REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports, 1–9, were presented by Jack McIntyre, MD, Chair:

1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2005 AMA HOUSE POLICIES

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND 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 2005 Socioeconomic Policies

Policy #	Policy Title	Recommended Action and Rationale
D-70.959	CPT Modifiers	Retain-in-part. Directives 1 – 3 have been accomplished and can be rescinded. D-70.959[4] is still relevant and should be retained.
D-70.972	Online Evaluation Procedure Codes	Rescind. CPT Code 99444 is available for online E&M services between physicians and established patients.
D-120.977	Medicare Patient Access to Implantable Morphine Pumps	Retain. Still relevant.
D-165.954	Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans	Retain-in-part. Modify by deleting (3) as that part of the directive was accomplished.
D-165.956	Guam's Gross Receipts Tax Discriminates Against Physicians	Rescind. Duplicative of intent of D-165.961, which more broadly refers to all members of the Federation.

D-165.961	Physician Taxes	Retain. Still relevant.
D-180.986	Update on the Individual Health Insurance Market	Retain. Still relevant.
D-185.991	Health Care for the Victims of the Postal Anthrax Attacks of 2001	Rescind. Directives accomplished.
D-220.981	JCAHO "Do Not Use" Abbreviations	Rescind. Directives accomplished.
D-225.985	Preventing Elimination of Medical Staffs and Independent Peer Review Through Hospital Economic Loyalty Policies	Rescind. Superseded by Policies D-230.991, H-230.958 and H-230.975
D-235.991	Medical Staff Standard MS 1.40, Element of Performance 8	Rescind. Rendered obsolete by the adoption of Joint Commission hospital accreditation standard MS.01.01.01.
D-280.990	Private Sector Options for Financing Long-Term Care	Rescind. Superseded by Policies H-280.991 and H-290.982.
D-290.987	Early and Periodic Screening, Diagnosis, and Treatment	Retain-in-part. Modify policy to read: Our AMA ~~(1) reaffirms~~ recognizes the importance of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program~~;~~ ~~(2)~~ and will advocate for EPSDT to remain intact as critical to the health and well-being of children~~; and (3) will instruct the Medicaid Advisory Commission of the desirability of this action~~.
D-290.988	Medicaid Funding Cuts	Rescind. Directive accomplished.
D-330.939	Medicare Cross-Over Claims	Rescind. Directive accomplished.
D-330.944	Admission Criteria for Inpatient Rehabilitation Services	Retain. Still relevant.
D-330.945	Benzodiazepine Restrictions	Rescind. Benzodiazepine medications are now covered by Medicare Part D for medically-accepted indications.
D-330.946	Provider Education	Rescind. Directive substantively accomplished. CMS no longer charges for workshops or seminars.
D-330.948	Medicare Demonstration Projects	Retain. Still relevant.
D-375.996	Peer Review Immunity	Retain-in-part. Rescind (4) which has been accomplished.
D-390.978	CMS Establishment of Safe Harbor Methodologies Affecting Reimbursement for Medical Director Services in Violation of the Administrative Procedures Act	Rescind. Directive accomplished. Safe harbor methodologies described were rescinded in 2007.
D-390.979	Economic Impact of Shifts in Site of Service	Retain. Still relevant.
D-445.998	Confusion Regarding Use of the Term "Doctor"	Retain.
D-450.982	Medicare Physician Voluntary Reporting Program	Rescind. Physician Voluntary Reporting program evolved into Physician Quality Reporting System. Superseded by Policies D-450.967 and H-450.936.
D-450.984	Physician-to-Physician Communication	Rescind. Superseded by Policies H-450.946 and H-160.942.
D-450.986	Evidence-Based Medicine	Rescind. Model legislation developed. Superseded by Policies H-460.909 and H-155.970.
D-475.999	Postoperative Care of Surgical Patients	Rescind. Directive accomplished with Council on Medical Service Report 3-I-06, which was referred for decision and the subsequent Board action, which resulted in Policies D-475.997 and D-70.955.
D-480.985	Home Anti-Coagulation Monitoring	Rescind. Directive accomplished. Superseded by Policy H-185.951.
H-005.998	Public Funding of Abortion Services	Retain. Still relevant.
H-040.992	Prohibition of Pay Allowances to Military Physicians Serving in Managerial and Administrative Positions	Retain. Still relevant.
H-070.965	CPT Coding of Emergency Interventions	Rescind. Obsolete. Use of prolonged service codes is accepted and paid for.
H-070.997	Medicare and Current Procedural Terminology	Retain. Still relevant.
H-155.965	Health Care Rationing	Retain. Still relevant.

H-155.978	Correcting Misinformation on Health Care Costs and Spending	Rescind. Superseded by Policy H-155.960.
H-155.980	Patient and Public Education about Cost of Care	Retain-in-part. Section 1 of the policy should be retained, and Section 2 should be rescinded.
H-155.994	Sharing of Diagnostic Findings	Retain. Still relevant.
H-160.922	Physician and Health Plan Provision of Uncompensated Care	Retain. Still relevant.
H-160.945	Subacute Care Standards for Physicians	Retain. Still relevant.
H-160.960	Corporate Ownership of Established Private Medical Practices	Retain. Still relevant.
H-160.971	Uncompensated Care	Retain. Still relevant.
H-165.849	Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans	Retain. Still relevant.
H-165.854	Health Reimbursement Arrangements	Retain. Still relevant.
H-165.863	Flexible Spending Accounts (FSAs)	Retain-in-part. Rescind second sentence, as employers are now permitted to allow workers to carry over up to $500 of unused FSA funds to the following year.
H-165.969	Federation and Physician Unity on Health System Reform	Rescind. Superseded by Policy H-165.838.
H-165.997	Prioritization of Health Care Services	Rescind. Superseded by Policies H-165.846 and H-165.838.
H-170.991	Information on Products and Services	Retain. Still relevant.
H-185.952	Elimination of Lifetime Maximums of Health Insurance Benefits	Retain. Still relevant.
H-185.953	Health Insurance Coverage of Specialty Pharmaceuticals	Retain. Still relevant.
H-185.955	Pap Smears as a Clinical Laboratory Test	Retain. Still relevant.
H-185.956	Health Plan Coverage for Over-the-Counter Drugs	Retain. Still relevant.
H-185.958	Equity in Health Care for Domestic Partnerships	Retain. Still relevant.
H-185.959	Health Care Benefit Discrepancies for Small Employers Under COBRA	Retain-in-part. Retain (1). Rescind (2). Medical Savings Accounts were discontinued.
H-200.991	Difficulties in the Fulfillment of National Health Service Corps Contractual Obligations	Retain. Still relevant.
H-205.995	Voluntary Health Planning	Rescind. Superseded by Policy H-205.997.
H-215.967	For-Profit Conversions of Health Care Organizations	Retain. Still relevant.
H-215.992	Hospital Security	Retain. Still relevant.
H-215.993	Medical Society-Governing Body (Trustee) Liaison Program	Retain. Still relevant.
H-220.951	Medical Staff Membership	Retain. Still relevant. Modify policy by replacing “JCAHO” with “The Joint Commission.”
H-220.952	JCAHO Accreditation Manual for Hospitals	Rescind. Superseded by Policies H-225.957 and H-220.990.
H-220.990	Principles for Revision of the Medical Staff Section of the Joint Commission on Accreditation of Healthcare Organizations “Accreditation Manual for Hospitals”	Retain. Still relevant.
H-225.987	Reporting of Incidents	Retain. Still relevant.
H-225.988	Hospital-Medical Staff Joint Ventures	Retain. Still relevant.
H-225.993	Medical Staff Policy Determination	Retain. Still relevant.
H-225.994	Hospital Advertising in Printed and Broadcast Media	Retain. Still relevant.
H-225.997	Physician-Hospital Relationships	Retain. Still relevant.
H-230.955	Clarification of Medical Staff Rights in Granting Clinical Staff Privileges	Retain-in-part. Modify policy to read: Our AMA: (1) policy is that medical staffs may establish any method of granting clinical privileges that complies with Joint Commission ~~on Accreditation of Healthcare Organizations~~ standard ~~MS.4.20~~MS.06.01.05; and (2) requests that its Commissioners to ~~JCAHO~~ The Joint Commission ask ~~JCAHO~~ The Joint Commission to notify all hospitals and medical staffs that there can be multiple ways to comply with ~~JCAHO~~ The Joint Commission standards.

H-230.958	Economic Loyalty Criteria for Medical Staff Privileges	Retain-in-part. Modify policy to read: Our AMA strongly opposes the implementation of economic loyalty criteria for medical staff privileges.
H-230.971	Economic Credentialing	Rescind (1) and (2) which are obsolete. Retain (3) and change "JCAHO" to "The Joint Commission."
H-230.985	Medical Staff Privileges	Retain. Still relevant.
H-230.987	Hospital Decisions to Grant Exclusive Contracts	Retain. Still relevant.
H-230.988	Guidelines for Maintenance and Exchange of Credentialing Information	Retain. Still relevant.
H-230.993	Physician Credentialing	Retain. Still relevant.
H-235.980	Hospital Medical Staff Self-Governance	Retain. Still relevant.
H-235.983	AMA Response to Hospital Governing Bodies in Challenging Medical Staff Self-Governance	Retain. Still relevant.
H-235.993	Representation of the Medical Staff on All Committees of the Governing Board and Administration of American Hospitals	Retain. Still relevant.
H-235.996	Bylaws and Rules and Regulations - No Incorporation by Reference	Retain. Still relevant.
H-240.985	Position Statement on the Federal DRG Program	Rescind. Superseded by Policy H-390.849.
H-240.995	Diagnostic Related Groups	Retain. Still relevant.
H-280.974	Medically Necessary Nursing Facility Visits	Retain. Still relevant.
H-280.995	Medicare Coverage of "Skilled Nursing Care"	Retain. Still relevant.
H-280.999	Physician Involvement in Long-Term Care	Retain. Still relevant.
H-285.914	Patient Access to Specialty Care in Managed Care Systems	Rescind. Superseded by policies addressing access to specialists (Policy H-285.973) and network adequacy (Policies H-285.908 and H-285.911).
H-285.969	Managed Care Education	Retain. Still relevant.
H-285.970	Physician Office Review by Third Party Payers	Retain. Still relevant.
H-285.987	Guidelines for Qualifications of Managed Care Medical Directors	Retain. Still relevant.
H-285.988	Vertical Divestiture in the Health Care System	Rescind. Superseded by Policy H-225.950. Also refer to the AMA Code of Medical Ethics, the AMA Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement.
H-290.974	Status Report on the Medicaid Program	Retain. Still relevant.
H-290.979	Strategies for Increasing Access and Expanding Health Insurance Coverage	Rescind. Superseded by Policies H-165.855, H-290.966, D-290.979 and D-290.982.
H-290.995	Case Management System for Outpatient Clinics	Retain. Still relevant.
H-315.995	Hospital Face Sheet: Physician Responsibility	Retain. Still relevant.
H-320.955	Conflict of Interest in Care Review	Retain. Still relevant.
H-320.958	Emerging Trends in Utilization Management	Retain. Still relevant.
H-320.969	Concurrent Review Procedures of Inpatient Care by HMO Representatives	Retain. Still relevant.
H-320.993	Utilization Management	Retain. Still relevant.
H-330.928	Managed Medicare Reimbursement	Retain in part. Medicare Advantage has replaced Medicare HMOs and Medicare Choice plans. Modify policy by replacing reference to Medicare HMOs, Medicare Choice plans with Medicare Advantage.
H-330.939	Reimbursement by Medicare for Psychotherapy Provided by Residents	Retain. Still relevant.
H-340.903	Quality Improvement Organization Status	Retain. Still relevant.
H-340.990	QIO Involvement in Quality Review and Physician Sanctions	Retain. Still relevant.
H-375.990	Peer Review of the Performance of Hospital Medical Staff Physicians	Retain. Still relevant.
H-375.994	Peer Review in All Health Care Facilities	Retain. Still relevant.

H-380.989	Patient and Physician Right to Privately Contract for Health Care	Rescind. Policy D-380.997 restates Policy H-380.989 in its entirety and refers to other related policies.
H-385.941	Opposition to CMS User Fees	Retain. Still relevant.
H-385.954	Producer Price Index for Physician Services	Rescind. Superseded by Policy H-400.966.
H-385.955	Denial of Payment for Treatment of Immediate Family Members	Retain. Still relevant.
H-385.957	Regulation of Fee Review Companies	Rescind. Superseded by more aggressive Policy H-70.962.
H-385.992	Reimbursement for CT Scans and Other Procedures	Retain. Still relevant.
H-390.868	Ambulatory Patient Groups	Rescind. No longer relevant and superseded by Policy H-330.925.
H-390.872	Compensation for Physicians Who Accompany Seriously Ill or Injured Patients to Hospitals	Retain. Still relevant.
H-390.991	CMS Reimbursement Policy for Physicians in Solo Practice "Covering" Medicare Patients for Each Other	Retain. Still relevant.
H-400.955	Establishing Capitation Rates	Retain. Still relevant.
H-400.994	Payment for Physician Services Under Medicare	Rescind. Superseded by Policies H-390.844 and H-390.849.
H-400.996	Physician Reimbursement Under Medicare	Rescind. Superseded by Policies H-390.844 and H-390.849.
H-405.989	Physicians and Surgeons	Retain. Still relevant.
H-406.993	Development and Use of Physician Profiles	Retain. Still relevant.
H-406.997	Collection and Analysis of Physician-Specific Health Care Data	Retain. Still relevant.
H-406.998	Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data	Retain. Still relevant.
H-435.955	Administrative and Liability Surcharges	Retain. Still relevant.
H-450.973	Outcomes Research	Retain. Still relevant.
H-465.986	Rural Health	Retain. Still relevant.

2. PHYSICIAN PAYMENT BY MEDICARE

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2014 Annual Meeting, the House of Delegates adopted Policy D-285.964, which states:

> That our American Medical Association (AMA) will study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice.

Policy D-285.964 was established after the House of Delegates adopted Substitute Resolution 104-A-14, which originally asked the AMA to examine the methodology behind Medicare fee schedules and also examine why Medicare payments are higher for hospital-based facilities than for private practice physicians. This report, which is provided for the information of the House of Delegates, reviews the literature on consolidation between hospitals and physician practices; describes the current empirical understanding of the effects of such consolidation on health care costs and other metrics; provides information on Medicare payment and hospital-based facilities; and summarizes relevant AMA policy and advocacy.

BACKGROUND

Policy discussions of consolidation in the health care sector, including hospital acquisition of physician practices, are not new to the AMA but have reignited in recent years, fueled by hospital employment of physicians, incentives for developing integrated health care delivery systems and higher Medicare payments to hospital-acquired, provider-based facilities performing outpatient procedures. Consolidation among hospitals, health insurers and physician practices is closely monitored by the AMA. For example, the AMA's Physician Practice Benchmark Survey produces highly regarded data on physician practice arrangements from which shifts toward hospital employment of physicians can be ascertained.

Consolidation between physicians and hospitals, a type of vertical integration, has been subject to fewer empirical investigations than mergers among hospitals, and therefore less can be generalized about its effects on health care costs and other variables. Current economic theory also does not provide clear predictions of what should be expected from such vertical integration.

Most studies of hospital mergers have found that the price of hospital care increases post-merger at consolidated facilities and, in some cases, their competitors. Research conducted on consolidation between physicians and hospitals has generally found that such consolidation has not led to lower health care costs or improved quality, possibly because consolidation did not lead to meaningful integration. Two recent studies on that type of vertical integration, coupled with key findings on mergers and acquisitions in the health care industry during 2013 and AMA/RAND field research on physician satisfaction, offer additional insights.

A study by Laurence Baker, M. Kate Bundorf and Daniel Kessler, published last year in *Health Affairs*, examined data from 2001 through 2007 and found increases in hospital ownership of physician practices were associated with increases in hospital prices and hospital spending.[1] No significant effect on hospital volume was found.[2]

A study by James Robinson and Kelly Miller, published last year in *JAMA*, examined health care cost data for 4.5 million HMO-covered patients in California. Expenditures per patient were found to be higher in physician organizations owned by local hospitals and multihospital systems than organizations owned by member physicians.[3]

Key findings from the 2014 edition of the Health Care Services Acquisition Report, published by Irvin Levin Associates, show what may be a downward trend in mergers and acquisitions involving physician groups overall and, in particular, acquisitions of physician practices by hospitals.[4] There were 41 merger and acquisition transactions involving physician groups in 2009 and 67 in 2010. After peaking in 2011 at 108, the number of deals involving physician practices fell to 70 in 2012 and 65 in 2013. Of the 65 deals announced in 2013, only six were acquisitions by hospitals.[5]

Data from the AMA's 2014 Physician Practice Benchmark Survey—a nationally representative sample of non-federal physicians who provide care to patients at least 20 hours per week—confirms a shift toward hospital employment of physicians, but indicates that this shift has not been as seismic as some articles have suggested. The AMA survey found that 26 percent of physicians worked in practices that were at least partially owned by a hospital and another 7 percent were directly employed by a hospital. In contrast, 57 percent of physicians worked in practices that were wholly owned by physicians.

The 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (hospital, corporate), although work controls and opportunities to participate in strategic decisions were found to mediate the effect of practice ownership on overall professional satisfaction.[6]

MEDICARE PAYMENT AND PROVIDER-BASED STATUS

Council on Medical Service (CMS) Report 3-A-13, "Payment Variations Across Outpatient Sites of Service," and CMS Report 3-A-14, "Medicare Update Formulas Across Outpatient Sites of Service," provide detailed information on the disparity in payments and patient cost-sharing for outpatient procedures performed at different sites of service. CMS Report 3-A-13 established Policy D-240.994, which directs the AMA to work with states to advocate that third party payers be required to: assess equal or lower facility coinsurance for lower-cost sites of service; publish and routinely update pertinent information related to patient cost-sharing; and allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. In CMS 3-A-14, the Council expressed concern regarding the effect of hospital acquisition of physician practices and ambulatory surgical centers (ASCs) on costs incurred by the Medicare program. An increase in payments to hospital-acquired ASCs and practices is suspected because, under the Medicare program, hospital-acquired ASCs and practices can be granted provider-based status by the Centers for Medicare & Medicaid Services (CMS) and subsequently bill for services as hospital outpatient departments (HOPDs).

A provider-based facility is defined as one that is either created by or acquired by a main provider (e.g., hospital) of health care services under the ownership and administrative and financial control of the main provider. To be granted provider-based status, hospitals must attest that their facilities are located within 35 miles of the hospital

campus; operate under the main provider's license (unless a separate license is required by the state); are financially integrated with the main provider; and meet the other requirements outlined at 42 CFR § 413.65. Provider-based facilities, including those off campus, are paid the same rate for outpatient services as hospitals, including a facility fee that is not included in Medicare payments for services performed in physician offices under the Medicare Physician Fee Schedule. In CMS Report 3-A-14, the Council highlighted its concern for patients who may reasonably assume they are receiving services at physician office rates and be taken aback by facility fees and higher cost-sharing amounts associated with hospital-based facilities.

As of January 1, 2015, CMS began collecting data on services furnished in off-campus, provider-based departments by requiring hospitals to report a modifier for these services furnished by the department and by requiring physicians and other eligible practitioners to report these services using a new place-of-service code on professional claims. Provision of this data is voluntary in 2015 and will be a requirement beginning in 2016.

RELEVANT AMA POLICY

The AMA strongly supports equitable Medicare payments across outpatient sites of service. Policy H-330.925 encourages CMS to fairly pay physicians for office-based procedures; adopt a single facility payment schedule for HOPDs and ASCs; and use valid and reliable data to develop payment methodologies for the provision of ambulatory services.

Policy D-330.997 supports defining Medicare services consistently across settings and encouraging CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service. This policy also encourages CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments. Policy H-240.993 further supports equity of payment between services provided in the HOPD and similar services furnished in physician offices.

Antitrust relief for physicians that enables physicians to negotiate adequate payment remains a top priority of the AMA under Policies H-380.987, D-383.989, D-383.990 and H-383.992. Under Policy H-160.915, antitrust laws should be flexible to allow physicians to engage in clinically integrated delivery models, such as accountable care organizations (ACO), without being employed by a hospital or ACO. Policy D-385.962 further directs the AMA to support antitrust relief for physician-led ACOs.

AMA ADVOCACY

AMA advocacy on antitrust policy encourages federal agencies to strike the right balance between allowing innovative integration among physicians and other providers, and monitoring market developments that may preclude physician engagement in new delivery models. The AMA has advocated that physicians be able to engage in integrated delivery models without being acquired or employed by a health care system. Similarly, the AMA has asked the Federal Trade Commission (FTC) to take a flexible approach in its evaluation of physician-driven collaborations. Because physician delivery models are often smaller and more vulnerable to anticompetitive market forces than hospitals, the competition generated by physician-driven clinical integrations may require additional antitrust protection.

The AMA has urged the FTC to examine health care entity mergers individually, taking into account the case-specific variables of market power and patient needs as determined, in part, by physician input. The AMA believes that health care markets should be sufficiently competitive to allow physicians to have adequate choices and practice options.

DISCUSSION

In response to Policy D-285.964, which directs the AMA to study the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practices, the Council reviewed recently published literature on the subject and consulted with the AMA's economic and health policy research unit, which monitors and analyzes consolidation in health care markets. The Council notes that there is limited understanding of whether, overall, hospital/physician practice consolidation is beneficial or harmful to physicians and patients or whether the consequences vary substantially by market. Furthermore, there is a paucity of data on how such consolidation impacts critical quality of care and patient outcome variables.

The Council recognizes that vertical integration between hospitals and physicians can have both positive and negative effects. Increased patient care coordination and operational efficiencies are possible favorable consequences, while increased provider market concentration could lead to higher prices. The empirical findings described in this report are limited and do not merit either generalizable conclusions by the Council or new AMA policy. Nevertheless, the well-documented effects of highly concentrated hospital and health insurer markets suggest the possibility that consolidation between hospitals and physicians may, in some instances, threaten competition in the market. Additional study is warranted. Accordingly, the Council will continue to actively monitor the impact of hospital/physician practice consolidation on costs, quality and access, and report back to the House of Delegates as appropriate.

REFERENCES

1. Baker, L.C., Bundorf, M. K, and Kessler, D. P. Vertical Integration: Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending. Health Affairs 2014;33(5):756-763.
2. Ibid.
3. Robinson, J.C. and Miller, K. Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California. JAMA 2014;312(16):1663-1669.
4. The Health Care Services Acquisition Report, Twentieth Edition, 2014.
5. Ibid.
6. RAND Corporation and American Medical Association. Research Report: Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. 2013.

3. ECONOMIC VIABILITY OF RURAL SOLE COMMUNITY HOSPITALS (RESOLUTION 133-A-14)

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 133-A-14 AND REMAINDER OF REPORT FILED
See Policies H-290.976, H-465.979, H-465.989 AND H465.990

At the 2014 Annual Meeting, the House of Delegates referred Resolution 133, "Economic Viability of Rural Sole Community Hospitals," which was introduced by the New Mexico Delegation. Resolution 133-A-14 asked:

> That our American Medical Association (AMA) study the complex economic factors that threaten the viability of sole community hospitals, and develop recommendations for advocacy and new policies addressing this urgent concern, with a report back by the 2015 Annual Meeting.

The AMA Board of Trustees assigned Resolution 133-A-14 to the Council on Medical Service. This report provides background on sole community hospitals and other federally designated rural hospitals; discusses factors affecting the economic viability of small rural hospitals; highlights organizations engaged in rural hospital advocacy; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

The sole community hospital (SCH) program was created by Congress in 1983 for the purpose of maintaining Medicare patient access to needed health services in geographically isolated communities. Section 1886(d)(5)(D)(iii) of the Social Security Act defines an SCH as a hospital that is more than 35 road miles from another hospital or that, by reason of factors such as isolated location, weather conditions, travel conditions or absence of "like" hospitals, is considered the sole source of inpatient care for Medicare patients in its area.[1]

Medicare pays SCHs the higher aggregate payment of either the federal inpatient prospective payment system (IPPS) rate or a hospital-specific rate. Hospital-specific rates are based on historic costs from the hospital's choice of either fiscal year 1982, 1987, 1996 or 2006, which is then updated for inflation.[2] Payments based on the IPPS may include add-ons such as outliers and disproportionate share hospital adjustments, which are not included in hospital-

specific payments. SCHs also receive a seven percent adjustment in payments for outpatient procedures above hospital outpatient prospective payment rates.[3]

The SCH program is one of several rural payment programs implemented by the Centers for Medicare & Medicaid Services (CMS) to preserve patient access to health care and support provider sustainability in rural communities. Other programs include critical access hospitals (CAHs), which are limited service, rural hospitals that are state-certified as being necessary providers and have 25 or fewer acute care beds, and the rural referral center program, which supports high-volume rural hospitals that treat a large number of complex cases. Special adjustments under these programs provide enhanced payments that rural hospital advocates claim are necessary to prevent these facilities from closing.

SCHs are by definition the sole source of care in a geographic area, and their numbers are small (approximately 400) in comparison to CAHs, which numbered over 1,300 in 2013.[4] Some hospitals qualify for more than one rural payment program. For example, a hospital can be both an SCH and a rural referral center and have its Medicare payments adjusted accordingly. Because states were able to waive CAH distance requirements for "necessary provider" hospitals if other requirements were met, some subsidized CAH-designated facilities are actually within miles of each other. Medicare rural payment adjustments to these hospitals subsequently came under scrutiny, with the bulk of the criticism aimed at state-designated CAHs. Criticism aside, it is generally accepted that rural providers and patients face unique circumstances, and that economically viable providers are critical to preserving access to high-quality care in rural communities.

The reasons behind the financial constraints confronting SCHs in New Mexico are complex and varied, and include modifications made by the state to the formula used to fund SCHs.[5] Nevertheless, many of the dynamics threatening SCHs in that state are generalizable to facilities in other parts of the country. For example, most SCHs are low-volume facilities. Many have experienced decreased utilization. These factors alone impact facilities' revenue and make small rural facilities vulnerable to economic downturns, unexpected expenses or reductions in Medicare and Medicaid payments. Certain shifts in patient coverage may also lead to payment reductions and declines in hospital revenue. In New Mexico, concerns regarding higher numbers of Medicaid patients seeking care at SCHs under the state's Medicaid expansion program have been documented by the local media.[6,7] Because Medicaid payment rates are on average 66 percent of Medicare rates, an increase in Medicaid patients—especially when coupled with a decrease in commercially insured patients—can threaten the financial health of small rural hospitals. These facilities also need resources to invest in electronic health records, quality initiatives and to meet other administrative requirements, although they may have less access to capital.

RURAL HOSPITAL ADVOCACY

As part of its study of the economic viability of small rural hospitals, the Council identified two organizations that lead federal advocacy efforts on behalf of these facilities: the American Hospital Association (AHA) and the National Rural Health Association (NRHA). For more than 30 years, the AHA and its Section for Small and Rural Hospitals have addressed the unique needs of this constituency through advocacy in Congress and in regulatory arenas. The AHA Advocacy Alliance for Rural Hospitals, with its focus on SCH, CAH, Medicare Dependent Hospital and Rural Referral Hospital priorities, is an additional resource for AHA member hospitals to engage on rural hospital issues.

Active in rural health advocacy for 30 years, the NRHA is an association of individuals and organizations whose mission is to improve the delivery of health services in rural areas. The NRHA legislative and regulatory agenda includes SCH, CAH and other rural hospital designations as priorities among a myriad of health policy issues that are routinely analyzed by NRHA for relevance to rural health. Infographics depicting some of the threats posed to rural hospitals have been developed by NRHA as part of its #SaveRural hospitals campaign.

RELEVANT AMA POLICY

Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach toward certification of small, rural hospitals. It is also AMA policy that implementation of legislation establishing SCHs be closely monitored to ensure that this program is implemented in a manner conducive to high-quality patient care and

consistent with AMA policy, and that state medical associations be encouraged to monitor legislation or regulations governing the development and operation of limited service rural hospital facilities (Policy H-465.989[2,3]).

Policy H-465.984 directs the AMA to strongly encourage CMS and state departments of health to review rural health clinic program eligibility and certification requirements to ensure that only facilities in areas that truly do not have appropriate access to physician services are certified.

Policy D-465.999 directs the AMA to call on CMS to support individual states in their development of rural health networks, oppose the elimination of the state-designated CAH necessary provider designation, and pursue steps to require the federal government to fully fund its obligations under the Medicare rural hospital flexibility program.

Finally, the AMA has long-standing policy in support of reasonable and adequate Medicaid payments which is relevant to this discussion. Policy H-290.976[2] advocates that Medicaid payments to medical providers be at least 100 percent of Medicare payment rates. Policy H-290.997[4] promotes greater equity in the Medicaid program through adequate payment rates that assure broad access to care.

DISCUSSION

The Council recognizes that the survival and sustainability of rural health care providers including SCHs is vital, given that approximately one-quarter of the population resides in these areas and 10 percent of physicians practice there. The Council further recognizes the special health care needs of rural communities as well as the confluence of factors placing financial pressures on small rural hospitals. Accordingly, the Council recommends reaffirmation of AMA Policies H-465.989 and H-465.990.

The Council believes that inadequate payments under the Medicaid program are a significant contributor to the financial hardship facing SCHs in New Mexico and elsewhere. Therefore, the Council also recommends reaffirming AMA policy H-290.976, which advocates for reasonable Medicaid payments to medical providers, defined as at minimum 100 percent of Medicare rates.

Having studied the issues brought forth in Resolution 133-A-14, and heard specifically from the New Mexico Medical Society about rural hospital closures in that state as well as the dramatic changes in the financial landscape of one hospital struggling to stay afloat, the Council is sufficiently concerned about the status of some SCHs. Accordingly, the Council recommends that the AMA recognize that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities.

The Council believes that rural providers benefit from AMA legislative and regulatory advocacy on a plethora of issues. Nevertheless, the Council recognizes the leadership roles of AHA and NRHA in advocacy that is specific to small rural hospitals. The Council therefore recommends supporting the efforts of organizations advocating directly on behalf of small rural hospitals, provided that these efforts are consistent with AMA policy.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 133-A-14, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-465.989, which directs the AMA to closely monitor implementation of legislation establishing sole community hospitals (SCHs) to ensure the program is conducive to high-quality care and consistent with AMA policy.

2. That our AMA reaffirm Policy H-465.990, which encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to care.

3. That our AMA reaffirm Policy H-290.976, which advocates for Medicaid payments to providers that are at minimum 100 percent of Medicare rates.

4. That our AMA recognize that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities.

5. That our AMA support the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

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4. PRICE TRANSPARENCY (RESOLUTION 819-I-14)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 819-I-14 AND REMAINDER OF REPORT FILED
See Policies H-373.998 and D-155.987

At the 2014 Annual Meeting, the House of Delegates adopted Policy D-155.989, which directs the American Medical Association (AMA) to "study appropriate mechanisms through which patients and physicians will be able to obtain price data from providers, facilities, insurers and other health care entities prior to the provision of non-emergent services, and that our AMA study the barriers to this goal and serve as a leading voice in this discussion."

Subsequently, at the 2014 Interim Meeting, the House referred Resolution 819, "Price Transparency," submitted by the Iowa Delegation. Resolution 819-I-14 asked "that the AMA: 1) develop an educational program by early 2015 for physicians that would make health care price and reimbursement site differences clear; and 2) work with the Center for Healthcare Transparency (CHT), the Health Care Cost Institute (HCCI), and the Centers for Medicare & Medicaid Services (CMS) to make their websites easier to access and use, and make their data for hospital and physician prices and payments more accurate and useful for physicians, purchasers, and patients."

Using Policy D-155.989 and referred Resolution 819-I-14 as a guide, the scope of this report is limited to identifying ways to expand the availability of health care pricing information that will allow patients (insured or uninsured) and their physicians to make value-based decisions when patients have a choice of provider or facility. The Council notes that increased transparency is needed throughout the health care system in order to help increase the value of health care spending by individuals, public and private insurers, and society at large. Board of Trustees Report 6, "Medical Information and Its Uses," also before the House at this meeting, establishes principles for data transparency that will help ensure that physicians in particular have access to timely and actionable data that will help them improve care and manage costs.

BACKGROUND

For many years policymakers and others have emphasized the need for increased transparency to help control rising health care costs. Many believe that the lack of timely, standardized information about the cost of health care services prevents health care markets from operating efficiently. Recent developments in the health care system have created a more immediate need for price transparency. Many health plan benefit designs and network strategies require patients to assume greater financial responsibility for their care choices. As deductible levels increase for standard plans, and more patients opt for high deductible health plans paired with a health savings account, the demand for better information about anticipated out-of-pocket costs will increase. Similarly, benefit design strategies such as reference pricing depend on transparent pricing information both to set fair benefit levels and to

enable patients to make decisions about where to seek care and understand how that choice may affect their out-of-pocket costs.

Patients enrolled in narrow network plans may face several layers of opacity that affect their ability to effectively manage their out-of-pocket spending. Determining a provider's network status may be difficult because of outdated provider directories or confusion associated with multiple plan contracts. Furthermore, the more services a patient needs, the more difficult it becomes to ensure that every provider involved in the care will be covered at in-network rates. Although some plans may offer an out-of-network benefit, patients who receive care from out-of-network providers face the potential of significant out-of-pocket costs, including higher cost-sharing requirements and a separate bill from the provider reflecting the difference between the provider's charges and the amount covered by the health plan. The increasing use of narrow networks requires that patients be fully informed not only about the network status of a physician or provider, but also the exact financial obligations associated with receiving in network or out-of-network services.[1]

The AMA has long-standing policy encouraging physicians to consider the relative cost of the treatment of services they are recommending for their patients (e.g., Policy H-450.938). Under alternative payment models such as shared savings arrangements, physicians are expected to be more actively engaged in helping patients make health care decisions that balance cost and quality. Price transparency, including pricing information from other providers, is necessary to allow physicians to assess cost of care implications of their treatment and referral recommendations.

BARRIERS TO PRICE TRANSPARENCY

The lack of transparency in health care pricing and costs is primarily the result of a health care financing system that depends largely on complex arrangements between and among employers, third-party payers, providers and patients. The health care system's reliance on third-party payers to negotiate prices for patients and pay providers makes it difficult to identify accurate and relevant information regarding costs associated with specific medical services and procedures. Individually contracted payment rates represent proprietary information, and insurer payment policies, coverage rules, and cost-sharing requirements are difficult to communicate in a standardized manner, and the cumulative effects of each of these factors often make it difficult to provide accurate pricing information for an individual patient in the absence of an actual service claim.

Because the vast majority of health care is compensated through third-party payers at individually contracted rates, many practices or facilities do not maintain standard fee schedules that reflect the amounts that patients would be reasonably expected to pay if directly billed by the provider. In some cases, providers may be concerned that developing and publicizing a cash-pay fee schedule could negatively affect contract negotiations with third-party payers. The lack of price information becomes a significant problem for patients who seek care from providers outside of their insurance network, and for patients who are uninsured or otherwise choose to pay for medical care directly.

Providers and insurers may be reluctant to make certain pricing information available because of concerns about antitrust laws.[2] Federal and state antitrust laws are intended to promote competition by discouraging entities from working together to set prices, and there is a risk that some transparency efforts that involve reporting rates negotiated between providers and payers could give the appearance of or result in collusion by either party in future price negotiations. The Department of Justice and the Federal Trade Commission, the primary enforcers of antitrust law, are aware of the potential competitive benefits associated with health care price transparency, and have issued guidance regarding situations that involve the release of health care price information that are unlikely to raise antitrust concerns.[3] Nevertheless, the complexity of antitrust law and the fear of increased scrutiny often serve as deterrents to the release of detailed pricing information.

Even if basic pricing information were widely available, there are additional barriers to achieving meaningful price transparency in health care. For example, an ideal price transparency system would allow patients to access relevant and accurate information prior to receiving care. This would enable patients to anticipate their potential costs in advance, and to choose among providers to seek the best value care. Yet, anticipating the need for health care services is often difficult. The urgent nature of some medical care, the inability to predict the particular course of treatment that might be indicated or identified subsequent to the initial complaint, and the intensity and scope of services required often leave patients without time to evaluate their options prior to receiving care.

Even for health care services that are more predictable, such as routine office visits or scheduled elective surgeries, developing and implementing a consumer-friendly health care cost tool that patients will actually use is another challenging task. According to a recent study by the Catalyst for Payment Reform, 98 percent of health plans surveyed offer some kind of cost estimator tool, but only two percent of plan members use the tools, which have varying levels of sophistication and functionality.[4] Even if comprehensive pricing and quality information were available, more work needs to be done to find ways to increase the relevance of the information and to encourage patients to use it to inform their health care decisions.

Finally, successfully integrating cost and quality information in health care transparency initiatives is challenging. In addition to the fact that many health care services still lack relevant quality metrics, designing tools that help patients interpret and balance quality and cost information is difficult. Studies indicate that patients are willing and able to make choices based on value (e.g., the best quality at the lowest price) as long as the information is presented clearly and effectively. Conversely, in the absence of quality information, or when information is difficult for patients to interpret, many patients believe that there is a direct correlation between cost and quality, and are likely to choose a higher cost provider if their priority is high quality care.[5]

PRICE TRANSPARENCY RESOURCES AND INITIATIVES

As noted, almost all major health insurers offer some kind of cost estimator tool to help enrollees research and predict their out-of-pocket costs for certain health care services. In addition, a 2013 survey by Towers Watson found that almost one-third of large employers have a cost and quality tool available for their employees, and more than 40 percent plan to add one within the next few years.[6] In the public sector, many states are exploring or pursuing various price transparency initiatives, including legislation that requires providers to disclose certain fees prior to the provision of care, health insurers to provide cost estimates to their enrollees, and state agencies to produce annual reports on the prices of common medical procedures.[7]

At the time this report was written, 12 states had established an all payer claims database (APCD), and another six states are pursuing APCD implementation.[8] APCDs serve as a centralized resource for data related to health care costs and charges, and in most cases payers are legally mandated to report claims information. APCDs typically include data derived from medical, pharmacy and dental claims from private and public payers. APCDs are potentially valuable sources of data for policymakers, physicians, patients, payers and purchasers of health care if the claims data is accurate and reported in a usable format. Although APCDs do not typically provide information directly to consumers, Maine and New Hampshire have created public-facing tools that allow patients to research health care prices and identify variations in prices of common services.
Resolution 819-I-14 identifies two organizations that are working to advance price transparency initiatives for patients and physicians, the Health Care Cost Institute (HCCI) and the Center for Healthcare Transparency (CHT). HCCI was established in 2011 to promote independent, non-partisan research and analysis related to health care costs in the United States. HCCI's goal is to create and maintain a database of information about public and private sector health care costs and utilization, including private claims data from several major health insurers.[9]

In February 2015, HCCI launched guroo.com, a free online transparency tool that provides national and local cost averages for common health care treatments and services based on claims information provided by Aetna, Humana, UnitedHealthcare, and Assurant Health. At the time of the site launch, information was searchable by health care condition, medical test, or "care bundle," which includes costs commonly associated with a particular course of treatment. HCCI envisions expanding the tool's capabilities to include more detailed price information, information about prescription drug prices, and quality information, which will be developed in partnership with the National Committee for Quality Assurance (NCQA).

CHT was established in 2014 and is leading an 18-month planning process to provide meaningful and actionable health care cost and quality information to health plans, employers or other health care purchasers, and consumers. CHT's executive committee includes representatives from the Centers for Medicare & Medicaid Services and the Office of the National Coordinator, as well as representatives of health plans, purchasers and providers. CHT is a partnership between the Network for Regional Healthcare Improvement and the Pacific Business Group on Health.[10]

For-profit price transparency services are emerging. Health Care Bluebook, Castlight, and HealthSparQ are examples of private vendors that use claims data and other information from insurers and employers to generate "fair price" cost estimates for various medical services. Basic consumer tools may be offered for free, but companies

often offer additional paid services that provide quality and cost information about providers. Such for-profit tools are generally marketed to large employers or health insurers, who make the tools available to employees or plan members.

PRICE VARIATIONS ACROSS SITES OF SERVICE

Resolution 819-I-14 asked that the AMA develop an educational program that would help explain site of service price and reimbursement differences. The Medicare program and private insurers frequently pay different rates and impose different patient cost-sharing amounts for the same service, depending on where it is performed. These site of service differentials primarily result from separate Medicare payment methodologies that are used for physician offices, ambulatory surgical centers (ASCs) and hospital outpatient departments (HOPDs). Medicare generally pays lower rates for services performed in a physician's office, and patient cost-sharing is also lower. Payment rates and cost-sharing are greater for services delivered in ASCs, and are generally highest for services delivered in HOPDs. Most private insurers mirror Medicare's fee schedule.

CMS Report 3-A-13, "Payment Variations across Outpatient Sites of Service," and CMS Report 3-A-14, "Medicare Update Formulas Across Outpatient Sites of Service," provide detailed information about the disparity in payments and patient cost-sharing for procedures performed across outpatient sites of service. The AMA also developed a concise briefing document, "Payment Variations across Outpatient Sites of Service," that discusses price and payment disparities across sites of service, and highlights policies that promote equitable payments across sites of service and enable patients to seek care in the most appropriate and cost-effective care setting. Reference Committee testimony on Resolution 819-I-14 highlighted these resources and suggested that they effectively achieve the intent of an educational program related to site of service price differences.

In addition, Council on Medical Service Report 2, "Physician Payment by Medicare," also before the House at this meeting, addresses the impact of hospital acquisition of physician practices on health care costs, patient access to health care and physician practice. The report includes a discussion of the impact of hospital acquisition of physician practices on health care costs.

DISCUSSION

Policy D-155.989 and referred Resolution 819-I-14 specifically address the need for increased price transparency, which is widely seen as essential for controlling health care costs. According to analyses by the Catalyst for Payment Reform, the overall functionality and utility of price transparency tools is improving. Patients generally have access to pricing estimates for a broader range of services and procedures, and many tools include options that can estimate costs for a full episode of care. Some health plans and vendors are introducing tools that provide provider-specific cost estimates for some common, elective procedures and services, although antitrust concerns or contractual restrictions can present barriers to comparative cost estimates for specific providers.

Successful implementation of any price transparency program will require cooperation and collaboration by all stakeholders. With approximately 87 percent of Americans covered by private or public health insurance, third-party payers control most of the information necessary to help patients understand the costs associated with the health care services they receive. Nevertheless, the Council believes physicians can provide leadership by demonstrating a willingness to communicate information about the cost of their professional services, which is particularly important in cases where physicians are not part of a patient's insurance network. As narrow networks gain market share, increasing numbers of patients may find themselves intentionally or inadvertently receiving out-of-network care. In such cases, patients need to know directly from their physicians what their total bill will be in order to determine total out-of-pocket obligations.

Our AMA should continue to advocate that health plans provide enrollees with complete information regarding plan benefits and cost-sharing information, such as the amount paid toward the deductible and annual out-of-pocket maximum, patient cost-sharing responsibilities associated with specific in-network providers or services, and specific amounts the insurance company would pay for out-of-network providers or services. Likewise, the Council recommends reaffirming Policy H-373.998, which supports empowering patients with understandable fee/price information, and challenges physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers to make this information available to patients.

The Council was encouraged to learn about the progress that has been made to advance price transparency in health care. It is critical that our AMA engage actively and positively with health plans, public and private entities and other stakeholders in their work promoting better, more actionable price and quality transparency. Physicians should find ways to facilitate price transparency efforts, and help ensure that entities promoting price transparency tools and services have processes in place to ensure the accuracy and relevance of the information they provide. Our AMA is already engaged in helping states advance the development and use of APCDs, and should continue supporting the growth of these valuable sources of information related to health care costs. The Council also believes that electronic health records (EHR) have the potential to facilitate price transparency, and recommends that our AMA encourage EHR vendors to include these capabilities as EHR products continue to evolve.

Efforts to promote price transparency and help patients better prepare for their out-of-pocket costs are highly dependent on a patient's willingness and ability to become a more engaged purchaser of health care. Patients need to be better educated about the complexity of health care pricing, including the implications of in-network and out-of-network coverage rules and out-of-pocket spending obligations. Our AMA should encourage efforts to promote health care economics literacy that give patients tools and information to allow them to be more proactive in researching the cost of health care services they receive or anticipate receiving.

The Council recommends rescinding Policy D-155.989, which was accomplished with this report.

RECOMMENDATIONS

The Council recommends that the following be adopted in lieu of Resolution 819-I-14, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-373.998, which supports the principle that all health care providers and entities should be required to make information about prices for common procedures or services readily available to consumers.

2. That our AMA encourage physicians communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.

3. That our AMA advocate that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.

4. That our AMA actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.

5. That our AMA work with states to support and strengthen the development of all-payer claims databases.

6. That our AMA encourage electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

7. That our AMA encourage efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

8. That our AMA request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

9. That our AMA rescind Policy D-155.989, which requested this report.

REFERENCES

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5. HOSPITAL INCENTIVES FOR ADMISSION, TESTING AND PROCEDURES

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2014 Annual Meeting, the House of Delegates adopted Policy D-215.989, which states:

> That our American Medical Association (AMA) will study the extent to which US hospitals interfere in physicians' independent exercise of medical judgment, including but not limited to the use of incentives for admissions, testing and procedures.

This report, which is presented for the information of the House, provides background on physicians' concerns about hospital interference in their independent exercise of medical judgment, emphasizes the importance of hospital-employed physician satisfaction and quality care, reviews hospital practices, identifies AMA resources and advocacy efforts, and summarizes AMA policy.

BACKGROUND

As more physicians become employed by large corporate health systems there are concerns that they may be pressured to admit patients to their health system's affiliated hospital and order more tests and procedures than necessary to avoid disciplinary actions or termination.

The media has presented examples in which hospital-employed physicians were encouraged to adopt practices to meet the hospital's financial goals. Some physicians reported being pressured to admit patients to the hospital if they could in any way justify the admission even if they did not deem inpatient care necessary. Other physicians described situations in which they had been told not to discharge patients until the time at which the maximum allowed Medicare payment had been reached. Some physicians stated that they had been monitored on how much revenue they brought into their hospital through the ordering of tests and procedures. These examples, if accurate, indicate potentially fraudulent practices. But it is difficult to determine how widespread the problem is.

HOSPITAL-EMPLOYED PHYSICIAN SATISFACTION AND QUALITY CARE

According to the AMA 2014 Physician Practice Benchmark Survey, 26 percent of physicians work in practices that are at least partially owned by a hospital, and another 7 percent are direct hospital employees.[1] Hospital-employed

physicians are expected to adhere to the policies of their employer, which potentially may be in direct opposition to their clinical expertise, ethical standards and commitment to their patients' well-being. According to a 2013 RAND Corporation study sponsored by the AMA (AMA-RAND study), being able to provide high-quality health care is a key component of job satisfaction among physicians, and obstacles to quality patient care are sources of dissatisfaction. The AMA-RAND study concluded that aligning values between physicians and practice leadership is an important contributor to physicians' professional satisfaction and a lack of control over operational, business, or managerial decisions affecting patient care can cause dissatisfaction. Including hospital-employed physicians in organizational decisions and leadership roles can help align priorities and goals, and is an important aspect of physician satisfaction and quality patient care.

HOSPITAL PRACTICES

The Centers for Medicare & Medicaid Services reported that hospital care represented about 30 percent of the $2.9 trillion in total expenditures for 2013, accounting for the largest share of health care spending.[2] The majority of hospitals and their employed physicians work in a fee-for-service environment that incentivizes volume of care, which can influence the frequency of hospital admissions and the ordering of tests and procedures. Recent studies have determined that hospital admission rates vary considerably across individual providers and emergency departments.[3,4] It is uncertain if the variations in admission rates represent inappropriate admissions or underutilization of hospital services. A study conducted by researchers at Beth Israel Deaconess Medical Center and Harvard Medical School found that approximately 30 percent of the most commonly performed hospital tests are unnecessary.[5]

Because physicians are increasingly entering into employment and other contractual relationships with hospitals, group practices, and other entities, the AMA offers a variety of resources to help meet the unique needs of physicians in this practice environment.

AMA RESOURCES

The AMA Office of General Counsel and Organized Medical Staff Section (OMSS) have developed the Annotated Model Physician-Hospital Employment Agreement as a resource to help prepare physicians to negotiate an employment contract with a hospital or related entity. This manual is not intended to be a substitute for legal advice from qualified, health care counsel experienced in representing physician clients. Instead, it provides a thorough description of basic contract terms typically found in employment agreements, as well as in-depth explanations of contract language that benefit physician employees and language that could be problematic.

The AMA has also developed educational webinars to assist physicians with employment arrangements. The 90-minute webinar, Negotiating Your Employment Contract, was developed by the OMSS and is available for continuing medical education (CME) credits. It describes how to negotiate with potential employers to develop an optimum employment agreement, addresses key areas to consider when reviewing a contract, and provides insight on negotiation details such as the provisions of an employment agreement that are most likely to be negotiable.

Another 90-minute webinar, AMA Principles for Physician Employment, was produced jointly by the AMA and the American Bar Association and is also available for CME credits. It provides an overview of AMA principles and their application to real-world situations in which the interests of the employer may differ from those of physicians and patients.

The Resident and Fellow Section also offers a webinar, Physician Employment Contracts, as part of a series of webinars to help medical students, residents, fellows and young physicians confront the nonclinical demands in a medical practice environment.

AMA ADVOCACY

Advocacy Resource Center

The corporate practice of medicine doctrine prohibits corporations from practicing medicine or employing a physician to provide professional medical services. While most states prohibit the corporate practice of medicine, almost every state has broad exceptions, such as for employment of physicians by certain health care entities.

Many states that allow hospitals to employ physicians specifically prohibit hospitals from interfering with the independent medical judgment of physicians in order to protect clinical decision-making. At the request of state medical associations, the AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs.

AMA Litigation Center

The AMA supports the self-governance of organized medical staffs and the enforceability of medical staff bylaws. In a recent Minnesota case, *Avera Marshall Medical Staff* v. *Avera Marshall Regional Medical Center*, the AMA Litigation Center filed friend-of-the-court briefs before the Minnesota Supreme Court and the Minnesota Court of Appeals on behalf of the medical staff of Avera Marshall Regional Medical Center. In addition, the Litigation Center provided financial and legal support to the medical staff, which had been seeking to re-establish its autonomy after the hospital governing board unilaterally amended the medical staff bylaws. The move threatened to prevent the medical staff from fulfilling its responsibility to oversee patient safety within the hospital.

Ultimately, the Minnesota Supreme Court overturned earlier rulings in this case in which the lower courts had said the medical staff lacked the capacity to sue the hospital for inappropriate actions and the medical staff bylaws did not constitute an enforceable contract between the hospital and medical staff. There are other cases in which the AMA Litigation Center has supported hospital medical staffs.

RELEVANT AMA POLICY

AMA policy emphasizes that the essential components of a contractual or financial arrangement between hospitals and hospital-associated physicians should be fair to all parties, promote the interests of patients, adhere to the ethical principles of medicine and support the provision of high quality health care and services (Policies H-225.997 and H-225.950).

When entering into a contract with health systems or hospitals, physicians should be aware of the potential for these entities to create conflicts of interest due to the use of financial incentives in the management of medical care (Policies H-285.951 and H-225.950). AMA policy opposes physician economic incentives that conflict with patients' welfare and believes the physician must remain the patient's advocate in the patient's relationship with the hospital (Policy H-225.986). AMA policy states that the use of financial incentives in the management of medical care should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care (Policy H-85.951). Pay-for-performance programs must not financially penalize physicians based on factors outside of the physician's control (Policy H-450.947). The AMA believes that physicians should be able to advocate for their patients' best interest without retaliation from their employer (Policies H-225.950 and H-225.952).

AMA Policy H-225.952 and Ethical Opinion E-10.015 support protecting a physician's right to freely exercise independent medical judgment, holding the best interests of the patient as paramount. The following professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician: the diagnostic tests that are appropriate, when and to whom physician referral and consultation is indicated, when hospitalization is necessary and the length of stay, and when surgery and invasive procedures are needed (Policies H-285.954, H-225.997 and H-320.965). As expressed in Policy H-315.995 it is the physician's responsibility to specify all diagnoses and procedures in the hospital records and no alterations should be made without his or her consent. A physician should not provide, prescribe or seek compensation for services he or she knows to be medically unnecessary, as treatment or hospitalization that is willfully excessive constitutes unethical practice (AMA Ethical Opinions E-2.19, E-4.04 and E-6.05).

Council on Ethical and Judicial Affairs Report 3-A-15, "Modernizing the *Code of Medical Ethics*," also before the House at this meeting, proposes consolidating and streamlining ethical opinions, including areas relevant to contracts, transparency and professionalism in the health care system.

DISCUSSION

The AMA is continuing to study the extent to which hospitals interfere in physicians' independent exercise of medical judgment. The Council believes that ensuring patient safety and professional satisfaction require hospital-employed physicians to preserve their clinical judgment.

The Council encourages physicians to use AMA resources when considering hospital employment. It is important that a physician consider all aspects of a contract before accepting an offer of employment. State medical associations and the AMA are useful resources if hospital-employed physicians want to seek advice on clinical practices requested of them by their hospital employer. The Council believes the AMA has sufficient resources and policy to help physicians prepare for hospital employment and to advocate on their behalf.

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6. INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED
See Policy H-345.983 and H-385.915

At the 2014 Annual Meeting, the House of Delegates adopted Policy D-345.987, which states:

> That our American Medical Association (AMA), along with interested specialty and state societies, will study and report back at the 2015 Annual Meeting on our current state of knowledge regarding integration of physical and behavioral health care, including pediatric and adolescent health care, and make recommendations for further study, implementation of models of physical and behavioral health care integration, and any other tools or policies that would benefit our patients and our health care system by the integration of physical and behavioral health care.

In response to the request in Policy D-345.987 for the AMA to work with interested specialty and state societies on this issue, the Federation was solicited for input. The Council received responses from the following national medical specialty societies and state medical associations: American Academy of Child and Adolescent Psychiatry/American Association of Child & Adolescent Psychiatry, American Psychiatric Association, Colorado Medical Society, Minnesota Medical Association, Medical Society of New Jersey and the Medical Society of Virginia. These national medical specialty societies and state medical associations are involved in a variety of activities to integrate physical and behavioral health care. The Council greatly appreciates all the information that was submitted and took it into consideration when developing this report.

This report provides background on the movement toward integrated physical and behavioral health care; presents examples of integrated care approaches, including for children and adolescents; highlights state and specialty society activities; identifies medical and continuing education opportunities; explains payment options for integrated care; summarizes relevant AMA policy; discusses barriers and potential solutions to implementing integrated care; and presents policy recommendations.

BACKGROUND

Less than half of the 43 million adults identified with a mental illness and the 6 million children identified as suffering from an emotional, behavioral, or developmental issue receive treatment.[1] Mortality rates for individuals with behavioral health conditions are estimated to be twice as high as in the population as a whole.[2] Individuals with a mental illness and coexisting physical health condition experience an increased risk of adverse health outcomes. However, research indicates that coordinated care management of mental and physical health conditions improves disease control.[3]

There is an increasing emphasis to integrate the delivery of physical and behavioral health care in one setting. The movement toward an integrated delivery approach stems from clinical factors such as: the majority of behavioral health care takes place in primary care settings, some of which lack psychiatric resources; many individuals with behavioral health conditions do not experience coordinated care for their comorbid conditions; and some patients feel more comfortable receiving behavioral health care in their medical home. Financial costs also play a role in the focus to integrate care. A 2014 Milliman economic analysis estimated that health care spending for individuals with behavioral health needs is $525 billion annually. Furthermore, medical costs for treating individuals with physical and behavioral health conditions can be 2-3 times higher than medical costs for individuals without comorbid conditions. The analysis concluded that effective integration of physical and behavioral health care could save $26-$48 billion dollars annually in general health care costs.[4]

CONTINUUM OF INTEGRATED CARE

A continuum of treatment approaches provide integrated physical and behavioral health care ranging from coordinated care to full team-based integration. Coordinated care involves primary care physicians routinely screening patients for behavioral illnesses and behavioral health providers screening patients for physical illnesses. Patients are then assisted in obtaining the prescribed behavioral health or physical health care treatment(s). Next on the continuum are primary care physicians who consult with psychiatrists who are not physically located in the practice setting. Co-location further integrates care by having behavioral health and primary care providers share a physical space to collaborate on patients' care. The most integrated treatment approach "embeds" behavioral health providers in primary care teams that maintain one treatment plan to address all of a patient's health needs in a shared medical record. Some models integrate primary care providers and services into behavioral health care settings especially for patients with more severe behavioral health conditions.

EVIDENCE-BASED INTEGRATED CARE

Among the most advanced and evidence-based integrated care models is the collaborative care model (CCM), which the University of Washington in Seattle has been developing and testing for the past 20 years. A meta-analysis of 57 treatment trials concluded that a CCM can improve physical and behavioral health outcomes across a wide variety of care settings.[5] According to the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center, CCM is defined as a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach. The specific principles of care for this model include patient-centered care, population-based care, measurement-based treatment, evidence-based care, and accountable care.[6] The AIMS Center has developed a step-by-step guide to provide a broad overview of the major steps needed to successfully implement a CCM program.[7]

Integrated physical and behavioral health care should include telemedicine as needed. Especially in areas with a physician workforce shortage, telemedicine can improve access to behavioral health care. The AMA has policy and advocacy resources related to telemedicine.

PEDIATRIC AND ADOLESCENT INTEGRATED HEALTH CARE

Improved access to mental health services for children, adolescents and their families is a priority for the American Academy of Child and Adolescent Psychiatry (AACAP). AACAP has developed best practices for integrating child and adolescent psychiatry into the pediatric health home to provide access to high quality mental health care. The principles include family-focused care, professional collaboration between primary care providers and child and adolescent psychiatrists, care plan development for children and adolescents with complex mental health needs, and care coordination.[8]

An example of a large pediatric medical home that provides integrated care is Goldsboro Pediatrics in North Carolina. The state is using concurrent 1915(b) and 1915(c) Medicaid waivers to provide a continuum of services to individuals with mental illnesses, developmental disabilities and substance use disorders. Through the waivers, Goldsboro Pediatrics has been supervising integrated care in six school-based health centers for more than 10 years. The health centers are integrated into the medical home through an electronic health record system. More than 5,000 behavioral health consultations are provided each year by private sector mental health professionals for at-risk students in the school-based health centers. Parents or guardians are invited to be involved in the treatment of their children. If needed, telemedicine consultation is provided.

STATE ACTIVITY

State activities to integrate care range from federally funded initiatives to local community networks. Following are three examples:

Colorado

In December 2014, Colorado was awarded a State Innovation Model grant of $65 million through the Centers for Medicare & Medicaid Services (CMS) to implement and test its state health care innovative plan, "The Colorado Framework." The funding will assist Colorado in integrating physical and behavioral health care for 80 percent of the state's residents in more than 400 primary care practices and community mental health centers comprised of approximately 1,600 primary care providers. The plan will create a system of clinic-based and public health supports to improve integration.

Massachusetts

The Massachusetts Child Psychiatry Access Project (MCPAP) aims to increase behavioral health screening and treatment for pediatric patients throughout the state. Any primary care provider can register with the program and receive phone and face-to-face behavioral consultations, help with referring children to community behavioral health centers, and continuing education through workshops and webinars. In 2014, the program included 455 practices, which totaled 2,915 primary care providers.[9]

Virginia

The North Virginia Primary Care/Mental Health and Patient Centered Medical Home (NoVa PCMH) Collaborative is a network of more than 100 primary care physicians, psychiatrists, psychologists and other mental health clinicians in Northern Virginia developed to provide mental health resources to primary care physicians. A website facilitates virtual consultations, connects local clinicians, stimulates collaboration about clinical situations, provides local resources, and develops relationships to foster potential co-location of mental health clinicians in primary care practices.

INTEGRATED MEDICAL AND CONTINUING EDUCATION

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) released a resource identifying core competencies on integrated practice relevant to behavioral health and primary care providers.[10] The recommended core competencies include: interpersonal communication, collaboration and teamwork, screening and assessment, care planning and care coordination, intervention, and cultural competence and adaptation. The development of these core competencies is intended to serve as a resource for provider organizations developing an integrated care practice as well as for educators who are developing curriculum and training programs.

The American Psychiatric Association (APA) recently reviewed the undergraduate, graduate medical education and continuing medical education environment to examine the availability of education on integrated health care.[11] The APA found that undergraduate medical education in integrated care is in the early stages of development, but that a significant number of general psychiatry and child and adolescent psychiatry residency programs are offering rotations and/or didactics in integrated care. The APA has taken a leading role in developing continuing medical education (CME) on integrated care through developing seminars and training programs, and providing courses at

APA meetings as well as online. The APA acknowledges that CME providers with a large multispecialty audience are in a strong position to offer multidisciplinary and multispecialty CME on integrated care.

PAYMENT FOR INTEGRATED CARE

A high prevalence of individuals with behavioral health disorders are seen by primary care physicians who may be unaware of payment options for providing both physical and behavioral health services in one day. According to the AMA's 2015 Current Procedural Terminology (CPT®) codebook,[12] patients can receive a medical evaluation and management (E/M) service on the same day as a psychotherapy service by the same physician. To report both E/M and psychotherapy, the two services must be significant and separately identifiable. These services are reported by using specific add-on codes for 30, 45 or 60 minute psychotherapy sessions (90833, 90836 and 90838) when performed in conjunction with E/M codes (99201-99255, 99304-99337, 99341-99350). Primary care physicians are not excluded from using these codes, however, private insurers may differ on whether they recognize them and pay for the services.

Medicare

Effective January 2015, primary care physicians can bill for chronic care management provided to their Medicare fee-for-service patients. The new CPT® code (99490) allows physicians to bill for non-face-to-face care for Medicare beneficiaries with two or more chronic conditions, including depression and anxiety. The code requires at least 20 minutes of chronic care management per month, such as reviewing lab reports, talking with families and patients by phone, arranging referrals, and helping to order medical equipment. Physicians can receive $42.60 per patient per month for providing these services.

Medicaid

Some state Medicaid programs prohibit same-day billing for physical and behavioral health care. The inability to receive both services on the same day is a significant barrier to integrated treatment for Medicaid beneficiaries.

In 2014, CMS released new guidance on the rule "Medicaid Payment for Services Provided without Charge" ("Free Care"). Schools that offer physical and behavioral health screenings to all children free of charge can now receive Medicaid payment for services provided to Medicaid-enrolled children as long as the services are covered under the state Medicaid plan. Not all state Medicaid plans cover these services, nor do all schools provide them. This new guidance allows for early identification and intervention in schools for all children with early-stage mental health conditions.

RELEVANT AMA POLICY

AMA policy supports access to and payment for integrated physical and behavioral health care regardless of the clinical setting and standards that encourage medically appropriate treatment of physical disorders in psychiatric patients and of psychiatric disorders in patients receiving medical and surgical services (Policy H-345.983). In addition, policy encourages the development of clinical approaches designed to improve outcomes for patients with depression and other mental illnesses who are seen in general medical settings (Policy H-345.984).

An adequate supply of psychiatrists, appropriate payment for all services provided, and sufficient funding levels for public sector mental health services is needed (Policies H-345.981, D-345.997, H-345.980 and H-345.978). Policy supports mental health insurance parity for mental illness, alcoholism, and related disorders under all governmental and private insurance programs (Policies H-165.888 and H-185.974).

AMA policy advocates for the provision of an adequate number of public psychiatric beds, comprehensive inpatient care, a full continuum of community-based outpatient psychiatric services, and the evolution of psychiatrist-supervised mental health care homes (Policies H-345.978 and H-345.976).

Age-appropriate education should be provided to students from preschool through high school, and to parents and caregivers, regarding mental illness (Policy D-345.994). Teacher education initiatives should be developed to help identify children at risk for psychiatric illnesses and potentially dangerous behaviors (Policy H-60.946). AMA policy encourages medical schools and primary care residencies to include the appropriate training to enable

graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition (Policy H-345.984). Policy also urges physicians to become more involved in pre-crisis intervention and treatment of chronically mentally ill patients (Policy H-345.995).

AMA policy emphasizes the need for mental health screening in routine pediatric physicals and recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children and adolescents have access to appropriate mental health screening and treatment services (Policy H-345.977).

DISCUSSION

There is an increasing recognition that the health of an individual includes both physical and behavioral components that should be treated holistically. Since a high prevalence of individuals with behavioral health disorders are seen by primary care physicians, there is a movement toward integrating the delivery of physical and behavioral health care in one setting. A key barrier to integrated treatment is the lack of payment for services provided on the same day. Accordingly, the Council suggests encouraging Medicaid and private health insurers to pay for physical and behavioral health care services provided on the same day.

Until integrated physical and behavioral health care is provided as early as possible to our nation's children, the lack of comprehensive services will continue to have devastating consequences for individuals and the health of our society. As such, the Council suggests encouraging state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings in order to identify and treat behavioral health conditions as early as possible.

A continuum of treatment options exists to integrate care for physical and behavioral health conditions. With knowledge of these various approaches, physician practices can choose the ones that fit best for their patient population and delivery model. The Council believes practicing physicians should seek out continuing medical education opportunities on integrated physical and behavioral care.

The Council recommends reaffirming Policy H-345.983, which endorses access to and payment for integrated physical and behavioral health care, and rescinding Policy D-345.987, which calls for the study that has been accomplished by 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) reaffirm Policy H-345.983, which endorses access to and payment for integrated physical and behavioral health care, and supports standards that encourage medically appropriate treatment.

2. That our AMA encourage private health insurers to recognize CPT® codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day.

3. That our AMA encourage all state Medicaid programs to pay for physical and behavioral health care services provided on the same day.

4. That our AMA encourage state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings.

5. That our AMA encourage practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care.

6. That our AMA promote the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.

7. That our AMA rescind Policy D-345.987.

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7. PHYSICIAN ACCESS TO ACO PARTICIPATION

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2014 Annual Meeting, the House of Delegates adopted Policy D-160.930, which calls on the American Medical Association (AMA) to study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. be excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (c) the implications of such criteria and processes for patient access to care outside the ACO; and (d) the effect of evolving system alignments and integration on physician recruitment and retention.

The following report, which is presented for the information of the House, provides background on different types of ACOs and addresses the issues raised in Policy D-160.930.

BACKGROUND

The ACO concept encompasses both a care delivery model and a provider payment model. ACOs are characterized by groups of providers who work together to provide coordinated care to a defined set of patients, and who agree to be held collectively responsible for the quality and cost of that care. As a payment model, ACOs are legal entities that enable clinically integrated provider groups to enter into contracts with third party payers that allow the providers to share in the savings, or losses, associated with the care provided to a specific patient population. The

savings accrued or losses incurred by an ACO are determined by its performance relative to quality benchmarks and risk adjusted spending targets established by the payers for a defined performance period. Base payment arrangements for ACOs and their participating providers could include fee-for-service or some form of capitated payments.

There is no single set of rules or characteristics that govern the formation or operation of an ACO. Broadly speaking, all ACOs are provider-led entities organized around the goals of improving patient outcomes, improving the experience of care, and lowering costs. The scope of these goals and how they are achieved varies, however, and may depend on the requirements and expectations of the payer or payers with whom an ACO contracts.

Leavitt Partners, a health care consulting firm, uses the concepts of integration, differentiation, and centralization to describe broad categories of ACOs.[1] Integration refers to the services the ACO directly provides to its patient population (e.g., outpatient, inpatient, or "full spectrum," which includes ambulatory and hospital care, along with other services such as post-acute care). Differentiation refers to the range of services that the ACO accepts responsibility for, either by providing the services directly, or by contracting with other providers. Centralization refers to the ownership of the ACO, specifically whether it is owned by a single entity or is a partnership among multiple owners. Using these concepts, Leavitt Partners describes the following six distinct types of ACOs:

- Independent Physician Group ACO: Single ownership, representing smaller physician groups that accept responsibility for providing outpatient care (generally limited to primary care) directly to their patient population.

- Physician Group Alliance ACO: Joint ownership between two or more multi-specialty physician groups that accept responsibility for providing outpatient care directly to their patient populations.

- Expanded Physician Group ACO: May include single or multiple owners, but characterized by providing outpatient care directly to their patient population and contracting with other providers to provide hospital or other services.

- Independent Hospital ACO: Single ownership that directly provides inpatient care. Outpatient services may be provided directly if owner is an integrated health system or physician-hospital organization, or may contract with other providers.

- Hospital Alliance ACO: Multiple owners with at least one owner providing direct inpatient services. Participants in this type of ACO tend to be smaller hospitals or hospital systems or small physician groups, particularly in rural areas.

- Full Spectrum Integrated ACO: May include single or multiple owners, but characterized by providing all aspects of care directly to patients.

Leavitt Partners' ACO taxonomy is useful for understanding the variety of organizational structures that are commonly used to help ACOs achieve their goal of better care at a lower cost, and underscores the diversity that exists in the ACO marketplace.

MEDICARE AND PRIVATE PAYER ACOS

The Centers for Medicare & Medicaid Services (CMS) offers three ACO contracting opportunities for Medicare providers. The Pioneer ACO program is administered by the Center for Medicare and Medicaid Innovation (the Innovation Center), and was designed to support provider systems that already had experience delivering integrated care to patient populations. Only 19 ACOs participate in this program. The Medicare Shared Savings Program (MSSP) is a much larger program, established by the Affordable Care Act (ACA) in order to encourage the development of ACOs to provide care for Medicare beneficiaries. Although all ACOs participating in the MSSP must meet certain requirements, the ACA and subsequent regulations allow considerable flexibility with respect to the specific composition and governance structure of an eligible ACO. More than 405 MSSP ACOs serving more than seven million beneficiaries have been established since passage of the ACA.[2]

In March 2015, the Innovation Center announced that it would accept applications for provider groups interested in participating in the Next Generation ACO Model. Participating ACOs will assume greater financial risks and have the potential to earn greater financial rewards than Pioneer ACO or MSSP participants. The Next Generation ACO Model will use a different benchmark methodology to determine ACO performance, and includes new tools that facilitate increased patient engagement and care coordination. According to CMS, the new model is intended to test whether increased financial incentives and patient engagement tools result in better health outcomes and lower costs for Medicare fee-for-service beneficiaries.[3]

Being an ACO is not synonymous with participating in a Medicare ACO initiative. Many other ACOs have been formed or are operating under contracts with private payers. Estimates of the total number of ACOs in the US vary, largely because there is no central list of non-Medicare ACOs and it can be difficult to identify ACO contracts with private payers. Leavitt Partners estimates that there are more than 600 ACOs operating across the US.[4] The majority of ACOs contract with public payers, but several private insurers, including Cigna, Aetna and UnitedHealthcare, have contracts with ACOs, as do a small number of self-insured employers. Leavitt estimates there are approximately 20.5 million patients enrolled in ACOs across the country. Oliver Wyman, another health care consultancy, estimates that more than two-thirds of Americans live in an area where an ACO is in operation.[5]

ACO NETWORK DEVELOPMENT AND CONTRACTING

The focus of Policy D-160.930 is on strategies ACOs use to include or exclude physicians from participation in the ACO. Unlike a managed care or provider network developed by an insurer, the composition and membership of an ACO is determined by providers. As provider-led entities, ACO leaders determine the particular goals and priorities they want their ACO to achieve, and then recruit and secure contracts with physicians and other providers who can help achieve those goals.

ACO networks are designed to meet the quality and cost transformation goals of the ACO. Participating physicians and other providers must be able to demonstrate a commitment to the clinical and financial goals identified by the ACO, and a willingness to transform clinical practices and participate in data collection and sharing efforts that support the goals of the ACO. In many cases, ACO networks may be developed based on existing formal or informal professional relationships between providers in a local community.

Local trends among payers offering risk-based contracting arrangements are likely to influence some decisions with respect to how physicians or physician groups are selected to participate in ACO networks. Contracts with payers will help determine the scope of services for which the ACO is responsible, specific cost and quality targets, reporting requirements, shared savings arrangements, and definitions of total quality of care. ACO leaders are likely to consider whether the inclusion of a physician or practice would contribute to the ability of an ACO to negotiate a strong payer contract and to successfully meet the terms of the contract.

For example, under current MSSP regulations, beneficiaries are retrospectively assigned to a Medicare ACO based on the patient receiving a "plurality" of primary care services from physicians within that ACO. Although CMS does not define the types of providers or services that must be included in an ACO, using primary care services as the basis of patient assignment requires that, at a minimum, an ACO include providers qualified to provide primary care services. Medicare ACOs must also agree to accept responsibility for at least 5,000 Medicare beneficiaries. Accordingly, groups wishing to form a Medicare ACO must ensure sufficient capacity among participants to care for and report data on a 5,000 member patient panel.

MSSP RULES REGARDING ACO PARTICIPATION

Publicly available information about specific contracting arrangements between physicians and ACOs is extremely limited, especially for ACOs that contract with private payers. The current rules governing the MSSP provide limited guidance regarding physician selection and deselection processes. Per the ACA, an ACO can be comprised of one or multiple types of providers or groups of providers, including group practices, networks of individual physicians and hospitals. ACOs must submit an application to CMS to participate in the MSSP, which includes several questions and attestations about provider participation and processes for ensuring accountability for the quality, cost and overall care of patients.[6] Prior to applying for MSSP participation, an ACO must secure individual agreements with all entities (defined as "participants" by CMS, and identified by a single Tax Identification Number [TIN]) confirming their participation in the ACO and agreeing to comply with the regulations governing the MSSP.

Since CMS currently uses Medicare-enrolled TINs to identify ACO participants, all providers who bill under a single TIN are considered part of the ACO. Accordingly, CMS also requires that ACOs ensure that all individual providers billing through the TIN have agreed to participate in the MSSP program and follow the program regulations. Individual physicians who are associated with a TIN that has a Medicare ACO contract cannot opt out of ACO participation, and cannot participate in more than one ACO that has a TIN number used to bill for primary care services. Entities that are unable to secure such agreements with all providers billing under a single TIN may not form a Medicare ACO.

The MSSP application also requires that ACOs specify "remedial measures that will apply to ACO participants and providers/suppliers who do not follow the requirements of their agreements with the ACO." ACO applicants are required to:

> submit a narrative describing how [the] ACO will require ACO participants and providers/suppliers to comply with and implement a quality assurance and improvement program including, but not limited to…processes to promote evidence-based medicine, beneficiary engagement, coordination of care, and internal reporting on cost and quality. Please include a description of remedial processes and penalties (including the potential for expulsion) that would apply for non-compliance.

Expelling a physician from a Medicare ACO would require severing the relationship between the physician and the TIN, or terminating the ACO agreement with the entire entity represented by the TIN, because all physicians billing under a single TIN are considered part of an ACO under current MSSP rules.

While not directly related to the processes by which physicians are selected to join an ACO, CMS' current method of beneficiary assignment may result in physicians being *de facto* excluded from participation in an ACO. Under MSSP rules, physicians that bill primarily for primary care services cannot participate in more than one ACO. This is because, as noted, beneficiary assignment is based on CMS' determination that a physician has provided a plurality of primary care services to a beneficiary during the benchmark period. According to current MSSP rules, non-primary care specialists are allowed to participate in more than one ACO, but CMS' beneficiary assignment methodology often makes this impractical or even impossible. CMS' decision to link providers and ACOs by TIN limits the flexibility of specialist physicians who wish to participate in more than one ACO by necessitating that they bill under a different TIN if they want to participate in multiple ACOs. In addition, in some cases, CMS has attributed non-primary care specialists' patients to ACOs based on office visits with those specialists, forcing ACO exclusivity.

In December 2014, CMS published a proposed rule that, once finalized, will change some of the regulations governing the MSSP ACOs. One of the new policy proposals, which the AMA supported, designates a list a specialties that will never be included in the beneficiary assignment process, thus allowing these specialist physicians, such as surgeons, to be involved with multiple ACOs. The AMA comments on the proposed rule also encouraged CMS to provide flexibility for specialist physicians who want to participate in more than one ACO by examining the possibility of using a combination of TIN and National Provider Identifier, instead of TIN alone, so that specialty and subspecialty physicians who provide some primary care services could choose on an individual basis whether or not to have these services included in the ACO beneficiary assignment process.[7]

PATIENT ACCESS TO CARE

Although it is to an ACO's advantage to directly or indirectly control all aspects of patient care, receiving care from an ACO does not, per se, limit a patient's ability to seek care outside the ACO. MSSP ACOs are expressly prohibited from restricting patient access to care outside the ACO, which has resulted in some MSSP ACO participants expressing concern about being held responsible for ACO-assigned patients who choose to receive care outside of the ACO. As noted, the Next Generation ACO Model includes components that are specifically intended to strengthen a beneficiary's engagement with an ACO, including allowing patients to confirm their relationship with ACO providers, and establishing incentives for patients to receive care from the ACO. Regardless of these incentives, however, beneficiaries retain access to their choice of services and providers under the original fee-for-service Medicare rules.[8]

The ACA and subsequent regulations ensure that Medicare beneficiaries have access to any physician who treats Medicare patients, regardless of whether the care is provided within or outside of an established ACO. Current

MSSP rules assign patients to ACOs retrospectively based on whether the patient receives primary care services from a physician who participates in an ACO. However, even when patients are assigned to an ACO, they retain the right to seek care from any physician who treats Medicare patients. In the December 2014 proposed rule, CMS proposed, and the AMA supported, establishing a process to allow patients to voluntarily align with an ACO.

It is to the ACO's advantage to encourage participating providers to refer patients to other providers within an ACO when appropriate, or to establish relationships with individual physicians or entities that provide care to its patient population but are not participants in its ACO network. MSSP ACOs are held accountable for the total cost of care for their attributed patient populations, whether ACO participating providers deliver that care or not. In addition to contracts with ACO participant providers, MSSP ACOs can also contract with physicians or facilities as "other entities," a designation that compels the contracted provider to comply with MSSP program rules and potentially qualify for shared savings, but does not require exclusive affiliation with one ACO.

It is unclear how private payers are integrating ACO contract arrangements with their plan offerings and benefit design structures. At this point, it is likely that plan offerings that involve receiving care from an ACO are being developed separately from broader plan network development strategies. Because there are still relatively few ACO-type contract arrangements with private payers, plan enrollees may have the option of receiving care from an ACO-affiliated provider where available, but retain access to the full panel of network providers. Private payers could potentially design plans that include incentives for patients to seek care from an ACO and within a single ACO network, as long as the network of physicians participating in the ACO satisfies established network adequacy requirements.

AMA POLICY AND RESOURCES

Policy D-385.963 encourages physicians "to make informed decisions before starting, joining, or affiliating with an ACO." The AMA has developed multiple resources to assist physicians with evaluating their options related to participation in ACOs or other practice arrangements. "Competing in the Marketplace: How physicians can improve quality and increase their value in the health care market through medical practice integration, third edition" describes a range of integration possibilities that address the desire of many physicians to retain some level of autonomy while also acknowledging the realities of today's marketplace.[9] "ACOs and other options: A 'How to' Manual for Physicians Navigating a Post-Health Reform World," provides a detailed overview of the various options physicians have in the changing environment, including the benefits and challenges associated with establishing or participating in physician and other health care provider collaboratives.[10] In addition, AMA comment letters, papers prepared by the AMA Innovators Committee, and other delivery reform resources are available on the AMA website at www.ama-assn.org/go/paymentpathways .

DISCUSSION

The vast majority of ACOs have physicians in leadership positions. According to the National Survey of Accountable Care Organizations, conducted by the Dartmouth Institute for Health Policy and Clinical Practice, 51 percent of ACOs are physician-led, and an additional 33 percent are jointly led by physicians and hospitals. In addition, 78 percent of ACOs have a majority of physicians on their governing boards, and 40 percent of ACOs are physician-owned.[11]

ACO contracting at the physician level is primarily a business decision made by ACO leaders based on the clinical and business goals of the particular ACO. Because ACOs are by definition collectively responsible for the care of their patients, it is in the best interest of all ACO participants to ensure that participation is limited to individuals or entities that can further the goals of the ACO. It is also in the best interest of the ACO to retain physicians who support the organizational goals and are willing to commit to the success of the ACO over the long term.

As with any other type of contracting arrangement, it is important that ACOs be transparent in their contracts with individual physicians, and that physicians carefully review ACO contracts to ensure there are clear guidelines with respect to how physician performance will be evaluated, and the circumstances under which a physician may be removed from an ACO panel.

The Council believes that it is likely that the trend of the rapid growth of ACO formation will continue. The ability of an ACO to attract and retain physicians who contribute effectively to the clinical and cost goals of the ACO will

be critical to its success. It is possible that ACO markets may evolve such that competition among ACOs for physician members could have a positive impact on physician recruitment and retention.

Given that the ACO concept is evolving, the Council believes that our AMA should continue to encourage flexibility and innovation in the design and development of ACOs supported by both public and private payers. Ensuring that patients have access to high quality, appropriate and timely physician-led care remains a priority for this Council, and for our AMA. Ensuring professional satisfaction and practice sustainability is one of our AMA's core focus areas, and efforts to identify and support current and emerging payment and care delivery models that work best for physicians across a variety of practice settings are ongoing. As the number of ACOs increases, it will be important for our AMA to continue to monitor the impact of ACOs on the ability of physicians to provide the best care for their patients.

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8. IMPROVING HOME HEALTH CARE (RESOLUTION 703-A-14)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 703-A-14 AND REMAINDER OF REPORT FILED
See Policy H-210.978

At the 2014 Annual Meeting, the House of Delegates referred Resolution 703, "Improving Home Health Care," which was sponsored by the Medical Student Section. Resolution 703-A-14 asked:

> That the American Medical Association (AMA) support the establishment of state-based certification for home health care workers and regulatory oversight over home health agencies.

This report provides background on home health and home health aides; outlines training standards for home health aides; describes existing regulation of home health agencies; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

Home health care services include a range of medical, therapeutic, and non-medical services, delivered by professionals and workers in a patient's home, including nurses; home health aides; physical, occupational and speech therapists; and medical social workers. The focus of Resolution 703-A-14 was on services normally

delivered by home health aides, including providing patients with assistance with activities of daily living, such as taking prescribed medications.

Thirty-seven percent of home health care patients ages 65 and over receive assistance with activities of daily living, often from a home health aide.[1] According to the Bureau of Labor Statistics, home health aides help patients in their daily personal tasks, such as bathing or dressing; provide basic health-related services according to a patient's needs, such as administering prescribed medication at scheduled times; arranging transportation to physician appointments; and other responsibilities.[2] Home health aides usually work for home health or hospice agencies that receive some level of government funding, and under the supervision of a registered nurse. There were 875,100 home health aides in 2012, and the number of such workers is expected to increase by 48 percent by 2022 to approximately 1.3 million. The median pay in 2012 for home health aides was $10.01 per hour, which reflects the lack of a formal education requirement for home health aides.[3]

Home health aides are different from personal care aides, who are also known as homemakers and personal attendants. While many responsibilities between home health aides and personal care aides overlap, personal care aides cannot provide any type of medical service.[4] Personal care aides in many cases can also be hired independently of a home health or hospice agency.

TRAINING STANDARDS FOR HOME HEALTH AIDES

Training requirements for home health aides vary based on whether the employing agency participates in Medicare and/or Medicaid, and by state. Overall, according to the National Home Health Aide Survey, 83.9 percent of home health aides had initial training. Among those aides who had taken initial training, 82.2 percent thought the training prepared them well for their jobs. Ninety-one percent of home health aides had taken continuing education, including in-service training, in the past two years. Seventy-nine percent of individuals receiving continuing education found it useful.[5] However, the Council notes that concerns have been raised with the low health literacy levels of some home health aides, as well as how well they are prepared to carry out all of their job responsibilities.

Home health aides employed by agencies that participate in Medicare or Medicaid must meet the requirements outlined in the Conditions of Participation (COPs). In 2012, 12,311 home health agencies participated in Medicare.[6] Medicare COPs for home health aide services state that home health aides must complete a training program, as well as a competency evaluation program or state licensure program that ensures aptitude in key subject areas, or a competency evaluation program or state licensure program that ensures proficiency in the subject areas taught in training.[7] Subject areas of the competency evaluation include observation, reporting and documentation of patient status and the care or service furnished; reading and recording temperature, pulse, and respiration; basic infection control procedures; recognizing emergencies and knowledge of emergency procedures; and adequate nutrition and fluid intake. The COPs state that the home health aide training program must total at least 75 hours, with at least 16 hours devoted to supervised practical training. After the initial training, the COPs dictate that home health aides must receive at least 12 hours of in-service training during each 12-month period, and receive a performance review at least annually.[8]

The Institute of Medicine (IOM) has called for federal requirements for the minimum training of home health aides to be increased to at least 120 hours. The IOM recommendation stemmed from the anticipated need for home health aides to assume more complex responsibilities, requiring additional knowledge and fluency in more skill areas.[9] Thirty-four states and the District of Columbia do not require more home health aide training than the standard of 75 hours outlined in the Medicare COPs. Sixteen states require more than 75 hours of training for home health aides, six of which meet the IOM standard of 120 hours.[10]

REGULATION OF HOME HEALTH AGENCIES

Home health agencies that participate in Medicare or Medicaid must meet the requirements outlined in the COPs. Additional requirements for oversight of home health agencies, including requirements for licensure and background checks, vary by state. Regarding background checks, 41 states require home health agencies to conduct background checks on prospective employees, with four states reporting having plans to require background checks in the future.[11] In addition, home health agencies can opt to become accredited by such entities as The Joint Commission, Community Health Accreditation Partner, and Accreditation Commission for Health Care. All three entities have been found to have standards that meet or exceed the standards outlined in the COPs, and therefore have been

granted deeming authority by CMS to survey home health agencies to determine whether they meet the Medicare COPs. Numerous states already have laws requiring home health agencies to meet the accreditation requirements of at least one accrediting body, allowing for additional quality oversight of home health care delivery. However, others do not and may also have weak regulations, which the Council recognizes may lead to lower quality thresholds.

RELEVANT AMA POLICY

Policy H-210.994 supports continued monitoring of the adequacy of the home health care system to meet the accessibility needs of homebound patients. Policy H-210.991 states that the AMA will foster physician participation, and itself be represented, at all present and future home care organizational planning initiatives, including those of The Joint Commission. The policy also encourages a leadership role for physicians as active team participants in home care issues such as quality standards. Policy H-25.999 states that the AMA will advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long-term care continuum. Policy H-25.993 states that the AMA supports accelerating its ongoing efforts to work responsibly with Congress, senior citizen groups and other interested parties to address the health care needs of seniors, including hospice and home health care.

DISCUSSION

The training of home health aides and oversight of home health agencies vary based on state, as well as home health agency accreditation status and Medicare and/or Medicaid participation. As such, there are notably fewer quality standards for home health agencies that do not participate in Medicare or Medicaid, and operate in states with weak regulations. Therefore, the Council reiterates the need for meaningful regulatory oversight of home health agencies that employ home health aides. In addition, the Council recognizes that the training of home health aides should reflect the scope of their responsibilities that are continuously changing and in many cases, increasing. The standards for training of home health aides outlined by the Medicare COPs, accreditation agencies and the Institute of Medicine should be used to guide the appropriate level and breadth of training required. To ensure that all states have appropriate training standards for home health aides, the Council believes that our AMA should work with interested state medical associations to support legislation that requires home health aides to obtain appropriate training before caring for patients.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 703-A-14, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the appropriate training of home health aides to ensure the quality of services they provide, guided by the standards of the Medicare Conditions of Participation, accreditation entities and the Institute of Medicine.

2. That our AMA support regulatory oversight of home health agencies that employ home health aides

3. That our AMA work with interested state medical associations to support state legislation that requires home health aides to obtain appropriate training before caring for patients.

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9. MEDICATION ADMINISTRATION IN ASSISTED LIVING FACILITIES (RESOLUTION 201-A-14)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 201-A-14 AND REMAINDER OF REPORT FILED
See Policy H-120.935, H-120.955 and H-280.999

At the 2014 Annual Meeting, the House of Delegates referred Resolution 201, "Medication Management in Assisted Living Facilities," which was sponsored by the Illinois Delegation. Resolution 201-A-14 asked:

> That our American Medical Association (AMA) create a national policy in support of medication management and administration by appropriately trained facility staff for residents of assisted living, sheltered care, and dementia care facilities; and
>
> That our AMA support or cause to be introduced federal legislation fostering medication management and administration by appropriately trained facility staff for residents of assisted living, sheltered care, and dementia care facilities.

This report provides background on medication administration in assisted living facilities; highlights the issue of Alzheimer's and dementia care in assisted living facilities; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

Assisted living facilities represent the range of facilities in the long-term care continuum between independent living and nursing homes. There is no singular definition of assisted living facilities. Such facilities, depending on the state, are also referred to using other terms, such as personal care homes, sheltered care facilities, supportive living arrangements and community residential settings. Assisted living facilities are regulated at the state level. As of 2012, there were approximately 22,200 assisted living facilities in the United States, providing care to 713,300 residents. Ninety-three percent of residents of assisted living facilities are ages 65 and over.[1]

Medications are an essential element of care for many residents of assisted living facilities. A care plan or assessment is typically carried out prior to a resident moving into an assisted living facility. Depending on the results of the care assessment, residents are either allowed to self-administer their medications, or staff members of the facility may be required to administer their medications to them to ensure that they take the correct dose of the medications at the right time. While some residents who self-administer their medications may be deemed to be able to do so without oversight, others may require medication reminders or other supervision. Seventy-seven percent of residents of assisted living facilities need help with taking their medications, including opening the bottle, remembering to take medications on time, and taking the prescribed dosage.[2] Ninety-one percent of assisted living facilities reported having to manage, supervise or store medications or provide assistance with self-administration of medications for at least 75 percent of their residents.[3]

Approximately 70 percent of assisted living facilities reported having a pharmacist or physician review the medications that residents receive for appropriateness.[4] More than 90 percent of assisted living facilities offer pharmacy or pharmacist services.[5] In terms of medication services offered to residents of assisted living facilities, 94 percent of assisted living facilities provide a central location where medications are stored prior to administration. Eighty percent of facilities provide medication reminders that prompt residents to take medications, with 91 percent of assisted living facilities providing oversight and cueing to ensure residents actually take their medications. Registered nurses and/or licensed practical nurses administer medications to residents in more than half of assisted living facilities. Certified medication aides, medication supervisors, or medication technicians also administer medications in half of assisted living facilities.[6] State laws and regulations differ in how they define medication assistance and administration, including who can assist with medications, who can administer medications, and the extent of staff training, supervision, and licensure required.

ALZHEIMER'S AND DEMENTIA CARE

Approximately 40 percent of assisted living facility residents have Alzheimer's disease or other dementias.[7] Individuals with dementia living in assisted living facilities either live in designated dementia care units, or in the traditional assisted living setting. In 2010, 17 percent of assisted living facilities had designated dementia units, the beds of which accounted for 13 percent of all assisted living beds.[8] Many states require assisted living facilities with designated dementia care units to have specially trained staff to care for residents with dementia, including unique requirements for medication management for residents of dementia/Alzheimer's units of assisted living facilities. Regarding medication management in designated dementia care units, many states have limited medication administration to registered nurses, physician assistants, licensed practical nurses and physicians.

RELEVANT AMA POLICY

Policy H-280.999 outlines guidelines for physicians attending to patients in long-term care facilities, including that the attending physician should be aware that the pharmacist may review the drug regimen of each patient at least monthly and report his comments to the medical director and administrator. In those instances where the medical director and the pharmacist question the appropriateness of the drug regimen, the question should be brought to the attention of the attending physician. Policy H-120.955 advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions. Policy H-280.963 states that the AMA will work closely with the American Medical Directors Association and other appropriate organizations to improve outcomes of drug therapy in nursing homes and to encourage CMS to review the issue of appropriate professional resources needed to provide optimal prescription use in nursing facilities.

Policy H-280.957 states that medical directors in nursing homes should be strongly discouraged from taking over the routine medical care of a physician's patient without the request of the patient, the patient's family, or the patient's physician. Policy H-280.967 encourages state medical associations to carefully evaluate the relevant practice acts in their jurisdictions and to identify any modifications needed to allow the most effective use of nurse practitioners and physician assistants in improving care in nursing homes and long-term care facilities while assuring appropriate physician direction and supervision of such practitioners. Policy H-160.906 states that within a physician-led team environment, physician leaders are focused on individualized patient care and the development of treatment plans, and non-physician practitioners are focused on providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.

Considering care for patients with Alzheimer's disease and other forms of dementia, Policy H-25.991 encourages: 1) physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias; 2) studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders; and 3) studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders. Policy H-25.989 states that the AMA will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; and supports efforts to provide additional research on

other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia.

DISCUSSION

Because states regulate assisted living facilities, the Council believes that supporting a federal approach to medication administration provided to residents of these facilities may conflict with and potentially undermine existing state laws and regulations on the issue. Rather, the Council believes that our AMA should support medication administration by appropriately trained facility staff for residents of assisted living and dementia care facilities who require assistance in taking their medications, which takes into consideration differences between patients and in state laws. The Council notes that medication administration is different from medication management and monitoring, the topics of the latter being addressed by Policy H-120.955, which advocates that prescriptive authority include the responsibility to monitor the effects of medications and attend to problems associated with the use of medications. The Council believes that, as outlined in Policy H-280.999, physicians in assisted living facilities should review and manage medications, noting that pharmacists may review the drug regimen of each patient at least monthly.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 201-A-14, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-280.999, which outlines guidelines for physicians attending patients in long-term care facilities.

2. That our AMA reaffirm Policy H-120.955, which advocates that prescriptive authority include the responsibility to monitor the effects of medications and attend to problems associated with the use of medications.

3. That our AMA support medication administration by appropriately trained facility staff for residents of assisted living and dementia care facilities who require assistance in taking their medications.

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