that the work product of this group be used in advocacy with health plans and accreditation organizations.

The current manual PA process is ripe for process standardization and automation. The Council recommends reaffirmation of Policies H-320.944 and H-160.906 and the continuation of the AMA's ongoing work to spur the industry to adopt standardized electronic transactions to support automated pharmacy and medical services PA. While the Council understands the intent behind the resolution's call for a single PA portal and agrees that the current multitude of payer portals places undue hardships on physician practices, the AMA should continue to prioritize adoption of standard electronic transactions as the preferred approach for PA automation due to the associated workflow and efficiency advantages.

Physicians have legitimately requested compensation for the time that they and their staff spend on health plans' burdensome PA requirements. As previously noted, existing AMA policies and an available CPT code both support payment for PA-related tasks. However, the Council notes that no major health plan currently compensates physicians for PA using CPT code 99080. Beyond health plans' general objections to offering additional payment for administrative tasks, obtaining compensation for PA would be challenging due to the difficulties in assigning value to the 99080 code when time requirements could vary significantly between individual PA requests. The Council harbors additional concerns that achieving widespread compensation for PA could have the perverse and unintended consequence of increasing payers' PA requirements: health plans could use provider compensation as justification for additional utilization review. The Council therefore recommends reaffirmation of the policies cited above that call for AMA advocacy to restrict PA programs and minimize associated administrative hassles. Prioritizing more realistic goals, such as reducing the impact of PA on practices through adoption of best practices, and achieving measurable success would preempt the need for PA payment and address the underlying concerns of Resolution 712-A-15's authors.

The Council concurs that PA is a top-of-mind issue for physicians and, as such, deserves substantial AMA attention and resources. As previously detailed, both the AMA PS2 and Advocacy Groups prioritize PA as one of their key issues and effectively collaborate to address physician concerns on this topic. The high volume of member and Federation inquiries on this issue ensure that PA will continue to be a leading priority for the AMA.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policies D-330.909 and D-320.988, which call for study of the time burdens associated with administrative tasks such as prior authorization (PA).
2. That our AMA reaffirm Policies H-130.970, H-285.998, and H-320.968, which address the timeliness of health plans' responses to PA requests and prohibit PA requirements for emergency services.
3. That our AMA reaffirm Policy H-320.961, which calls for the AMA to support legislation or regulations that would prevent the retrospective denial of payment for any services for which a physician previously obtained PA.
4. That our AMA reaffirm Policies H-320.944 and Policy H-160.906, which call for the AMA to support the adoption of standard electronic transactions to facilitate PA automation.
5. That our AMA address the negative impact of medication step therapy programs on patient access to needed treatment by supporting state legislation that places limitations and restrictions around the use of such programs and their interference with a physician's best clinical judgement.
6. That our AMA, in collaboration with state medical associations and national medical specialty societies and relevant patient groups, create a set of best practices for PA and possible alternative approaches to utilization control; advocate that accreditation organizations include these concepts in their program criteria; and urge health plans to abide by these best practices in their PA programs and to pilot PA alternative programs.

7. That our AMA explore and report on potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures.

REFERENCES

- 1 Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? *Health Aff* (Millwood). 2009;28:w533-w543.
- 2 Morley CP, Badolato DJ, Hickner J, Epling JW. The impact of prior authorization requirements on primary care physicians' offices: report of two parallel network studies. *J Am Board Fam Med*. 2013;26:93-95.
- 3 Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP. US physician practices versus Canadians: spending nearly four times as much money interacting with payers. *Health Aff* (Millwood). 2011;30:1443-1450.

8. BILLING OF "INCIDENT TO" SERVICES (RESOLUTION 708-A-15)

Reference committee hearing: see report of [Reference Committee G](#).

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy H-160.908

At the 2015 Annual Meeting, the House of Delegates referred Resolution 708, "Incident to" Billing and NPI Numbers on Claims, which was sponsored by the Iowa delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2016 Annual Meeting. Resolution 708-A-15 asked:

That our American Medical Association (AMA) work to eliminate "incident to" billing so that all charges to patients accurately reflect the practitioners' care to avoid misrepresentation on a medical claim that the physician provided services, which will result in all payments being relevant to the skills and qualifications of the rendering practitioner; and

That our AMA work to ensure all National Provider Identifiers (NPI) on a claim form accurately reflect the practitioner who provided the care rather than reporting under the physician's NPI while maintaining that all such reimbursement be paid to physicians or their institutions.

This report provides background on billing of "incident to" services; highlights developments in "incident to" billing requirements included in the 2016 Medicare Physician Payment Schedule final rule; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

For services and supplies that are provided in a physician's office, a patient's home or other institution excluding a hospital and skilled nursing facility, the Medicare Benefit Policy Manual states that, in order "to be covered incident to the services of a physician or other practitioner, services and supplies must be:

- An integral, although incidental, part of the physician's professional service;
- Commonly rendered without charge or included in the physician's bill;
- Of a type that are commonly furnished in physician's offices or clinics; and
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision."

If services are provided incident to a physician's professional services, then they are billed as Part B services as if the physician provided them, and are paid according to the physician fee schedule. Depending on the service and physician judgment, "incident to" services can be provided by non-physician practitioners (e.g., nurse practitioners, physician assistants, clinical nurse specialists, certified nurse midwives, clinical psychologists, or clinical social workers) or non-physician employees (e.g., nurses and technicians). Services provided incident to a physician's professional services by non-physician practitioners can be broader in scope, depending on state law. Depending on the non-physician practitioner, a range of services could potentially be provided "incident to," from basic clinical

services including taking blood pressures and administering injections, to services usually performed by a physician allowed for under state law including minor surgery, reading x-rays, and other services that entail the non-physician practitioner evaluating or treating a patient's condition.¹ When non-physician practitioners furnish evaluation and management services incident to a physician's service, the physician bills the CPT code appropriate for the evaluation and management service provided.

When non-physician employees provide evaluation and management services incident to, and not part of, a physician's service, the physician bills code 99211 for the service, which is appropriate for an "office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional." The Council notes that "incident to" billing is the only way to obtain Medicare payment for services by: a) non-physician practitioners who are not enrolled in Medicare (including many who are employed by hospitals); and b) health professionals who are not permitted to enroll in Medicare (e.g., nurses, medical assistants, and pharmacists) or to bill directly for that service (e.g., psychologists, social workers, and chiropractors may not bill for evaluation and management services).²

Physicians should be aware that non-physician practitioners may be licensed under state law to perform specific medical procedures and services without physician supervision and have the service separately covered and paid for by Medicare as a service independently provided by them. For example, services billed separately and provided by nurse practitioners are paid at 85 percent of the physician fee schedule. In addition, while the majority of "incident to" billing is done by physicians, services and supplies may also be billed incident to certain non-physician practitioner's professional services, including clinical psychologists, physician assistants, nurse practitioners, clinical nurse specialists and nurse-midwives. In these cases, such services supervised by non-physician practitioners are paid as if they were performed by the supervising non-physician practitioners.³

The determination of whether services provided by non-physician practitioners may be billed as incident to a physician's professional services depends on whether the service was performed under the direct supervision of a physician as an integral part of the physician's in-office service. The Centers for Medicare & Medicaid Services (CMS) has clarified that direct supervision does not mean that the treating physician or any physician in the physician's group must be in the same room as the non-physician practitioner providing the service. Rather, a physician must be present in the larger office suite and immediately available to provide assistance and direction during the provision of "incident to" services. In addition, the physician billing "incident to" must have first seen the patient and initiated the course of treatment, and provided subsequent services at a rate that shows active participation in and management of the course of treatment. If services provided by non-physician practitioners do not meet the requirements of "incident to" billing, non-physician practitioners would bill under their own national provider identifier (NPI) number; the payment for most non-physician practitioners (except nurse-midwives and nurse anesthetists) is a percentage (65 to 85 percent) of the physician rate.¹

There are some differences in supervision requirements depending on the site of care. For those services and supplies that are provided incident to a physician's service in a physician-directed clinic, several physicians may provide supervision for "incident to" services versus an individual attending physician. There are also some exceptions to the direct supervision requirement for a limited set of services provided to homebound patients in medically underserved areas, and when services provided to homebound patients comprise an integral part of the physician's professional services to the patient, provided by personnel meeting relevant state requirements. In these exceptions, general physician supervision is required, which means "that the physician need not be physically present at the patient's place of residence when the service is performed; however, the service must be performed under his or her overall supervision and control."¹

Outpatient hospital services may also be covered "incident to" the outpatient services of physicians or certain non-physician practitioners. Partial hospitalization services can also be billed "incident to" the services of a physician or other practitioner. In these cases, payment for these services would be made to a hospital under Part B.^{1,4}

THE 2016 MEDICARE PHYSICIAN PAYMENT SCHEDULE FINAL RULE

In the 2014 Medicare Physician Payment Schedule (MFS) final rule, CMS set explicit requirements that "incident to" services must be furnished consistent with applicable state law, including state licensure and other requirements for the "auxiliary personnel" providing the services. In the 2016 MFS, CMS modified existing language around its requirement that "the physician or other practitioner who bills for incident to services must also be the physician or

other practitioner who directly supervises the auxiliary personnel who provide the incident to services.” The change removed a sentence explaining that the physician supervising the services did not need to be the physician who initiated the patient’s treatment and is overseeing their general care. The AMA and other physician groups argued that this change could be interpreted as prohibiting this practice which is common for certain types of services such as periodic drug injections or infusions where one physician is managing the overall plan of care but another may supervise the provision of individual services during the course of that care. Fortunately, CMS clarified in the MFS that the supervising physician (or practitioner) for a particular incident to service does not have to be the same person who is “treating the patient more broadly” and added clarifying regulatory language to that effect.

RELEVANT AMA POLICY

Policy H-35.992 states that reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel, and stipulates that such personnel should be under the supervision of practicing physicians. Policy H-360.988 supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician’s supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. Policy H-35.993 opposes legislation or programs that would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician.

Policy defines the valued role of non-physician practitioners within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety. Payment mechanisms for such physician-led team-based care are outlined in Policy H-160.908, which states that our AMA advocates that physicians who lead team-based care in their practices receive the payments for health care services provided by the team and establish payment disbursement mechanisms that foster physician-led team-based care. The policy advocates that payment models for physician-led team-based care should be determined by physicians working collaboratively with hospital and payer partners to design models best suited for their particular circumstances. The policy stipulates that physicians should make decisions about payment disbursement in consideration of team member contributions, including but not limited to: volume of services provided; intensity of services provided; profession of the team member; training and experience of the team member; and quality of care provided. Finally, Policy H-160.908 states that our AMA advocates that an effective payment system for physician-led team-based care should:

- a. Reflect the value provided by the team and that any savings accrued by this value should be shared by the team;
- b. Reflect the time, effort and intellectual capital provided by individual team members;
- c. Be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and
- d. Be sufficient to sustain the team over the time frame that it is needed.

DISCUSSION

Payment resulting from “incident to” services can be an important revenue source for physician practices that choose to fulfill the conditions and administrative requirements to do so. Medicare “incident to” billing provides several advantages to physicians. For some services, it yields a higher rate of payment. For other services, it is the only way to receive any payment under Medicare. As such, it may serve as a disincentive for additional non-physician practitioners and employees to seek provider status so they can bill independently. Overall, “incident to” billing values physician leadership of the health care team and the supervision they provide over the members of the team, with the ultimate responsibility of “incident to” services and the patient’s treatment generally resting with the physician. As such, the Council recommends the reaffirmation of Policy H-160.908, which outlines parameters for payment mechanisms for physician-led team-based health care.

The Council notes that “incident to” billing is a construct of Medicare’s fee-for-service payment system. As outlined in Council on Medical Service Report 9-A-16, “Physician-Focused Alternative Payment Models,” being considered at this meeting, some physician-focused alternative payment models may transition away from fee-for-service payment toward value-based payment, such as episode-based payment. The transition toward value-based payment may reduce the need to bill services “incident to,” as the care provided by all members of a physician-led health care team may be included in the same payment. The Council believes that physicians who choose to participate in

alternative payment models that incorporate aspects of Medicare fee-for-service should retain the ability to bill services provided by non-physician practitioners and employees incident to physician professional services.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 708-A-15, and that the remainder of the report be filed.

That our American Medical Association reaffirm Policy H-160.908, which outlines parameters for payment mechanisms for physician-led team-based health care.

REFERENCES

- 1 Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Health Services. Revised November 6, 2015. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>.
- 2 Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 12: Physicians/Nonphysician Practitioners. Revised November 6, 2015. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>.
- 3 Centers for Medicare and Medicaid Services. MLN Matters SE0441. "Incident to" Services. April 9, 2013. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf>.
- 4 Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual, Chapter 6: Hospital Services Covered Under Part B. Revised December 18, 2015. Available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf>.

9. PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS

Reference committee hearing: see report of [Reference Committee A](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies H-385.913, H-385.926, H-390.844 and D-385.963

During the past six years, the nation has seen adoption of significant public policies aimed at moving physicians to a payment system that can help them lower spending growth and improve the quality of patient care. The 2010 Affordable Care Act (ACA) included a variety of reforms intended to lay the groundwork for a shift in how the US pays for health care with an emphasis on improving quality and reducing cost in addition to expanding coverage. In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) eliminated the Sustainable Growth Rate (SGR) and created new opportunities to create better physician-led payment systems. MACRA ends the uncertainty and the constant threat of double-digit pay cuts to which physicians were subject under the SGR and creates new incentives designed to accelerate payment reform progress.¹ Specifically, the new law creates incentives for physicians to participate in Alternative Payments Models (APMs) and provides opportunities for them to participate in the development and implementation of Physician-Focused Payment Models (PFPMs).²

Meeting the demands of a shifting health care payment paradigm requires physician leadership guiding the direction of APMs. This report, initiated by the Council, provides an overview of MACRA provisions relevant to physician-focused APMs; explains what physician-focused APMs are and provides examples; summarizes relevant policy; and presents policy recommendations.

BACKGROUND

Driven by the ACA and MACRA, the Centers for Medicare & Medicaid Services (CMS) has developed and implemented a number of initiatives to test APMs. In January 2015, the Department of Health and Human Services (HHS) Secretary Sylvia Burwell announced national goals for transitioning to value-based payment and APMs.³ The shift in focus to APMs is grounded in the notion that coordinated, integrated, and technically supported care will result in better health outcomes at a lower cost.⁴

The MACRA legislation provides incentive payments to physicians who reach threshold levels of APM participation for each year from 2019 through 2024.⁵ APMs that are recognized by MACRA include Medicare Shared Savings Program accountable care organizations (ACOs) and models established by the CMS Center for Medicare & Medicaid Innovation (CMMI), such as the Bundled Payments for Care Initiative, and medical home models that are expanded by the CMMI, which may potentially include a future expansion of the Comprehensive Primary Care Initiative. However, the APMs currently being implemented by CMS do not represent the full range of potential APMs authorized by MACRA. In addition, MACRA specifically encourages the development of PFPMs by creating a permanent advisory committee to review proposals from physicians and other stakeholders and make recommendations to HHS and CMS as to which models to implement.

MACRA allocates funding to enable the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review physician-focused payment model proposals and to provide comments and recommendations to HHS as to which such payment models should be implemented.⁶ Additionally, the law allocates \$100 million over five years for HHS to support technical assistance to help small practices and practices in health professional shortages areas to participate in payment reform efforts.⁷

BARRIERS IN THE CURRENT PAYMENT SYSTEM

There are significant barriers to changing the way health care services are delivered in order to improve patient health and reduce spending because current payments are tied to utilization of services. Under the current fee-for-service (FFS) system, practices lose revenue if physicians perform fewer or lower-cost services even though their practice costs often remain the same.⁸ Additionally, providers may be financially penalized for providing higher quality services. For example, if a practice reduces errors and complications resulting in the need for fewer services, the practice's operating margins can decline and threaten its financial viability.⁹

Moreover, Medicare and most health plans do not pay for beneficial services like patient education and care coordination activities that can help reduce avoidable spending.¹⁰ For example, there is generally inadequate or no payment for providing proactive telephone outreach to high-risk patients to ensure they receive preventive care.¹¹ Outreach could prevent serious health problems and avoid more expensive services like hospital admissions.

A number of the current APMs, such as ACOs, are subject to regulatory policies that favor large practices, multi-specialty practices, and health systems, not small physician practices, and, as a result, they can make it difficult for independent physicians who wish to participate in the APMs to remain independent.¹² Current APMs also have not been designed to include many specialists or their patients. Many physicians participating in these APMs have expressed concern that they impose significant administrative burdens.¹³ Many of these APMs were not structured in a physician-driven manner with the needed flexibility. For example, nearly all of the CMS APMs that have been implemented to date are based on a shared savings model which can reward denying needed care as well as reducing unnecessary care, and which does not remove the barriers in the underlying payment system. Further, these APMs require the participating physicians to take accountability for total spending on the APM's patients instead of limiting accountability to the components of care delivery that the physicians can reasonably influence. As a result, the current APMs may increase financial risks for physicians without giving them the appropriate resources and flexibility to manage that risk. What some policymakers perceive as unwillingness by physicians to move away from FFS payment may be more a reflection of physicians' legitimate concerns about the way APMs have been structured to date by CMS and private health plans.

OPPORTUNITIES UNDER MACRA

No single approach to payment reform will yield the best outcome for every physician or every specialty. Opportunities to improve care will differ in every community, and both providers and payers will differ in their capabilities to manage and implement payment system changes.¹⁴ PFPMs provide a chance to create a family of APMs that enable successful participation by all physicians in all specialties and practice settings. If properly structured, PFPMs create an opportunity for physicians to improve patient care in ways that are feasible in their unique practice environments. Specialty-specific and condition-based models allow physicians to redesign care for the specific types of patients for whom the physicians deliver care.

The goal of PFPMs should be to break down the barriers in the current payment system that prevent physicians from taking advantage of opportunities to improve patient care that can also help control growth in spending. For

example, if better management of a patient's chronic disease can prevent the patient from being hospitalized, the patient receives better care while spending is reduced. Yet currently there is no payment for training patients to manage their conditions at home and provide feedback by phone, or for physicians taking time to consult with other specialists about how to successfully manage a patient's condition. PFPMs could provide an opportunity to be paid for such valuable services that support improved patient health. If better surgical care helps patients avoid infections and other complications, then the patients have better outcomes and spending is reduced. Patients are heterogeneous, and different interventions are required for different patients. Physicians are best poised to balance the goal of reducing health care costs while delivering high quality care. Accordingly, physicians should have a leadership role in steering the models.

With strong leadership, physicians can provide the ethical foundation needed to design models that help to reduce costs appropriately and improve patient care. Because some value-based payment designs can lead to reductions in necessary care, not just inappropriate services, properly risk adjusted PFPMs that pay physicians for high-value services that they may already be providing is a way to mitigate these concerns. APMs should be physician-driven to ensure an understanding of proper health care delivery and quality patient care.

MACRA is designed to increase physician accountability, and the development of PFPMs allows accountability to be focused on what each physician can influence in practice and to provide the resources and flexibility physicians need to accept that accountability. The Council has previously expressed concern that the established CMS APMs could force physicians to join large health systems or ACOs in order to participate in an APM. Properly constructed PFPMs could be flexible and allow physicians across practice size, setting, and specialty to participate in APMs. Developing physician-focused APMs gives physicians the resources and flexibility needed to implement their own solutions for improving care for their patients rather than having CMS dictate the way care should be delivered.

EXAMPLES OF ALTERNATIVE PAYMENT MODELS

American Society of Clinical Oncology (ASCO)

ASCO has developed the Patient-Centered Oncology Payment (PCOP) model for a potential oncology APM. The PCOP model addresses the serious barriers in FFS faced by oncologists: lack of payment in the current FFS structure for an array of services critical to supporting patients with cancer and managing complex illness.¹⁵ The PCOP offers three payment approaches for oncology practices, recognizing that oncology practices across the US have different capacities and face different marketplace and practice environment challenges.¹⁶ The PCOP allows oncologists to direct more resources to activities such as spending time with patients in shared decision making about alternative treatments, developing care plans, and providing triage and in-office treatment in order to avoid emergency visits and hospital admissions. The model identified opportunities to reduce spending during an episode of chemotherapy such as reduced emergency department visits and hospital admissions for chemotherapy-related complications, unnecessary or duplicative testing, and unnecessary drugs. Additionally, the model supports team-based care by providing funding for the use of educators, social workers, and triage nurses with the recognition that the whole team manages a patient. ASCO estimates that oncology practices would receive a significant increase in payments for patient services compared to the current FFS payments, yet overall spending on cancer care would decrease by avoiding expensive hospitalizations and unnecessary tests and treatments.¹⁷

American Society for Radiation Oncology (ASTRO)

ASTRO has created two "bundled payment" models that could serve as APMs: one focused on palliative care for bone metastases and the other on treatment of breast cancer. Both models are designed to provide flexibility to radiation oncologists in choosing the most appropriate treatment modality for patients without financially harming the practice when it uses lower-cost treatments. ASTRO arrived at these two models by analyzing Medicare data to identify areas of potential savings. The ASTRO model provides a clear definition of services in specified treatment categories and rewards maintaining and improving performance on quality measures and disease specific measures. To ensure adequacy of payment, a base payment rate using the weighted average of the FFS payments is developed for all clinically appropriate radiation therapy services, and a bonus is applied for compliance with care pathways and care coordination. The ASTRO models help reduce overutilization of existing services without harming radiation oncology practices financially.

American College of Cardiology (ACC)

The ACC has created the SMARTCare model to improve the appropriate use of diagnostic testing and interventions for patients with stable ischemic heart disease.¹⁸ SMARTCare assists physician and patient decision-making, incorporating practice guidance required for guideline-based optimization of care, and, based on evidence-based standards, avoiding care that is unlikely to help in many clinical situations. SMARTCare uses data collection and numerous tools at the point of care that are integrated into the physician's workflow. These tools include an ACC tool embedded in the electronic health record that guides physicians through the collection of patient data on appropriate use to identify performance gaps and ultimately implement a quality improvement plan for the practice. Additionally, SMARTCare uses a tool that helps physicians assess the risk of heart attacks for patients. The ACC believes that these tools will bring more evidence-based clinical information to the point of care and ultimately reduce usage of unnecessary services. Further, SMARTCare works to re-establish the strength of the physician-patient relationship through patient-specific consent and education. The SMARTCare model is being piloted for three years across 10 sites and is expected to save \$42.2 million over the course of those three years.¹⁹

American Society of Anesthesiologists (ASA)

The ASA developed a learning collaborative to implement the Perioperative Surgical Home (PSH).²⁰ The PSH is a physician-led, patient-centered, team-based model to coordinated care that guides patients through the surgical experience from the decision to undergo surgery to discharge and medical and social supports.²¹ The PSH model aims to reduce variability in perioperative care because variability increases the likelihood of errors and complications.²² The model assures continuity of care and treats the entire perioperative episode as one continuum of care.²³ The PSH model has been implemented in a variety of settings including medical centers, community health systems, and independent group practices. Because the PSH is primarily a method of organizing and delivering care, PSH payment systems may be flexible.²⁴ For example, PSH may use shared savings arrangements, bonus payments, and bundled payments among others.²⁵ The PSH has demonstrated success as both a financially sustainable model and a beneficial model of care for patients.²⁶ The model has been shown to result in increased patient satisfaction, improved postoperative outcomes, reduced length of stay, and reduced risk of hospital-acquired infections.²⁷

Individual Physician-Led Model

Many individual physician leaders are developing provider-specific models that work for their practices, including the Minnesota Birth Center model. Consistent with American Medical Association (AMA) policy recognizing certified freestanding birth centers as a suitable setting for labor, delivery, and immediate post-partum care, the Minnesota Birth Center is a physician-led freestanding birth center (Policy H-245.971). The center employs team-based care to offer a bundled payment and care delivery model that includes pre-natal, intra-partum, and post-partum care. The goal of the center is to lower the cost of childbirth by providing care in a birth center setting for those women who are classified as low risk and who continue as low risk through delivery. Mothers who need care in the hospital during the delivery process are transferred there to complete the delivery. The Minnesota Birth Center provides a way to improve outcomes and reduce costs in normal childbirths and also to provide greater predictability about costs for new parents and health insurance plans.

AMA ACTIVITY

The AMA is actively engaged in the development and implementation of better health care payment systems. The AMA has convened regular meetings with CMS on APMs and has hosted MACRA and APM workgroup meetings with representatives from state and specialty societies to build on physician experiences and offer best practices. These workgroups are identifying common themes and potential strategies to overcome the challenges of transitioning to APMs. Additionally, the workgroups participated in developing robust comments on APM aspects of the CMS Request for Information and continue to advocate with CMS and be actively involved with MACRA implementation. Further, in April 2016, CMS released the MACRA notice of proposed rulemaking, and the AMA is working with the Federation to analyze and respond to the MACRA proposed rule, including criteria for PFPs and proposals from the PTAC for how it will review and develop recommendations on stakeholder APM proposals.

Moreover, the AMA has been working for many years to encourage the development and implementation of successful and sustainable payment systems that achieve the following goals:

- Give physicians more resources and flexibility to deliver care;
- Improve financial viability in physician practices;
- Minimize administrative burdens that weigh physicians down;
- Enable physicians to control aspects of spending that they can influence; and
- Avoid transferring inappropriate financial risk to physicians.

Additionally, the AMA's Physician Satisfaction and Practice Sustainability strategic focus area has developed multiple tools to help physicians thrive in practice and adopt sustainable new models of care delivery and payment. STEPS Forward, launched in 2015, intends to drive physician internal practice improvement with a focus on small practice. STEPS Forward will be enhanced with the recent award of a CMS Transforming Clinical Practices Initiative grant to provide practice transformation resources for physicians. New modules are being identified and were released, in April 2016, including a module on implementing new payment models in practice. Additional tools include:

- Leadership training for physicians focused on episodic leadership training for practicing physicians in area of professional development, personal development, and health systems;
- Commercial payer contracting resources on new payment models of pay-for-performance and bundled payments;
- AMA and American Hospital Association joint principles on physician-hospital integrated leadership; and
- Development of an interactive online education assessment tool for individual physicians to evaluate the financial and patient care delivery impacts of new payment models under MACRA and provide physicians with tools and resources to assist them in practice transformation and sustainable payment model adoption.

RELEVANT AMA POLICY

Policy D-390.953 directs the AMA to advocate with CMS and Congress for alternative payment models developed in concert with specialty and state medical organizations.

The AMA has extensive policy related to physician-led payment reform models. AMA policy is committed to promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs (Policy D-385.963). Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients. In transitioning from the SGR, the AMA advocates for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions (Policy H-390.844).

Policy H-390.849 directs the AMA to advocate for the adoption of physician payment reforms that promote improved patient access to high-quality and cost-effective care and that such reforms be designed with input from the physician community. The policy also states that reformed payment rates must be sufficient to maintain a sustainable medical practice and that payment reform implementation should be undertaken within a reasonable timeframe and with adequate assistance.

Policy H-450.931 recognizes that physicians will need assistance transitioning to alternative payment models. To that end, the AMA is committed to helping physician practices optimize the quality and content of physician work under APMs and addressing physician concerns. The policy also recognizes that physician practices will need data and resources for data management and analysis to participate in an APM.

The AMA has significant policy on avoiding financial incentives that could potentially conflict with the best interests of their patients or influence their judgment related to quality of care. Ethics Opinion E-8.0501 provides guidelines for physician leaders to ensure that practices for the financing and delivery of care are ethical, and the policy further directs physicians to address potential conflicts of interest in payment models and financial incentives. Ethics Opinion E-8.0501 states that physicians are free to enter into a wide range of contractual agreements and should be mindful of and negotiate the removal of terms that are known to compromise professional judgment or integrity, particularly when compensation varies according to performance. Further, Policy H-140.978 states that physicians must not deny their patients access to appropriate medical services based upon the promise of personal financial reward or the avoidance of financial penalties.

DISCUSSION

In response to the growing pressures to control costs and the increasing emphasis on value-based payment, MACRA has prompted payers to begin moving away from traditional FFS payment and toward experimentation with APMs.²⁸ The ACA and MACRA codified this shift to new innovative payment models, marking a significant shift in policy. As payment reform surges forward, it is important for physicians to take a leadership role in order to ensure that future changes fulfill the promise of delivering better care for patients as well as lower costs for payers in ways that are financially viable for physician practices. Physicians must have the freedom to choose their mode of practice and method of earning a living. Accordingly, physicians should be driving this change. Physicians should determine what infrastructure is needed to deliver good care for patients in a workable environment for physicians, patients, and practice sustainability. The AMA is in the unique position to help physicians shape payment reform appropriately through its advocacy efforts. Current AMA policy is silent on the intended goals of APMs and how physicians may be active in developing and piloting new payment models tailored to their practices and patient populations, and physicians have an opportunity to shape advocacy efforts moving forward.

Value-based health care should be the goal of any health reform initiative. However, even with the repeal of the SGR, there are major challenges to achieving the goal of value-based care, including the lack of an agreed-upon patient-centered definition of value; shortage of streamlined, meaningful performance metrics; a deficiency of health information technology to support the type of information-gathering and data analysis necessary to transition to new systems; and a lack of physician-focused APMs.²⁹

The implementation of MACRA means that the shift toward better value will accelerate. Therefore, it is imperative that physicians are aware of and become involved in the shifting payment reform structure in order to ensure its success and mitigate possible administrative burdens on physician practices.

The Council strongly encourages physicians to be at the forefront of this payment reform shift. Using flexible PFPMs provides a way for providers and payers to support improved care in the most efficient and effective fashion. For example, in many cases, there is no need to create complex bundled payment models; a provider and payer may need only agree to create new fees for currently uncompensated services along with feasible targets for avoidable utilization and spending that the physician works to achieve and maintain.³⁰ Physicians must lead payment reform initiatives to ensure new payment initiatives are approached with caution and that changes work for them and their patients. They must organize themselves to advocate for a transitional approach to models and push for an adequate transition period.

Small and solo practitioners are likely to need additional support to transition to value-based payment. Payment reform activities must recognize that these practices may have additional obstacles to participation for which solutions need to be identified. For example, the calculated cost per patient may be much higher with a small patient panel, and small and solo practices will experience greater swings in revenues and costs from low probability events. Approaches to ensure these problems do not inappropriately penalize small practices include measuring performance over multiple years, measurement for all patients regardless of payer, and defining composite measures of utilization or spending that can be directly controlled by the physician. All practices should receive adequate support to enable them to make the transition to new payment models. Models and practice supports should be physician-driven and developed with the support of the AMA working jointly with specialty societies.

It is important to note that APM participation will not be appropriate for every patient or every service. There may not be an APM for every patient, and most models will exclude certain patients. For example, some highly complex patients may require customized services that are best supported by FFS payment, not an APM. Additionally, there are services for which FFS remains appropriate. Routine services associated with fewer complications may be best addressed by FFS. These considerations must be built into proposed payment reform models.

Physicians and payers must be cognizant of the potential ethical implications of entering into an APM. While one goal of moving to value-based payment is to help reduce unnecessary services, APMs must also work to avoid underuse of necessary services. Ethical scrutiny around financial incentives is important to achieve appropriate use of services in APM designs while avoiding unintended consequences such as underuse. To mitigate these concerns, the Council recommends physicians remain actively involved in the development of APMs in order to lead improvement in patient care while avoiding ethical conflicts that can arise from conflicting duties to their patients and their contractual obligations. There are ethical challenges ahead in the transition to value-based payment, and

physicians should lead this evolution to ensure the focus remains on appropriate care and improved patient outcomes.

Though the transition to value-based payment will no doubt be difficult, the Council believes, with a united physician voice and strong leadership, that payment reform will allow physicians to provide higher quality care to patients and better sustain their physician practices. In this report, the Council recommends establishing a set of APM goals consistent with AMA policy and advocacy. The Council recognizes that minimal resources exist to help physicians identify and develop viable APMs for their practices. As such, the Council recommends guidelines to help physicians identify feasible models for their practices. An additional recommendation offers principles to both educate physicians and help physicians reach the goals of APMs. Physicians need tools to move from delivering care under the current FFS payment rules to building the infrastructure and establishing the partnerships that will enable them to implement sustainable APMs. Physicians must be equipped to shape payment reforms appropriately and to resist imposition of inappropriate models by payers. The Council is hopeful that its recommendations will help physicians as they transition to value-based payment reform.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-385.926 supporting physician choice of practice and the freedom of physicians to choose their method of earning a living.
2. That our AMA reaffirm Policy D-385.963 promoting physician-led payment reform and Policy H-390.844 emphasizing the importance of physician leadership and providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions.
3. That our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
4. That our AMA support 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.
5. That our AMA support 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.

6. That our AMA encourage 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.
7. That our AMA 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.

REFERENCES

- 1 How Physicians Can Adapt to Compensation Changes. Advisory Board Company. 10 July 2015. Available at <https://www.advisory.com/daily-briefing/2015/07/10/law-review>.
- 2 42 U.S. Code § 1395ee. Available at <https://www.law.cornell.edu/uscode/text/42/1395ee>.
- 3 Sylvia M. Burwell Setting Value-Based Payment Goals - HHS Efforts to Improve U.S. Health Care. *New England Journal of Medicine*, 5 Mar. 2015. Available at <http://www.nejm.org/doi/full/10.1056/NEJMp1500445>.
- 4 Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System. Centers for Medicare & Medicaid Services, 26 Jan. 2015. Available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html>.
- 5 Stuart Guterman. With SGR Repeal, Now We Can Proceed with Medicare Payment Reform. *The Commonwealth Fund*, 15 Apr. 2015. Available at <http://www.commonwealthfund.org/publications/blog/2015/apr/repealing-the-sgr>.
- 6 Physician-Focused Payment Model Technical Advisory Committee (PTAC). US Government Accountability Office. Available at <http://www.gao.gov/about/hcac/ptac.html>.
- 7 Jim Hahn. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; P.L. 114-10). Congressional Research Service, 10 Nov. 2015. Available at <https://www.fas.org/sgp/crs/misc/R43962.pdf>.
- 8 Harold Miller and Sandra Marks. A Guide to Physician-Focused Alternative Payment Models. American Medical Association and Center for Healthcare Quality and Payment Reform. Available at <https://download.ama-assn.org/resources/doc/washington/alternative-payment-models-physician-guide.pdf>.
- 9 Harold Miller. Ten Barriers to Healthcare Payment Reform and How to Overcome Them. Center for Healthcare Quality and Payment Reform. Available at <http://www.chqpr.org/downloads/OvercomingBarrierstoPaymentReform.pdf>.
- 10 Miller, *supra* note 8.
- 11 *Id.*
- 12 Carol Kane. Payment and Delivery in 2014: The Prevalence of New Models Reported by Physicians. Available at <https://download.ama-assn.org/resources/doc/health-policy/x-pub/practicepay-prp2015.pdf>.
- 13 Mark W. Friedberg, Peggy G. Chen, Chapin White, Olivia Jung, Laura Raaen, Samuel Hirshman, Emily Hoch, Clare Stevens, Paul B. Ginsburg, Lawrence P. Casalino, Michael Tutty, Carol Vargo, Lisa Lipinski. Effects of Health Care Payment Models on Physician Practice in the United States. RAND Corporation and American Medical Association. Available at http://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR869/RAND_RR869.pdf.
- 14 Harold Miller. The Building Blocks of Successful Payment Reform: Designing Payment Systems that Support Higher-Value Health Care. Center for Healthcare Quality and Payment Reform. Available at <http://www.chqpr.org/downloads/BuildingBlocksofSuccessfulPaymentReform.pdf>.
- 15 ASCO Proposes Payment Reforms to Support Higher Quality, More Affordable Cancer Care. American Society of Clinical Oncology, 21 May 2015. Available at <http://www.asco.org/press-center/asco-proposes-payment-reforms-support-higher-quality-more-affordable-cancer-care>.
- 16 *Id.*
- 17 *Id.*
- 18 Angela Marshall. SMARTCare Holds Potential to Save Billions in Heart Care Costs. *Cardiovascular Business*, June 2014. Available at <http://www.cardiovascularbusiness.com/topics/healthcare-economics/smartcare-holds-potential-save-billions-heart-care-costs>.
- 19 *Id.*
- 20 American Society of Anesthesiologists and Premier, Inc. Launch Second Perioperative Surgical Home Learning Collaborative. American Society of Anesthesiologists, 26 Oct. 2015. Available at <https://www.asahq.org/~media/sites/psh/files/102615pshlearncollab2pressrelease.pdf?la=en>.

- 21 Michael Schweitzer. The Perioperative Surgical Home: From Concept to Reality. MONITOR, April 2015. Available at <http://monitor.pubs.asahq.org/data/Journals/ASAM/934397/26.pdf>.
- 22 Zeev Kain. The Perioperative Surgical home as a Future Perioperative Practice Model. The Open Mind, May 2014. Available at <http://clinicaldepartments.musc.edu/anesthesia/intranet/education/Journal%20Club/May%202014/The%20Perioperative%20Surgical%20Home.pdf>.
- 23 *Id.*
- 24 Marc Leib. Payment Models for the Perioperative Surgical Home. MONITOR, April 2015. Available at <http://monitor.pubs.asahq.org/article.aspx?articleid=2433288>.
- 25 *Id.*
- 26 *Supra* note 19.
- 27 Schweitzer, *supra* note 21.
- 28 Mark McClellan. Physician Payment Reform in Medicare: A Landmark Achievement, and a Long Way to Go. American Society of Clinical Oncology. 29 May, 2015. Available at <http://am.asco.org/physician-payment-reform-medicare-landmark-achievement-and-long-way-go>.
- 29 John O’Shea. Physician Payment Reform in a Post-SGR World: Challenges Remain. Health Affairs Blog. 3 Sept. 2015. Available at <http://healthaffairs.org/blog/2015/09/03/physician-payment-reform-in-a-post-sgr-world-challenges-remain/>.
- 30 Miller, *supra* note 12.

10. MEDICATION “BROWN BAGGING” (RESOLUTION 827-I-15)

Reference committee hearing: see report of [Reference Committee G](#).

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies H-100.951, H-330.884 and D-330.960

At the 2015 Interim Meeting, the House of Delegates referred Resolution 827-I-15, which was sponsored by the Organized Medical Staff Section. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2016 Annual Meeting. Resolution 827-I-15 asked:

That our American Medical Association (AMA) study the potential benefits and harms of medication “brown bagging,” which is the practice of patients bringing their own medications into their physicians’ offices or into hospitals for administration in those settings, with report back at the 2016 Interim Meeting.

This report explains the practice of “brown bagging,” highlights its risks and benefits, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

“Brown bagging” is a colloquial term describing the practice of patients acquiring pharmaceuticals, such as chemotherapy drugs, through their pharmacy benefit and bringing the drugs to a physician’s office or hospital to have them administered. “Brown bagged” (patient-acquired, physician-administered) drugs are shipped directly from a pharmaceutical wholesaler either to a patient or to an in-network pharmacy where the patient picks up the medication and transports it to a facility to be administered.¹ This practice differs from the traditional “buy and bill” arrangement in which providers purchase and stock infused and injectable medications, administer them and then bill payers for the drugs and their administration under patients’ medical benefits.

Office-administered drugs are generally covered under an insurer’s medical benefit (Part B for Medicare patients), while self-administered drugs are covered under an insurer’s pharmacy benefit. “Brown bagging” shifts coverage of office-administered drugs from a medical benefit to a pharmacy benefit, and it is the pharmacy that then bills payers for the drugs, presumably at lower cost.² Pharmacies also bill payers directly under the practice of “white bagging,” whereby the drug is shipped by a specialty pharmacy directly to the facility for administration to a particular patient. Because specialty and biologic agents drive up the overall cost of prescription drugs, payers may incentivize alternative distribution methods for these drugs such as “brown” and “white bagging.” While there is evidence that the use of “white bagging” is increasing,³ the extent of “brown bagging” by patients is less well-defined.

“Buy and Bill”

Fee-for-service Medicare generally pays for office-administered drugs through its Part B benefit using a drug’s average-sales-price (ASP) plus six percent, which is subject to the federal budget sequester. ASPs are posted quarterly by the Centers for Medicare & Medicaid Services (CMS) and based on calculations submitted to CMS by pharmaceutical companies six months prior. When the cost of a drug increases, there is a gap between what physician practices or hospitals pay to acquire the drug and what Medicare reimburses them for it. This cost differential must be borne by these facilities until CMS increases the ASP.

Payments for office-administered drugs by private insurers can be higher than the Medicare formula. However, providers who “buy and bill” are still vulnerable to increases in pharmaceutical prices, the proliferation of costly specialty drugs and the risk that some patients may be unable to pay their cost-sharing expenses. Acquisition costs for biologics and other new specialty medications may be prohibitive for small practices that are unable to pay for them up front. Large practices and hospitals are often better positioned to “buy and bill” high-priced pharmaceuticals because they have greater purchasing power.

Benefits of “Brown Bagging”

An advantage of “brown bagging” is that it permits physician practices to avoid financial pressures under “buy and bill” that have led to a shift in the administration of office-infused drugs from private practices to hospital settings. Under “brown bagging,” practices no longer bill for the costs of the medications; rather, they bill only for the drug’s administration and related services.

Patient acquisition of their physician-administered drugs may enable physician practices to administer certain costly medications that they cannot afford to “buy and bill.” Practices are also relieved from storage and inventory responsibilities. In these cases, “brown bagging” may facilitate patient access to effective medications when the administering facility cannot otherwise provide them. Patients are thus able to have their medication administered at their physicians’ offices, where they have an established physician-patient relationship, instead of a hospital.

“Brown bagging” also benefits patients if their physician-administered drugs are more affordable when purchased directly from the pharmacy or because of reduced cost-sharing expenses. Some insurers or pharmacy benefit managers may be able to negotiate more favorable prices for certain high cost drugs, and that savings could theoretically pass down to patients. It is the potential for decreased costs that likely makes “brown bagging” attractive to insurers and perhaps some patients, especially patients who are unable to access office-administered medications through other distribution channels.

Risks of “Brown Bagging”

Because the chain of custody of “brown bagged” medications is broken during distribution, providers administering these drugs cannot ensure their integrity. There may be additional liability issues associated with administering these medications if they have not been properly handled or if their potency or efficacy has been compromised. Biologic and other specialty drugs are complex to manufacture, prepare and dispose of, and include strict handling and storage instructions that patients may not be equipped to manage. Storage and handling become larger concerns when volatile drugs are delivered to patients through the mail, or if patients travel large distances to have the drugs infused. “Brown bagging” medications may also inconvenience patients; those who are neither trained nor at ease handling therapeutic medications may not be appropriate custodians. Physicians may be unable to determine visually whether a drug has been compromised during transit, which could render a drug less effective and potentially jeopardize a patient’s safety.

There is also risk that a “brown bagged” medication will be wasted if, because of changes in laboratory values or disease progression, a patient cannot be infused at the time the drug is transported or before it expires. Medications that are acquired and stored by a practice can be given to another patient; however, “brown bagged” drugs cannot. Patients who are unable to have their “brown bagged” drugs administered in a timely manner may be responsible for returning the drugs or otherwise disposing of them. Billing may be complicated, and there is also a risk of medication misuse.

Although “brown bagging” may make certain office-administered drugs more affordable for some patients, it is also possible for patient cost-sharing to be higher when drugs are procured through a specialty pharmacy rather than the administering physician. Finally, it is important to point out that facilities whose patients “brown bag” their pharmaceuticals can only bill for administration of these drugs. These physician practices and hospitals thereby forego the margin on medications made available under the “buy and bill” system.

AMA POLICY

No current policy speaks specifically to “brown bagging,” although AMA policy supports physician access to office-administered drugs and the ability to dispense them. Policy H-330.884 states that the AMA will: (1) advocate that physician access to in-office administered drugs, including drugs dispensed by pharmacies, be preserved; (2) work with involved national stakeholders to improve and support patient access to in-office administered drugs; and (3) advocate for coverage for in-office administered drugs and related delivery services for patients who are physically unable to self-administer the drug. Policy H-330.888 supports exempting physician-administered drugs from Medicare sequestration.

Policy H-120.990 supports the physician’s right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA’s ethical guidelines. Under Policy D-330.960, the AMA supports efforts to ensure that Medicare payments for drugs fully cover the physician’s acquisition, inventory and carrying cost and that Medicare payments for drug administration and related services are adequate to ensure continued patient access to outpatient infusion services. Policy D-330.960 also calls for strong advocacy efforts working with relevant national medical specialty societies to ensure adequate physician payment for Part B drugs and patient access to biologic and pharmacologic agents.

Policy H-55.995 states that carriers should recognize and encourage the administration of chemotherapy in physicians’ offices, wherever practical and medically acceptable, as being more cost-effective than administration in many other settings. The AMA supports existing policy principles in evaluating legislative language on matters relating to Medicare reimbursement for physician acquisition and administration of prescription drugs under Policy H-330.897. More broadly, AMA policy opposes interference by pharmacy benefit managers in the provision of medical care by physicians (Policies D-125.997 and H-125.986[4]).

DISCUSSION

The Council clarifies that the “brown bagging” practice as described in referred Resolution 827-I-15 refers to patients acquiring medications through their pharmacy benefit and bringing them to a physician’s office or hospital to be administered. Patients who bring self-administered medications into hospitals or clinics for use or for medication reconciliation are not addressed in this report.

Although the prevalence of “brown bagging” is not known, the Council recognizes that the proliferation of high-priced specialty drugs could potentially fuel growth in the practice. [Council on Medical Service Report 2-I-15](#), Pharmaceutical Costs, discussed the increased financial burdens on payers, physicians and patients resulting from utilization of biologics and specialty drugs, many of which are office-administered. One way for insurers to gain control over the cost of these agents is to integrate them into their pharmacy benefits through “white bagging” or “brown bagging” programs.

The Council weighed the risks and benefits of “brown bagging” against several criteria, including patient safety, patient access, provider responsibility, and preservation of the physician-patient relationship. The Council reiterates its support for adequate payments for office-administered medications that are procured and stocked by physician practices in order to maintain the medication’s chain of custody. The Council further acknowledges the value of care provided by independent and small practices that administer chemotherapy, anti-rheumatic and other medications to patients in the office setting. Accordingly, the Council recommends reaffirming Policies H-330.884 and D-330.960, which advocate for the preservation of physician and patient access to office-administered drugs and adequate payment that ensures continued patient access to outpatient infusion services.

The Council recognizes that patients are administered therapeutic medications by a variety of specialists—including oncologists, hematologists, dermatologists, rheumatologists and gastroenterologists—and that best practices and safety protocols fall under the purview of the outpatient facilities administering pharmaceuticals and their respective

specialty societies. Most hospitals, infusion centers and physician practices have protocols in place around the management of office-administered drugs to ensure the safety of patients and staff.⁴

The Council recognizes that physicians who administer infused and injectable agents as part of their clinical practice may hold a variety of views about “brown bagging,” depending on their specialty, practice size, individual patients, payer contracts and the volatility of medications they administer. A physician may opt to accept a “brown bagged” drug of a non-toxic nature as long as the physician confirms that the patient is equipped to handle, store and transport the drug. Another physician may be willing to take extra precautions to ensure that a patient can safely “brown bag” a medication if the patient cannot access the medication by other means. Other physicians may refuse to accept any “brown bagged” products because the practice does not meet the administering facility’s safety and quality control protocols, and would require responsibilities above and beyond what is required to administer medications that are procured and stocked in-house. Given concerns about patients’ ability to safely handle and store “brown bagged” drugs, coupled with liability issues, it is understandable why many physicians prefer not to administer “brown bagged” medications. Accordingly, the Council recommends that the AMA affirm that decisions to accept or refuse “brown bagged” (patient-acquired, physician administered) pharmaceuticals be made only by physicians responsible for administering these medications.

The Council further believes that physicians should decide whether a given patient has the proper knowledge and training to “brown bag” therapeutic drugs without posing safety or other concerns. Accordingly, the Council recommends that the AMA affirm that “brown bagged” pharmaceuticals be accepted for in-office administration only after the physician responsible for administering these medications determines that the individual patient, or his or her agent, is fully capable of safely handling and transporting the medication.

An increase in insurer mandates or incentives to “brown bag” office administered drugs would be disconcerting, given the multitude of risks associated with the practice. In 2014, Ohio enacted the first state law to ban “brown bagging” of non-self-injectable cancer drugs. The Ohio law prohibits pharmacists from dispensing chemotherapy drugs directly to patients, their representatives or their private residences.⁵ Rather than banning “brown bagging” unilaterally, the Council recommends working with interested national medical specialty societies and state medical associations to oppose third party payer policies and legislative and regulatory actions that require patients to utilize “brown bagging” to ensure coverage of office-administered medications. The Council further recommends working with interested national medical specialty societies and state medical associations to oppose payer policies that reimburse office-administered drug costs at less than the provider’s cost of acquiring the drug if the provider does not accept “brown bagging.”

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 827-I-15, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-330.884, which advocates for the preservation of physician and patient access to office-administered drugs.
2. That our AMA reaffirm Policy D-330.960, which supports Medicare payments that fully cover the costs of physician acquisition, inventory and administration of office-administered drugs, and also calls for working with relevant national medical specialty societies to ensure adequate physician payment for Medicare Part B drugs and patient access to biologic and pharmacologic agents.
3. That our AMA affirm that decisions to accept or refuse “brown bagged” (patient-acquired, physician-administered) pharmaceuticals be made only by physicians responsible for administering these medications.
4. That our AMA affirm that “brown bagged” pharmaceuticals be accepted for in-office or hospital administration only after the physician responsible for administering these medications determines that the individual patient, or his or her agent, is fully capable of safely handling and transporting the medication.
5. That our AMA work with interested national medical specialty societies and state medical associations to oppose third party payer policies and legislative and regulatory actions that require patients to utilize “brown bagging” to ensure coverage of office-administered medications.

6. That our AMA work with interested national medical specialty societies and state medical associations to oppose third party payer policies that reimburse office-administered drug costs at less than the provider's cost of acquiring the drug if the provider does not accept "brown bagging."

REFERENCES

- 1 American Academy of Dermatology and AAD Association. Position Statement on Patient Access to Affordable Treatments. 2015. Available online at: <https://www.aad.org/forms/policies/Uploads/PS/PS%20-%20Patient%20Access%20to%20Affordable%20Treatments.pdf>.
- 2 Robinson, JC and Howell, S. Specialty Pharmaceuticals: Policy Initiatives to Improve Assessment, Pricing, Prescription, and Use. *Health Affairs*, 33, no. 10 (2014):1745-1750. Available online at: <http://content.healthaffairs.org/content/33/10/1745.full.pdf>.
- 3 Polite, BN, Ward, JC, Cox, JV et al. Payment for Oncolytics in the United States: A History of Buy and Bill and Proposals for Reform. *Journal of Oncology Practice*. Volume 10, Issue 6, November 2014.
- 4 2013 Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards Including Standards for the Safe Administration and Management of Oral Chemotherapy. *Journal of Oncology Practice*. Volume 9, Issue 2, Supplement to March 2013.
- 5 Ohio State Medical Association. Government Relations Statehouse Update: Lawmakers Take a Summer Break. *Ohio Medicine*. 2014 – Issue 2, Page 6. Available online at: <https://www.osma.org/Documents/Public-Affairs/Publications/Ohio-Medicine/Ohio-Medicine-2014-Issue-2.pdf>