

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports, 1–10, were presented by Peter S. Lund, MD, Chair.

1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2007 AMA HOUSE POLICIES

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

HOUSE ACTION: RECOMMENDATIONS ADOPTED 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 our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of the report be filed.

APPENDIX - Recommended Actions on 2007 Socioeconomic Policies

Policy #	Policy Title	Recommended Action and Rationale
H-70.937	Bundling and Downcoding of CPT Codes	Retain. Still relevant.
H-70.949	Bundling of Codes for Physician Services	Retain. Still relevant.
H-70.950	Unacceptable Editing of the CPT-4 Code Book	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-70.956	Coding for Medically Indicated Diagnostic and Surveillance Services	<p>Retain-in-part. Under ICD-10-CM, these services will be reported under a new set of codes-Z codes. Modify policy to read as follows:</p> <p>The AMA will continue to advocate to third party payers' acceptance of symptoms, signs, ill-defined conditions, and supplementary classification of factors influencing health status (Y-Z codes), as valid, medically necessary reasons for patient encounters, work toward expansion of these codes for screening examinations where appropriate, and urge payers to provide reimbursement for these services within the parameters of the patient's health insurance coverage.</p>
H-70.966	Current Procedural Terminology Process	Retain. Still relevant.
H-70.972	Physicians' Current Procedural Terminology	Retain. Still relevant.
H-70.973	AMA CPT Editorial Panel and Process	Retain. Still relevant.
H-70.986	CPT Coding Initiatives	Retain. Still relevant.
H-70.991	Coding and Payment for Patient Management in Ambulatory Settings and Skilled Nursing Facilities	Retain. Still relevant.
H-70.998	Revision of CPT	Retain. Still relevant.
H-90.978	Community Mobility Devices	Retain. Still relevant.
H-110.991	Price of Medicine	Retain. Still relevant.
H-125.982	Medicare Part D Modifications	Rescind. Accomplished by elimination of the Part D coverage gap.
H-125.990	Medicaid Payment for Over-The-Counter Drugs When They are the Drug of Choice	Retain. Still relevant.
H-155.961	Transparency of Employer Sponsored Health Insurance	Retain. Still relevant.
H-160.920	Financial Impact of Immigration on the American Health System	Retain. Still relevant.
H-160.923	Offsetting the Costs of Providing Uncompensated Care	<p>Retain-in-part. Clarify that (1) refers to disproportionate share hospital (DSH) payments, and delete Texas example in (2) as it is limiting. Modify policy to read as follows:</p> <p>Our AMA: (1) supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured;(2) supports the use of innovative federal- or state-based projects that are not budget neutral, such as the Texas Designated Trauma Facility and Emergency Medical Services Account, for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.</p>
H-160.935	Policy on Phone Counseling	Retain. Still relevant.
H-160.943	Definition of "Principal Care"	Retain. Still relevant.
H-160.969	Tax Deduction for Care Provided the Indigent	Retain. Still relevant.
H-160.975	Planning and Delivery of Health Care Services	Retain. Still relevant.
H-165.843	Trends in Employer-Sponsored Health Insurance	Retain. Still relevant.
H-180.952	Physician Penalties for Out-of-Network Services	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-180.960	Insurance Company Medical Test Disclosures	Retain. Still relevant.
H-180.961	Defining Levels of Health Insurance Coverage	Retain. Still relevant.
H-180.965	Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured	Retain. Still relevant.
H-180.967	Economic Credentialing by Insurance Companies	Rescind. Superseded by Policies D-285.972, H-285.991 and H-450.941.
H-180.980	Sexual Orientation and/or Gender Identity as Health Insurance Criteria	Retain. Still relevant.
H-185.960	Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans	Retain. Still relevant.
H-185.973	Simple, Honest Summary Statement	Rescind. Superseded by Policy D-155.987.
H-190.971	Physicians' Right to Receive Billing and Remittance Information	Retain. Still relevant.
H-190.973	Uniform Physician and Physician Group Identifiers	Retain. Still relevant.
H-195.993	Oversight of Medicare Managed Care Plans	Retain. Still relevant.
H-195.994	Mandatory HMO Enrollment	Retain. Still relevant.
H-205.992	Supply and Distribution of Health Care Facilities	Retain. Still relevant.
H-205.993	Licensure of Health Care Facilities	Retain. Still relevant.
H-205.994	Definition of Health Care Facilities	Retain. Still relevant.
H-210.982	Home Health Nursing Costs	Retain. Still relevant.
H-210.996	Providing Cost Estimate with Home Health Care Order Authorization	Retain. Still relevant.
H-220.971	Joint Commission Medical Staff Standard on the Amendment of Bylaws	Retain-in-part. Update policy to read as follows: The AMA formally expresses its support for maintaining JCAHO Medical Staff Standard 2.1 Joint Commission Standard MS.01.01.03 , which establishes that neither the medical staff nor the hospital governing body may unilaterally amend the medical staff bylaws.
H-220.972	Medical Staff Participation in the Joint Commission Site Surveys	Retain. Still relevant.
H-225.963	Unilateral Imposition of Medical Staff Development Plans and Economic Credentialing Controlled by the Hospital	Retain. Still relevant.
H-230.975	Economic Credentialing	Retain. Still relevant.
H-230.976	Economic Credentialing	Retain. Still relevant.
H-230.982	Clinical Privileges - Model Medical Staff Bylaws	Retain. Still relevant.
H-230.983	Credentials Files for Members of Hospital Medical Staffs	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-230.986	JCAHO Recognition of Specialty Boards Recognized by American Board of Medical Specialties and AMA and AOA	Retain. Still relevant.
H-235.984	Hospital Medical Directors Designated as the Representative of the Medical Staff	Retain. Still relevant.
H-280.957	Continuity of Care in Nursing Homes	Retain. Still relevant.
H-285.916	Accuracy in Managed Care Organizations' Physician Listings	Rescind. Superseded by Policy H-285.924.
H-285.960	Incorporation of Organized Medical Staff in Managed Care Accreditation Standards	Retain. Still relevant.
H-285.964	Admitting Officer and Hospitalist Programs	Retain. Still relevant.
H-285.981	Fair Market Practices	<p>Retain-in-Part. Delete (2), which refers to obsolete federal legislation from 1994, as follows.</p> <p>Our AMA: (1) continues to advocate for the enactment of state and federal laws and regulations that would provide for patient protection and physician fairness, including ... (e) providing enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals for appropriate dissemination regarding the quality of service rendered by the managed care organization; and (2) continues to encourage all state medical associations and national medical specialty societies to advocate vigorous support of the Patient Protection Act.</p>
H-285.986	Standardization of Managed Care Office Safety Standards	Retain. Still relevant.
H-290.986	Medicaid and Efforts to Assure it Maintains its Role as a Safety Net	Retain. Still relevant.
H-290.993	Coverage of Drugs by Medicaid	<p>Retain-in-part. Modify (1) by replacing "drugs necessary to treat life-threatening and other serious medical conditions" to "medically necessary drugs" and modify (2) editorially, to read as follows:</p> <p>Our AMA (1) urges CMS to develop meaningful guidelines for state Medicaid agencies to pay for drugs necessary to treat life threatening and other serious medical conditions <ins>medically necessary drugs</ins>, even if such drugs are manufactured/distributed by non-rebating firms, and (2) asks CMS to grant states reasonable autonomy in decisions to cover these medically necessary drugs without retroactive economic penalty.</p>
H-315.990	Confidentiality of Computerized Patient Records	<p>Retain-in-Part. Delete (3), which has been accomplished with Ethical Opinion E-3.3.2, to read as follows:</p> <p>The AMA (1) reaffirms the importance of confidentiality of patient records regardless of the form in which they are stored; and (2) will study and incorporate into its model legislation, Confidentiality of Health Care Information, a provision regulating third parties' use of computerized patient records in physicians' offices; and (3) will develop guidelines for physicians using computerized medical record systems to protect the confidentiality, integrity and security of patient records.</p>

Policy #	Policy Title	Recommended Action and Rationale
H-320.947	Third Party Intervention Requests	Retain-in-part. Delete (2) because intervention examples are no longer being provided to the AMA. 1. AMA policy is that physicians only should be asked to effect clinical interventions on behalf of their patients as requested by third parties when such interventions are evidence-based and appropriately compensated. 2. Our AMA encourages physicians to submit to it instances of inappropriate interventions by health insurance plans, disease management companies, radiology benefit managers, or pharmacy benefit managers; and, if warranted, consider developing AMA resources to stem future requests that are not evidence based and appropriately compensated.
H-320.984	Mandated Second Opinions	Retain. Still relevant.
H-320.986	Confidentiality and Utilization Review	Retain. Still relevant.
H-330.894	Demonstration Project Regarding Medicare Part D	Retain. Still relevant.
H-330.895	Medicare Beneficiary Access to Pulmonary Rehabilitation Services	Rescind. Medicare Part B covers comprehensive pulmonary rehabilitation for patients with moderate to very severe chronic obstructive pulmonary disease (COPD). These services may be provided in a doctor's office or a hospital outpatient setting that offers pulmonary rehabilitation programs.
H-335.966	Medicare Carrier's Responsibility to Reveal Reasons for Denial	Retain. Still relevant.
H-340.971	Medicare Program Due Process	Retain. Still relevant.
H-365.981	Workers' Compensation	Retain-in-part. In (3), model legislation was developed; (5) and (6) were accomplished; and (7) is dated. Modify only these clauses as follows: The AMA:....(3) will develop model state legislation mandating the appropriate encourages the use of the Guides to the Evaluation of Permanent Impairment... (5) will work with state medical societies to educate physicians about workers' compensation and state workers' compensation laws. Physicians treating injured workers should be aware of the state workers' compensation act in order to understand the patient's rights and the physician's responsibilities. Knowledge of the law and an increased understanding of the system may also result in an increased willingness, on the part of physicians, to participate in the workers' compensation system. One means of educating physicians which is being investigated is the development of an AMA publication which would provide an overview of workers' compensation in general (background on the system's history, the physician's role, problems with the system, and potential solutions). State medical societies could then be encouraged to develop more specific workers' compensation publications detailing individual state law. (6) will work with state medical societies and other responsible entities to develop workers' compensation medical care data collection systems to improve the quality and efficiency of state workers' compensation systems. (7) encourages the use of uniform claim forms (CMS 1500, UB82, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information, and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.
H-375.963	Reduced Physician Role in Governance of Federally Contracted Quality Improvement Organizations	Retain. Still relevant.
H-385.944	Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day	Retain. Still relevant.
H-385.945	Equal Payment for Services	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-385.982	Payment for Physician Standby Services	Retain. Still relevant.
H-390.850	Limiting Charge Rule Adjustment	Retain. Still relevant.
H-390.851	Changes to the Medical Profession Resulting from Medicare Administrative Contracting Reforms	Retain-in-Part. Modify (1) to reflect change in nomenclature as follows: 1. Our AMA will review and monitor the impacts of the Medicare Administrative Contracting reforms as they evolve over the next several years with periodic reports to the House of Delegates, to include at a minimum: (a) growth, nature and outcomes of actions against physicians by Payment Safeguard Contractors, Zone Program Integrity Contractors, and Recovery Audit Contractors;...
H-390.856	Eliminate Medicare's "Limiting Charge"	Retain. Still relevant.
H-390.965	Medicare Denial Relief Act	Rescind. Superseded by Policy H-270.999.
H-390.972	Special Payment Arrangements for Low-Income Medicare Beneficiaries	Retain. Still relevant.
H-415.993	AMA Initiatives in Health Delivery Systems	Rescind. Superseded by Policy H-165.985.
H-425.992	Coverage of Preventive Medical Services by Medicare	Rescind. Medicare now covers preventive services recommended with a grade of A or B by the USPSTF.
H-435.988	Risk Management	Retain. Still relevant.
H-445.989	Government Statements Regarding the Delivery and Cost of Medical Care	Retain. Still relevant.
H-450.988	Guidelines for Quality Assurance	Retain. Still relevant
H-465.980	Rural Community Health Networks	Retain. Still relevant.
H-465.996	Change in Criteria for Rural Referral Center Designation	Retain. Still relevant.
D-70.956	Development of a Drug Classification Advisory Panel to Facilitate Appropriate Use of CPT Drug Administration Codes	Rescind. Directive accomplished.
D-70.966	Electronic Communication Service Codes	Rescind. Superseded by Policy H-70.919.
D-70.974	Reimbursement for Evaluation and Management Visit Performed on the Same Day as a Preventive Visit	Rescind. Directive accomplished.
D-70.975	Appropriate Reimbursements and Carve-Outs for Vaccines	Retain. Still relevant.
D-75.997	Access to Emergency Contraception	Retain. Still relevant.
D-120.962	Joint Commission Interpretations of Medication Reconciliation and Other Standards	Rescind. Directive accomplished.
D-120.964	Standardized Pharmacy Telephone Answering Machines	Rescind. Directive accomplished. The AMA sent a letter asking the National Association of Chain Drug Stores (NACDS) to work with their member chain pharmacies to implement "standardized" telephone answering system to allow physicians to bypass messages.
D-130.975	Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services	Retain. Still Relevant.

Policy #	Policy Title	Recommended Action and Rationale
D-160.984	CMS Rule 4105F: Notification of Hospital Discharge Appeal Rights	Rescind. No longer relevant. Inclusion of hospital discharge appeal notices in the Important Message from Medicare (IM) and Detailed Notice of Discharge (DND) provided to hospital inpatients has been the standard for 10 years.
D-160.986	The Alliance of Retail Clinics with Pharmaceutical Chains	Retain. Still relevant.
D-165.949	Assessing the Health Care Proposals of the US Presidential Candidates	Rescind. Directive accomplished.
D-165.953	Crisis Commission on the State of Health Care in America	Rescind. Directive accomplished.
D-220.974	The Joint Commission Leadership Standards	Retain. Still relevant.
D-220.984	Use of Physicians as Surveyors in Hospital Surveys	Rescind. Joint Commission hospital survey teams nearly always include a physician. Additionally, Joint Commission seeks to include surveyors who are active in their fields; at a minimum, physician surveyors must complete continuing medical education work.
D-225.980	Confidentiality of Medical Staff Members' Personal Proprietary Financial Information	Rescind. The Joint Commission Standards for Management of Information underwent substantive revisions that make this policy obsolete. The principles in this policy have also been superseded in part by Policy H-225.955.
D-225.981	Marketing Low Cost Internet-Based Education Programs for Medical Staff Leadership	Retain. Still relevant.
D-225.982	Principles for Strengthening the Physician-Hospital Relationship	Retain. Still relevant.
D-225.984	Hospitalists and the Changing Hospital Environment	Rescind. Directive accomplished. The AMA endorses the <i>Principles for Developing a Sustainable and Successful Hospitalist Program</i> , developed by the AMA Organized Medical Staff Section, the American Hospital Association, The Joint Commission, and the Society of Hospital Medicine, and included in the <i>AMA Physician's Guide to Medical Staff Organization Bylaws, Sixth Edition</i> .
D-240.995	Patients Admitted for Observation	Rescind. Superseded by Policies D-280.987 and H-160.944
D-285.969	Inaccurate Health Plan Physician Directories	Rescind. Directive accomplished. The AMA solicited through various AMA communication vehicles member complaints regarding inaccuracies contained in each health plan's physician provider listings. Additionally, AMA solicited feedback from the Federation for their current efforts or interest in collaboratively addressing inaccurate health plan physician provider listings.
D-320.992	Notification, Precertification, and Appeals for Medications and Imaging Studies	Retain. Still relevant.
D-330.929	Medicare Abdominal Aortic Aneurysm Screening	Rescind. Medicare now covers preventive services recommended with a grade of A or B by the USPSTF.
D-330.932	Medicare National Health Care Information Center Electronic Reform	Rescind. Superseded by Policy D-190.974.
D-330.957	AMA Support for Revision of the CMS 75% Rule - Rehabilitation Classification Criteria	Rescind. Superseded by Policy H-215.962.
D-335.992	Medicare Carrier Medical Directors	Retain. Still relevant.
D-350.992	Medicaid Coverage for American Indian and Alaska Native Children	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
D-390.967	Elimination of Subsidies to Medicare Advantage Plans	Retain-in-part. The SGR has been repealed. Modify policy to read as follows: 1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services, and that any savings from the elimination of subsidies to private plans be used to address the Sustainable Growth Rate (SGR) . 2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.
D-405.993	Defining "Loss of Practice" in Catastrophic Events	Retain. Still relevant.
D-406.995	Safeguard NPI and Physician Privacy	Retain. Still relevant.
D-406.996	Insurance Company Economic Profiling of Physicians	Retain. Still relevant.
D-406.997	One Fee, One Number	Rescind. Directive accomplished. The AMA also drafted Board of Trustees Report 5-I-08 completing the request study. The AMA also sent the DEA a letter that advocates for physicians to have only one DEA number that is physician-specific and not site-specific.
D-440.985	Health Care Payment for Undocumented Persons	Retain. Still relevant.
D-450.973	Certification and Accreditation Programs for Disease-Specific Care	Rescind. Directive accomplished. PCPI has developed measurement sets for at least 47 clinical conditions.
D-478.991	Consequences of Accepting Hospital and Health Care System Based EMRs/EHRs	Rescind (1) as follows since the contracting guidelines have been developed. Our AMA will: (1) develop contracting guidelines for physicians considering accepting or donating Electronic Medical Records and Electronic Health Records systems (EMRs/EHRs) from or to hospitals and health care systems; (2) (1) educate physicians regarding the potential adverse consequences of receiving EMRs/EHRs from hospitals and health care systems; and (3) (2) encourage interoperability of information systems used by hospitals and health care facilities.
D-480.997	Teleconsultations And Medicare Reimbursement	Retain. Still relevant.

2. HEALTH CARE FINANCING MODELS

Informational report; no reference committee hearing.

HOUSE ACTION: FILED

At the 2016 Annual Meeting, the House of Delegates adopted Policy D-165.936, "Updated Study on Health Care Payment Models," which asked that the American Medical Association (AMA) research and analyze the benefits and difficulties of a variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and international experiences. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2017 Annual Meeting.

This report, which is provided for the information of the House of Delegates, provides background on varying models of health system financing; outlines the role of patient out-of-pocket payments in such systems; describes the range of roles private health insurance plays in health care financing; reviews the diversity of approaches used for

provider payment; highlights the impact of health care financing models on health status and disparities; and summarizes relevant AMA policy.

MODELS OF HEALTH SYSTEM FINANCING

Health systems in general have four significant roles: to collect revenue, to pool funds, to purchase services and to provide services. Depending on the country and health system design, revenue can be collected in the form of taxes, premiums and other contributions from individuals to payers, which can include governments, private insurers and employers. Revenues collected are pooled and ultimately used to pay physicians, hospitals and other providers for services provided to covered patients, with patient cost-sharing sometimes also being required. Health systems also have a role in implementing strategies in order to ensure the safety and quality of care provided.

As outlined in the appendix, various mechanisms are used to finance health systems, including taxation, government funding, private insurance and patient out-of-pocket payments. How countries finance health care, as well as the level of funding allocated to health care and other social services, impacts health care quality, health outcomes and health disparities. While health system financing varies from country to country, countries can fall into one overarching financing model, with some countries, including the United States, incorporating multiple financing models in their health systems. Such models include a single payer system financed through taxes; employer-sponsored insurance and coverage provided by non-profit, private insurers; and direct payments by patients for medical services, without a widespread health insurance system in place.

Many countries finance their health systems generally through taxes, with the government serving as single payer. Partly as a result of the level of health care benefits provided by the government, countries with single payer systems tend to have higher tax rates and social insurance contributions. Overall, taxes that fund social insurance programs are often higher in other developed countries than in the United States. Various tax revenues are used to finance single payer systems. While some governments use general taxation, other governments use taxes earmarked for health care, payroll taxes and other tax types. For example, in Denmark, health care is financed predominantly through a national health tax, equal to eight percent of taxable income.¹ In the United Kingdom, the majority of financing for the National Health Service comes from general taxation and a payroll tax.² In Canada, provinces and territories administer their own universal health insurance programs, with financing predominantly coming from general provincial and territorial spending.³ Italy's National Health Service is financed primarily through a corporate tax and a defined portion of national value-added tax revenue.⁴

Other countries have employer-sponsored insurance and coverage provided through non-profit, private insurers. For example, health insurance in Germany is mandatory for all citizens and permanent residents, and is primarily provided by competing "sickness funds," not-for-profit, nongovernmental health insurance funds. Sickness funds are financed by mandatory contributions imposed as a percentage of employees' gross wages up to a ceiling. High-income individuals can choose to opt out and instead purchase substitutive private coverage.⁵ Switzerland requires residents to purchase mandatory statutory health insurance, which is offered by competing nonprofit insurers. Direct financing for health care providers, predominantly for hospitals providing inpatient acute care, comes from tax-financed government budgets. Residents pay premiums for statutory health insurance coverage; premiums are redistributed among insurers by a central fund, adjusted for risk.⁶

In the Netherlands, all residents are required to purchase statutory health insurance from private insurers. Its statutory health insurance is financed through a combination of a nationally defined, income-related contribution; a government grant for insured individuals below age 18; and community-rated premiums set by each insurer. Such contributions are collected centrally and allocated to insurers according to a risk-based capitation formula.⁷ In Japan, the universal public health insurance system, which includes more than 3,400 insurers, is funded by premiums, tax-financed subsidies and user charges.⁸ In France, the predominant sources of funding for statutory health insurance provided to all residents are employer and employee payroll taxes, with contributions also from a national earmarked income tax; taxes assessed on tobacco, alcohol, the pharmaceutical industry and voluntary health insurance companies; state subsidies; and transfers from other branches of Social Security.⁹

Singapore offers universal health care coverage to its citizens, financed by government subsidies, multilayered financing arrangements, and individual medical savings accounts. Government subsidies cover up to 80 percent of the total bill at public health care institutions. All Singapore citizens and permanent residents are covered by MediShield Life, which is a basic health insurance plan that helps individuals pay for hospital and select, high-cost

outpatient expenses. Low- and middle-income individuals and families receive premium subsidies funded by the government to afford coverage. MediShield Life premiums may be fully paid from Medisave, which is a mandatory medical savings program. Medisave contributions can also be used for expenses associated with hospitalization, day surgery and certain outpatient services. Medisave requires most workers to contribute 8 to 10.5 percent, depending on age, of their monthly salary to a personal Medisave account, with matching contributions from employers. The Medisave contribution rates of low-income workers are based on a range of phased-in contribution rates. Individual contributions to and withdrawals from Medisave accounts are tax-exempt.^{10,11,12}

THE ROLE OF PATIENT OUT-OF-POCKET PAYMENTS

The role of patient out-of-pocket payments in contributing to health care financing varies. In Canada, there is no patient cost-sharing for publicly insured physician, diagnostic and hospital services.³ Likewise, in Denmark, there is no cost-sharing for hospital and primary care services.¹ In the United Kingdom, there is limited cost-sharing for publicly covered services; patient out-of-pocket responsibilities are mainly limited to services that fall outside the purview of the National Health Service.² In Israel and Italy, there is no cost-sharing for primary care visits or for hospital admissions.^{4,13} In these countries where for many services patients have no cost-sharing, patients may have out-of-pocket responsibilities for outpatient prescription drugs, dental care and vision care. In many cases, vulnerable groups in these countries are either exempt from or face lower prescription drug copayments.

In the United States, on the other hand, deductibles and cost-sharing provisions can be significant, and vary based on the health plan in which patients are enrolled. For the half of the US population enrolled in employer-sponsored coverage, it is common to have a general annual deductible for coverage. Eighty-three percent of covered employees are enrolled in a plan with a general annual deductible for single coverage; the average deductible for single coverage was \$1,478 in 2016. Individuals covered by employer-sponsored coverage also face cost-sharing requirements. In general, roughly two-thirds of covered employees have copayment responsibilities for primary care and specialist physician visits, whereas a quarter has coinsurance. Among covered employees with copayments for in-network physician visits, the average copayment was \$24 for primary care and \$38 for specialty physician office visits in 2016. The average coinsurance rates for employees with coinsurance responsibilities for in-network physician office visits in 2016 were 18 percent and 19 percent for primary care and specialist physician office visits respectively.¹⁴

Relevant to both employer-sponsored and plans offered on health insurance exchanges, the Affordable Care Act (ACA) requires non-grandfathered health plans to have an out-of-pocket maximum of \$7,150 or less for single coverage and \$14,300 for family coverage in 2017.¹⁵ In 2016, the median individual deductible for health plans offered in states using the HealthCare.gov platform was \$850. That being said, the median average deductible for bronze plans (covers 60 percent of benefit costs) in states using HealthCare.gov, in which 21 percent of HealthCare.gov exchange enrollees were enrolled, was \$6,300.¹⁶ Cost-sharing subsidies are available to individuals and families with incomes between 100 and 250 percent federal poverty level (FPL) (133 and 250 percent FPL in Medicaid expansion states) who enroll in a silver plan (covers 70 percent of benefit costs). Cost-sharing subsidies effectively raise the actuarial value (percent of benefit costs covered) of the silver plan, leading patients to face lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. For publicly insured individuals, while Medicare requires deductibles for hospital stays and ambulatory care and copayments for physician visits and other services, Medicaid requires minimal cost-sharing.

Residents of Switzerland have similar types of cost-sharing exposures as privately-insured individuals in the US. Insured individuals are responsible for deductibles for statutory health insurance coverage, which can be lower, closer to \$200, or higher, more than \$1,800, depending on patient choice. After the deductible is met, individuals pay 10 percent coinsurance for all services up to an annual maximum of more than \$500 for adults, with the cap for children being roughly half of that for adults. Low-income individuals are eligible for premium subsidies, and regional governments or municipalities cover the health insurance expenses of individuals receiving social assistance benefits or supplementary old age and disability benefits.⁶ Residents of Singapore face cost-sharing responsibilities that are often higher than many other countries. Copayments after government subsidy and applicable MediShield Life coverage can be paid by individual medical savings accounts and/or cash. In addition, Singapore's safety net program covers medically necessary treatment, based on patient and family income, medical condition and treatment costs. Often, all outstanding treatment costs for disadvantaged individuals are covered.¹⁰

In Japan, while there are no deductibles, most enrollees pay a 30 percent coinsurance rate for health care services and goods, with children under age three and adults ages 70 and older with lower incomes subject to lower coinsurance rates. There are catastrophic coverage limits on monthly out-of-pocket spending according to enrollee age and income. There are also subsidies and lower coinsurance rates based on income for patients with designated chronic conditions, mental illness and disabilities.⁸

Overall, several other countries, while requiring deductibles and/or copayments, also impose caps on cost-sharing, which limit patient out-of-pocket responsibilities. There are also exemptions from cost-sharing for vulnerable populations. For example, in Germany, there is an annual cap on cost sharing for adults equal to two percent of household income; the cap is equal to one percent of household income for chronically ill individuals.⁵ In Sweden, annual out-of-pocket payments for health care visits are capped below \$200.¹⁷

THE ROLE OF PRIVATE HEALTH INSURANCE

Private insurance can play a complementary, supplementary and/or substitutive role to public health insurance options. Based on the country, premiums for private coverage can be paid by individuals and/or employers, unions or other organizations. Complementary insurance, available in several countries, covers services that are excluded or not fully covered in the statutory plan, which could include prescription drug, dental and/or vision coverage. The United States has a version of complementary insurance in the Medicare program; Medicare supplemental plans provide various levels of complementary coverage for individuals enrolled in original Medicare. Supplementary insurance builds off the statutory coverage provided to improve coverage and can provide increased choice of or faster access to providers. For example, private health insurance in Australia and Norway offers more choice of providers, as well as expedited access to nonemergency care.^{18,19}

Substitutive insurance is duplicative of coverage offered in the statutory plan, and could be available to populations not covered by or those who opt out of the statutory plan. In Germany, many young adults with higher incomes take advantage of substitutive private health insurance, because health insurers offer them coverage for a more extensive range of services, as well as lower premiums.⁵ On the other hand, in Italy, citizens and legal residents cannot opt out of the National Health Service; as such, private health insurance can only be complementary and/or supplementary in nature.⁴ In the United States, Medicare Advantage can be thought of as substitutive to original Medicare.

APPROACHES TO PROVIDER PAYMENT

Approaches to paying providers vary, and are not wholly dependent on a country's health care financing model. Physicians can be salaried, or be paid via fee-for-service and capitation. Payments to physicians can also depend on whether patients have registered with and/or received a referral from their primary care physician. Physician fee schedules can be regulated or set by national, regional or local health authorities, negotiated between national medical societies/physician trade unions and the government, or negotiated/set by sickness funds or health plans. Physicians in some countries can also receive performance-based payments. Patient out-of-pocket payments contribute varying levels to physician payment, depending on cost-sharing responsibilities.

Hospital financing can depend on whether hospitals are public, private, nonprofit or for-profit. Public hospitals can operate under a global budget determined by the responsible health authority, or receive a majority of their funding from federal, regional or local governments. Both public and private hospitals can receive funding from health insurer compensation, as well as patient out-of-pocket payments. In many countries, diagnosis-related group (DRGs) or similar systems inform hospital payment levels.

IMPACT ON HEALTH STATUS

Health care financing models can impact population health status based on how health care dollars are distributed, how health care spending affects other spending on social services and other factors. While the United States surpasses its peers on health care spending, both as a percentage of gross domestic product and per capita spending, some data indicate that this has not led to better health outcomes for the population as a whole. Americans have fewer physician and hospital visits than residents of many countries highlighted in this report. At the same time, Americans tend to be greater consumers of medical technology, including diagnostic imaging and pharmaceuticals, and pay the highest prices for physician and hospital services, as well as prescription drugs.²⁰ These differences in

prices largely are the result of the majority of the US health care system being market-based in nature, versus the government influencing prices and health care costs.

While governments can have a role in the prices paid for health care services and pharmaceuticals, as well as health care budgets, there sometimes is a negative impact of such government intervention and funding on access to needed hospital and physician services, as well as prescription drugs. Such impacts can include prescription drugs not being on a national formulary, wait times for medically necessary physician services and hospital procedures, and medical innovations not being made available to patients. In the United States, such issues have been recently experienced by patients in the Veterans Health Administration. Presently, due to system underfunding, the National Health Service in the United Kingdom is experiencing hospital overcrowding, with reports of operations being canceled.^{21,22,23}

HEALTH CARE DISPARITIES

The distribution of health care finances and health professionals, as well as variations in health insurance coverage, can impact health care disparities. On the whole, health disparities exist between insured and uninsured individuals. In countries with universal coverage, such disparities are evident in the undocumented immigrant population. In several countries, including the US and those that offer private, voluntary health insurance in addition to statutory health insurance, health disparities, and disparities in access, can result from variations in health insurance benefit packages. Disparities also result from whether or not patients have additional private coverage. In some countries including Australia, having private health coverage varies by socioeconomic status.¹⁸ In France, individuals who did not have complementary insurance reported poorer health.⁹

Income-related health disparities in self-reported health status exist in several countries, including the United States, Italy and the Netherlands.^{4,7} Geographic disparities also exist, which are sometimes the result of how health care is financed. For example, in Italy, there are geographic disparities based on region, and interregional equity has long been a concern based on the economic differences between the regions of the country. While taxes received for health care are pooled nationally and redistributed back to the regions, the funding in some regions for health care remains insufficient. The funding disparity is exacerbated by the ability of regions to contribute additional revenue toward health care.⁴ Similarly, health disparities also exist between prefectures of Japan.⁸

Rural/urban, and racial and ethnic health disparities are common, as are disparities across socioeconomic groups. For example, in the Netherlands, there is a difference of up to seven years in life expectancy between the highest and lowest socioeconomic groups.⁷ In France, there is a gap in life expectancy between males in the highest and lowest social categories.⁹ In Australia, the most prominent disparities in health outcomes are between the Aboriginal and Torres Strait Islander population and the rest of Australia's population.¹⁸ In the United States, there are disparities in health status and health insurance status based on race and ethnicity, and residents of rural areas face barriers to health care.

RELEVANT AMA POLICY

Policy H-165.985 supports free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion. Policy H-285.998 reaffirms that the needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems. Policy H-165.920 supports pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services.

CONCLUSION

The AMA has long supported pluralism of health care financing mechanisms to obtain universal coverage and access to health care services. Importantly, the AMA also has supported free market competition among all modes of health care financing. In its analysis, the Council found that the health care financing models studied have their respective advantages and disadvantages. Some health care financing models were tied to systems of increased government regulation of prices and budgets across the health system, which undermines the free market principles that the AMA has long supported. The Council also recognizes that the diversity of health care financing models represents different country-to-country priorities, societal beliefs, and a matter of acceptable trade-offs. Such trade-offs can include the level of health insurance coverage achieved by the financing model; individual tax burdens; the

level of government regulation required; and the model's support for, use of and impact on innovation in the health care system.

Compared to the countries outlined in this report, the United States is the only country without a publicly-financed system of universal health care. At the same time, the United States surpasses its peers on health care spending, both as a percentage of gross domestic product and per capita spending. It also spends more public dollars per capita on health care than most other countries highlighted in the report. As outlined in the appendix, the level of investment of the United States on health care, and its pluralistic model of health care financing, has not necessarily translated to better health outcomes for the population as a whole. That being said, the Council recognizes that some of the differences in health outcomes between the United States and other countries may partly be the result of divergent definitions of indicators compared, as well as other factors that drive health care costs. The Council affirms that within the United States, as with any health system, improvements can be made to achieve better population health status and outcomes, and ensure the provision of quality care.

The Council recognizes that the US health system and its mechanisms of financing are in a time of transformation and change. The United States is continuing to move forward with implementing various new and innovative payment and delivery models, which prioritize patient engagement and health outcomes. Moving forward, the Council will continue to monitor the impact of health system transformations and financing changes on coverage, access to and quality of health care, and health status and outcomes.

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APPENDIX - Health Care System Financing, Coverage and Performance of Selected Countries¹

Country	% GDP, 2013	Government role	Public system financing	Role of private insurance	% adults waited 2 months or more for specialist appt, 2013	% adults experienced access barrier due to cost in past year, 2013	Avoidable deaths per 100,000 population, 2013
Australia	9.4% (2012)	Universal public medical insurance program (Medicare), national & state public hospital funding	General tax revenue; earmarked income tax	Complementary, supplementary	18%	16%	68 (2011)
Canada	10.7%	Regionally administered universal public insurance program	Provincial/federal general tax revenue	Complementary	29%	13%	78 (2011)
France	11.6%	Statutory health insurance system, insurers in national exchange	Employer/employee earmarked income and payroll tax; general tax revenue; earmarked taxes	Complementary, supplementary	18%	18%	64 (2011)
Germany	11.2%	Statutory health insurance system, insurers in national exchange; high income can opt out for private coverage	Employer/employee earmarked payroll tax; general tax revenue	Substitutive, complementary, supplementary	10%	15%	88
Netherlands	11.1% ²	Statutory health insurance system with universally-mandated private insurance, regulated and subsidized by government	Earmarked payroll tax; community-rated premiums; general tax revenue	Complementary	3%	22%	72
New Zealand	11.0%	National health care system	General tax revenue	Complementary, supplementary	19%	21%	89 (2011)
Norway	9.4%	National health care system	General tax revenue; national and municipal taxes	Supplementary	26%	10%	69
Sweden	11.5%	National health care system, with responsibility for most financing devolved to county councils	General tax revenue raised by county councils; national tax revenue	Supplementary	17%	6%	72

Country	% GDP, 2013	Government role	Public system financing	Role of private insurance	% adults waited 2 months or more for specialist appt, 2013	% adults experienced access barrier due to cost in past year, 2013	Avoidable deaths per 100,000 population, 2013
Switzerland	11.1% ²	Statutory health insurance system, with universally mandated private insurance, with state government responsible for financing through subsidies	Community-rated insurance premiums; general tax revenue	Complementary, supplementary	3%	13%	n/a
United Kingdom	8.8%	National health service	General tax revenue	Supplementary	7%	4%	86
United States	17.1%	Insurance coverage mandated, with some exceptions; Medicare; Medicaid; subsidies for health insurance exchange coverage	Payroll tax, federal and state tax revenues, premiums	Individual and employer-sponsored, Medicare supplemental	6%	37%	115 (2010)

1. Excerpted from 2015 International Profiles of Health Care Systems. The Commonwealth Fund. January 2016.
 2. Current spending only, and excludes spending on capital formation of health care providers.

3. ENSURING CONTINUITY OF CARE PROTECTIONS DURING ACTIVE COURSES OF TREATMENT (RESOLUTION 108-A-16)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
 IN LIEU OF RESOLUTION 108-A-16
 REMAINDER OF REPORT FILES**

See Policies H-285.908, H-285.911, H-285.924, H-285.952 and H-385.936

At the 2016 Annual Meeting, the House of Delegates referred Resolution 108, “Continued Surgical Care,” which was sponsored by the New York Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2017 Annual Meeting. Resolution 108-A-16 asked:

That our American Medical Association (AMA) seek legislation/regulation which would allow a physician who has performed an initial surgical procedure, to continue to follow the patient and perform any necessary follow-up surgery, regardless of the physician’s change in participation status; and

That any follow-up surgery performed by a physician whose participation status changed after the initial surgery was performed, be reimbursed appropriately based on their current participation status.

This report provides background on health plan continuity of care processes; highlights the Health Benefit Plan Network Access and Adequacy Model Act of the National Association of Insurance Commissioners (NAIC); outlines continuity of care protections of marketplace, Medicare Advantage and Medicaid health plans; summarizes relevant AMA policy and model state legislation; and presents policy recommendations.

BACKGROUND

When patients transition between health plans, or when providers, including physicians, leave or are terminated from health plan networks, patients with usual sources of care face potential care disruptions due to the need to find new in-network physicians and hospitals. Such care disruptions can be especially detrimental to patients in the middle of a course of treatment.

Some health plans have implemented continuity of care processes to prevent care disruptions for enrollees undergoing active courses of treatment. Health plan continuity of care processes can provide eligible new enrollees of a health plan undergoing an active course of treatment with a pathway to continue to receive care from non-participating providers accessed prior to health plan enrollment at in-network cost-sharing levels. For existing plan enrollees in an active course of treatment, continuity of care processes can provide a mechanism to access the care of providers no longer in the network at in-network cost-sharing levels. There are outlined time limitations for such continuity of care periods, which vary based on the health plan, physician discretion and patient needs. State and federal laws and regulations, and model laws, also provide parameters and guidance for health plan continuity of care processes and protections. Ultimately, the goal of continuity of care processes is to transition affected plan enrollees to new in-network providers.

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS MODEL ACT

The Health Benefit Plan Network Access and Adequacy Model Act of the NAIC,¹ which provides a model for state legislation and regulations, contains provisions to assure continuity of care protections for health plan enrollees in an active course of treatment whose provider leaves or is removed from the plan's network without cause. A health plan enrollee who has been treated on a regular basis by a provider removed from or leaving the network is considered under the model act to be in an active course of treatment. The following treatments and conditions meet the definition of "active course of treatment" under the model act:

- An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
- An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care that the covered person is currently receiving, such as chemotherapy, post-operative visits or radiation therapy;
- The second or third trimester of pregnancy; and
- An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

The act also states that when a provider of a health plan enrollee leaves or is removed from the network, the health plan should establish reasonable procedures to transition the plan enrollee in an active course of treatment to a participating provider in a manner that provides for continuity of care. In addition to providing the plan enrollee with notice of the provider leaving or being removed from the plan network, the model act states that the health plan also should make available to the patient a list of available participating providers in the same geographic area who are of the same provider type. Importantly, the model act stipulates that the health plan must provide information about how the plan enrollee may request to continue care with a provider that is no longer participating in the plan. The model act stresses that any health decisions made with respect to a request for continuity of care should be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations. The care to be continued must also be medically necessary.

Time limitations for the continuity of care period for health plan enrollees undergoing an active course of treatment are also outlined in the model act. Under the model act, the period should extend to the earlier of:

- The termination of the course of treatment by the covered person or the treating provider;
- A time period determined by the state, while noting that the current accreditation standard for the length of the continuity of care period is 90 days, unless the health plan's medical director determines that a longer period is necessary;
- The date that care is successfully transitioned to a participating provider; or
- Benefit limitations under the plan are met or exceeded.

For health plan enrollees who are in their second or third trimester of pregnancy, the model act stipulates that the continuity of care period should extend through the postpartum period. Twenty-nine states have laws consistent with this provision of the model act.²

Under the model act, granting continuity of care requests is contingent upon the provider accepting certain payment and billing parameters. First, the provider must agree in writing to accept the same payment from and abide by the same terms and conditions with respect to the health plan for that patient as provided in the original provider contract. Second, the provider must agree in writing not to seek any payment from the health plan enrollee for any amount for which the enrollee would not have been responsible if the physician or provider were still a participating provider.

HEALTH PLAN CONTINUITY OF CARE PROTECTIONS

Health Insurance Marketplaces

The final rule outlining the HHS Notice of Benefit and Payment Parameters for 2017 purposefully aligns with the NAIC model act. The final rule included a new continuity of care protection for patients enrolled in plans in federally facilitated marketplaces (FFMs) undergoing an active course of treatment. The rule requires health plans participating in FFMs, in cases where a provider is terminated without cause, to allow a health plan enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. The regulation used the definition of "active course of treatment" included in the NAIC model act, and added that ongoing treatments for mental health and substance use disorders also fall within the definition.³

Addressing physician payment and balance billing, the Center for Consumer Information and Insurance Oversight (CCIO) of the Centers for Medicare & Medicaid Services (CMS) stated in its 2017 letter to issuers in FFMs that it expected health plans to negotiate with a provider for payment of services under the new continuity of care protection. However, if a provider agrees to provide continuity of care under this new requirement, health plans in FFMs would only be responsible for paying a provider what was previously paid under the same terms and conditions of the provider contract, including any protections against balance billing. That being said, CCIO also stated that it cannot require non-contracted providers to accept a particular payment rate, and as such, cannot prohibit balance billing for non-contracted providers.⁴

As outlined in the final rule outlining the HHS Notice of Benefit and Payment Parameters for 2017 and subsequent letters to issuers in FFMs, the new continuity of care standards for FFMs are not intended to, and do not, preempt state provider transition notices and continuity of care requirements, and CMS intends to defer to a state's enforcement of substantially similar or stronger standards.^{3,4,5} As of April 2016, 39 states and the District of Columbia have continuity of care standards similar to those outlined in federal rules. However, the length of the continuity of care protection varies from state to state. Sixteen states extend continuity of care protections to enrollees that have switched to a new health plan, which is stronger than current federal rules. Eleven states do not have continuity of care protections as defined in the federal rule, but patients enrolled in plans offered through FFMs in some of these states will still have some continuity of care protections.² To review the status of continuity of care protections by state, please refer to <http://www.commonwealthfund.org/publications/blog/2016/apr/continuity-of-care-protections>.

Medicare Advantage

Continuity of care protections for patients enrolled in Medicare Advantage (MA) plans are largely limited to cases of significant no-cause provider terminations. CMS has stated that, as a best practice, MA plans should include certain information in notices to health plan enrollees in addition to identifying the provider(s) being terminated from the network, including names and phone numbers of in-network providers that enrollees may access for continued care, and information regarding how enrollees may request continuation of ongoing medical treatment or therapies with their current providers. CMS has stated that in the case of significant no-cause provider terminations, it may be necessary for MA plans to allow care to continue to be provided on an interim, transitional basis, by providers who have been terminated from the network in order to address continuity of care needs of affected enrollees. In addition, MA plan enrollees substantially affected by a significant no-cause provider termination during

a plan year may be afforded a special election period, so they can switch plans prior to the next open enrollment period.⁶

Medicaid

Under Medicaid, states are required to have a transition of care policy in effect to ensure continuity of care during Medicaid program transitions when an enrollee, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. The transition of care policy would be applicable during a transition from a Medicaid fee-for-service program to a Medicaid managed care plan, or a transition from one Medicaid managed care plan to another. The transition of care policy must ensure that enrollees have access to services consistent with the access they previously had, and are permitted to retain their current provider for a period of time if their providers are not in the Medicaid managed care plan's network. In addition, enrollees must be referred to appropriate providers of services that are in the network.⁷

RELEVANT AMA POLICY AND ADVOCACY

Policy H-285.952 states that patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of/restrictions on their licenses/certifications or fraud. The policy states that patients eligible for transitional care should specifically include, but not be limited to those who are: undergoing a course of treatment for a serious or complex condition, undergoing a course of institutional or inpatient care, undergoing non-elective surgery, pregnant, or are terminally ill at the time that they receive notice of the termination. The policy stipulates that transitional care should be provided at the physicians' and hospitals' discretion, and should continue for an appropriate length of time. Physicians and hospitals also should continue to receive payment for the services provided during this transitional period. Policy H-285.924 states that health plans should continue to cover services provided by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their medical licenses/certifications or fraud, until a new printed directory is distributed. Policy H-385.936 advocates for appropriate reimbursement for follow-up care of complications and staged procedures from payers, including state and federal agencies.

In addition, Policy H-285.952 states that when a participating physician leaves a managed care plan, patients of the physician be informed, in a timely manner, of the departure by the physician and/or the managed care plan, and, if applicable, of their right to elect continued transitional care from that physician. Policy H-285.908 supports requiring provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when selecting and enrolling in a health insurance plan.

Based on existing AMA policy, the AMA has model state legislation addressing network access and adequacy, which contains provisions to assure continuity of care protections for health plan enrollees in an active course of treatment. These provisions of the model bill largely align with those contained in the NAIC model act. In the arena of provider payment, like the NAIC model bill AMA's model state legislation underscores that granting continuity of care requests is contingent upon the provider accepting certain payment and billing parameters. While the NAIC model act states that the provider must agree in writing to accept the same payment from and abide by the same terms and conditions with respect to the health plan for that patient as provided in the original provider contract, the AMA model bill builds upon this language and states that the provider can also accept new payment and terms agreed to by the provider and health plan.

DISCUSSION

The Council believes that additional measures are needed to prevent disruptions in care for patients in an active course of treatment, both for new enrollees in a health plan, and existing enrollees receiving care from providers whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certifications, or fraud. As an underlying principle, as outlined in Policy H-285.911, health insurance provider networks should be sufficient to provide meaningful access to all medically necessary and emergency care, at the preferred, in-network benefit level, on a timely and geographically accessible basis. Overall, patients, including those in an active course of treatment, should have continued access throughout the coverage year to the network they reasonably relied upon when selecting and enrolling in a health insurance plan. To achieve that goal, the Council recommends reaffirming Policy H-285.908, which supports requiring that provider terminations without

cause be done prior to the enrollment period. In cases in which provider terminations without cause happen over the course of the coverage year, the Council also recommends the reaffirmation of Policy H-285.952, which states that patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certifications, or fraud.

The Council proposes the modification of Policy H-285.924[4] to ensure that health plans continue to cover services provided by physicians who involuntarily leave a plan without cause, until the provider directory is updated online and a new printed directory is distributed. This amendment to Policy H-285.924 not only provides needed updates to the policy to account for the existence of online provider directories, but the proposed new wording of the policy would provide patients in an active course of treatment with strong continuity of care protections. To ensure physician payment for any transitional care associated with complications and staged procedures is adequate, the Council recommends modifying Policy H-385.936, which currently only advocates for appropriate payment for follow-up care in such scenarios.

The Council recognizes that current AMA policy addressing continuity of care for patients in an active course of treatment focuses on existing health plan enrollees receiving care from providers whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certification, or fraud. Patients in an active course of treatment who switch to a new health plan should also have the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Following what is already outlined in Policy H-285.952, continued transitional care for new health plan enrollees should be provided at the physicians' and hospitals' discretion, and should continue for an appropriate length of time. Such care should only be provided after payment terms have been agreed to with the health plan. Moving forward, the AMA should continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure continuity of care protections for patients in an active course of treatment – both for existing and new health plan enrollees.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-16, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy H-285.911, which states that health insurance provider networks should be sufficient to provide meaningful access to all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis.
2. That our AMA reaffirm Policy H-285.908, which supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when selecting and enrolling in a health insurance plan.
3. That our AMA reaffirm Policy H-285.952, which states that patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss of or restrictions on their licenses and/or certifications, or fraud.
4. That our AMA modify Policy H-385.936 by addition and deletion to read as follows:

Our AMA advocates for appropriate reimbursement payment for follow-up care of and transitional care associated with, complications and staged procedures from payers, including state and federal agencies.

5. That our AMA modify Policy H-285.924[4] by addition to read as follows:

It is the policy of our AMA that health plans: ... (4) should continue to cover services provided by physicians who involuntarily leave a plan, for reasons other than loss of/restrictions on their medical license/certification or fraud (i.e., with cause), until the provider directory is updated online and a new printed directory is distributed.

6. That our AMA support patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Transitional care should be provided at the physicians' and hospitals' discretion.
7. That our AMA continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure continuity of care protections for patients in an active course of treatment.

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4. SURVEY OF ADDICTION TREATMENT CENTERS' AVAILABILITY (RESOLUTION 115-A-16)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 115-A-16
REMAINDER OF REPORT FILED**
See Policy H-95.926

At the 2016 Annual Meeting, the House of Delegates referred Resolution 115, "Survey of Addiction Treatment Centers' Availability," which was sponsored by the American Academy of Pain Medicine. Resolution 115-A-16 asked:

- (1) That our American Medical Association (AMA) survey practicing physicians about the availability of mental health resources for the treatment of addiction within their local community; (2) That this should specifically address the availability of referrals for a) Medicare patients, b) Medicaid patients, c) managed care patients, and d) patients with private insurance; and (3) That our AMA publicly release the results of this study with the intention of helping to remedy the probable shortage of addiction treatment centers, especially for our Medicare and Medicaid patients.

This report provides links to numerous resources that make information available on substance use disorder treatment programs; describes AMA efforts to increase patient access to treatment; summarizes AMA policy; and makes recommendations.

BACKGROUND

Several existing “locators” that provide information on treatment facilities for substance abuse/addiction and/or mental health disorders are readily available to physicians and the public. The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains a “behavioral health treatment services locator” that includes substance abuse/addiction treatment providers at <https://findtreatment.samhsa.gov/>. Users may call a National Helpline (samhsa.gov/find-help/national-helpline) or enter their city, state or zip code into the “locator” to identify treatment facilities in their geographic area. Users can then click on a particular facility to find links to the facility’s website as well as the services and type of care provided; payment and insurance accepted for those services; treatment approaches (e.g., individual psychotherapy, cognitive behavior therapy); service setting (e.g., outpatient, inpatient); and age groups accepted. SAMHSA’s National Directory of Drug and Alcohol Abuse Treatment Facilities can be found at samhsa.gov/data/sites/default/files/2015_National_Directory_of_Drug_and_Alcohol_Abuse_Treatment_Centers_v1.pdf.

SAMHSA takes steps to keep its “locator” current, and updates provider information annually using facility responses to SAMHSA’s National Survey of Substance Abuse Treatment Services and National Mental Health Services Survey. New facilities that have completed an abbreviated survey and met other qualifications are added monthly. Updates to facility names, addresses, telephone numbers, and services are made weekly for facilities informing SAMHSA of changes.

SAMHSA also maintains a Buprenorphine Treatment Physician Locator (samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator), where patients can find physicians authorized to treat opioid dependency with buprenorphine, organized by state. An opioid treatment program directory maintained by SAMHSA can be found at <http://dpt2.samhsa.gov/treatment/directory.aspx>. It is important to note that not all eligible providers apply to be added to SAMHSA’s inventory of programs or opt in to be listed publicly, rendering SAMHSA’s “treatment locators” incomplete.

Links to self-help groups such as Alcoholics Anonymous and Narcotics Anonymous can be found at <https://findtreatment.samhsa.gov/locator/link-focSelfGP>. Person-centered information on opioid treatment options, including medication-assisted treatment (MAT), can be found at <http://archive.samhsa.gov/MAT-Decisions-in-Recovery/>. This site includes multimedia tools designed to help people compare medications and address common concerns about MAT. A free, downloadable handbook (<http://store.samhsa.gov/product/SMA16-4993>) is similarly intended to help people with opioid use disorder make informed decisions about their care.

A free app for practitioners who provide MAT or plan to do so in the future can be found at <http://store.samhsa.gov/apps/mat/>. The app includes information on treatment approaches and medications used to treat opioid use disorders, a buprenorphine prescribing guide, and clinical support tools such as treatment guidelines, ICD-10 coding and recommendations for working with special populations.

The American Academy of Addiction Psychiatry (AAAP) maintains an online Physician Locator (aaap.org/patient-resources/find-a-specialist), as does the American Society of Addiction Medicine (ASAM) (https://asam.ps.member-suite.com/directory/SearchDirectory_Criteria.aspx). ASAM has conducted payer surveys in the past including research on Medicaid coverage of addiction treatment by state.¹ A review of addiction coverage benefits in Affordable Care Act plans was conducted by the National Center on Addiction and Substance Abuse.² Directories of addiction treatment facilities, support services and related resources are also maintained by most state substance use/addiction services agencies, and these directories can be easily accessed online.

State fact sheets that include contact information for the single state authorities overseeing each state’s SAMHSA block grant are maintained by the National Association of State Alcohol and Drug Abuse Directors (<http://nasadad.org/state-fact-sheets/>). These state fact sheets also include the number of residents receiving services in the state and the number of opioid overdose deaths. The Addiction Technology Transfer Network (<http://attcnetwork.org/home/>), another useful resource comprised of regional centers, was established by SAMHSA to accelerate the adoption of evidence-based and promising addiction treatment services, and also to increase the knowledge and skills of addiction treatment professionals.

AMA ACTIVITY

Enhancing patient access to treatment and reducing the stigma of substance use disorders are longstanding priorities of the AMA, which supports initiatives addressing substance use disorders and also identifying treatment gaps and appropriate targeting of funding and other resources. Reducing the stigma of substance use disorders and enhancing access to treatment is one of the five goals of the AMA Task Force to Reduce Opioid Abuse (Task Force), which was established in 2014 and is made up of more than 25 state medical associations, national medical specialty societies and other health care organizations. The work of the Task Force includes helping physicians learn how to better identify patients at risk for developing a substance use disorder, and when such disorders are present, identify the most appropriate treatment options. The Task Force has made increasing access to MAT a key recommendation, and several medical organizations offer waiver-qualifying MAT training to help physicians recognize patients with substance use disorder and become certified as a means of increasing access to treatment.

In addition to the work of the Task Force, the AMA continues to collaborate with state medical associations to address legislation and regulation ranging from developing effective prescription drug monitoring programs, continuing medical education, restrictions on treatment for opioid use disorder as well as enactment of naloxone access and Good Samaritan overdose protections. Additionally, the AMA worked with the Medical Association of the State of Alabama and the Rhode Island Medical Society to produce state-specific toolboxes that provide physicians and other health professionals with data and practical resources designed to help reverse the opioid epidemic. Rhode Island's toolbox (<http://www.health.ri.gov/healthrisks/addiction/for/providers/>) includes instructions for physicians on how to request assessments by licensed chemical dependency professionals for patients at high risk of opioid medication misuse, and also outlines steps physicians should take to refer patients to treatment and recovery programs. Alabama's toolbox (<http://smartandsafeal.org/wp-content/uploads/2015/11/AL-AMA-opioid-grant-toolbox-FINAL-Nov-2016-updated2FINAL.pdf>) helps physicians educate patients about pain and also provides them with resources for overdose prevention and links to treatment program directories.

To promote coverage of MAT, the AMA urged the nation's attorneys general this year to help end insurance company policies that delay or deny care for substance use disorders. On March 1, 2017, Aetna became the third insurer (joining Anthem and Cigna) to eliminate prior authorization for opioid disorder treatment.³

The AMA advocates with Congress and the Administration, and in states, on issues related to substance misuse and the opioid epidemic. For example, the AMA commented on SAMHSA's rulemaking that increased the number of patients who can be treated with buprenorphine by qualified physicians to 275.⁴ The AMA also supported the launch of the National Institute on Drug Abuse web page designed to educate medical professionals on issues related to substance misuse and provide practical resources (<https://www.drugabuse.gov/nidamed-medical-health-professionals>). The AMA has also developed several webinars on topics related to the intersection of pain, substance use disorders and opioids.

AMA POLICY

AMA policy supports health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorders (Policy H-165.888[3]). Under Policy H-95.975, the AMA recognizes that substance use disorders are a major public health problem, while Policy H-95.981 states that federal drug policy should expand the availability and reduce the cost of substance use treatment programs. Policy H-95.956 endorses the concept of prompt access to treatment for addiction and urges the Administration and Congress to provide significantly increased funding for alcohol/drug dependency treatment. Policy H-95.932 supports legislative and regulatory efforts that increase access to and coverage of naloxone. The AMA advocates for the elimination of "fail first" policy implemented by some insurers for addiction treatment under Policy H-320.941. Policy H-95.944 opposes federal, state, third-party and other laws and policies including those imposed by pharmacy benefit managers that limit patient access to medically necessary pharmacological therapies for opioid use disorder.

Policy H-300.962 encourages all physicians, particularly those in primary care fields, to undertake education in the treatment of substance abuse and affirms that many physicians in fields other than psychiatry have the education and experience appropriate for substance abuse treatment and should be entitled to compensation. Policy D-120.953 directs the AMA to work to end the limitation of 100 patients per certified physician treating opioid dependence after the second year of treatment (the limit has been increased to 275 patients). Policy H-95.991 urges physicians to

acquaint themselves with the various chemical dependency programs available for the medical treatment of alcohol and drug use, and where appropriate, to refer their patients to them promptly.

Policy H-345.975 supports maintaining essential mental health services at the state level, including addiction treatment centers. Policy H-95.976 encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infants. A joint report developed by the Council on Medical Service and the Council on Science and Public Health established Policy H-185.931, which in part advocates for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.

DISCUSSION

After thorough study of resources that collect and make available information on substance use disorder treatment programs, the Council concludes that a costly national survey of practicing physicians will do little to accomplish the intent of Resolution 115-A-16 which, according to the sponsor,⁵ is to measure access to treatment resources and identify gaps in treatment capacity. Physicians may not know whether treatment programs in their communities accept Medicare, Medicaid, or private insurance, and the Council is not persuaded that self-reported data collected by the suggested survey would produce reliable information.

Instead, the Council directs AMA members to utilize the “treatment locators” and numerous other resources described in this report. The main source of national data is SAMHSA’s “behavioral health treatment services locator” (<https://findtreatment.samhsa.gov/>), which is updated using substance use/addiction treatment provider responses to SAMHSA’s National Survey of Substance Abuse Treatment Services and National Mental Health Services Survey. According to SAMHSA’s Medical Director, with whom the Council met during the development of this report, information in the agency’s “treatment locators” is incomplete because not all certified providers have opted to have their information listed publicly.

The Council observes that increased awareness of treatment providers in a community as well as a breakdown of public and/or private insurance accepted by these programs would be of great assistance to physicians looking to make patient referrals. Accordingly, the Council makes two recommendations intended to increase the inclusiveness of SAMHSA’s “treatment locators.” First, the Council recommends that the AMA encourage SAMHSA to use its national surveys to increase information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs. Additionally, the Council recommends that the AMA encourage physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSA’s “treatment locators.”

The Council believes that states are well-positioned to gather licensed treatment provider information, and emphasizes the availability of state resources, including fact sheets for each state maintained by the National Association of State Alcohol and Drug Abuse Directors (at <http://nasadad.org/state-fact-sheets/>). The Council finds the state-specific toolboxes developed by the AMA in conjunction with the Medical Association of the State of Alabama and the Rhode Island Medical Society to be of particular value, and encourages the development of similar resources.

Finally, the Council recognizes that there are too many communities where the availability of substance use disorder treatment services does not meet demand, and points to existing AMA policy supporting increased availability of these services. The Council is hopeful that its recommendations, along with links to the many resources described in this report, will help physicians increase their knowledge of substance use disorder treatment services in their communities.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 115-A-16 and the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSA's "treatment locators";
2. That our AMA encourage physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSA's "treatment locators"; and
3. That our AMA encourage SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities.

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3. AMA Commends Aetna Commitment to End Prior Authorization on Opioids Treatment. AMA Press Release. February 16, 2017.
4. American Medical Association. Letter to Kana Enomoto, Principal Deputy Administration, SAMHSA.
5. American Academy of Pain Medicine. Letter to the AMA dated October 3, 2016.

5. HOSPITAL CONSOLIDATION (RESOLUTION 216-A-16)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 216-A-16
REMAINDER OF REPORT FILED**

See Policies H-140.984, H-160.906, H-215.968, H-225.947, H-225.950 and H-380.987

At the 2016 Annual Meeting, the House of Delegates referred Resolution 216, "Hospital Consolidation," which was sponsored by the Washington Delegation and assigned to the Council on Medical Service for study. Resolution 216-A-16 asked the American Medical Association (AMA) to:

- (1) study the current market power of hospitals and hospital conglomerates in the largest state metropolitan statistical areas; (2) compare the market power of hospitals and hospital conglomerates and health plans; (3) study the effects of hospital consolidation on price, availability of services, physician satisfaction, and quality; and (4) develop an action plan to manage adverse effects of the current consolidation of hospitals and hospital conglomerates.

This report describes AMA efforts to promote competition in health care markets and address health care entity consolidation; outlines findings from a recent AMA analysis of hospital market concentration levels; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation among health care entities (e.g., hospitals, health insurers, and physician practices), and the consequences that mergers may have on patients, physicians, and health care prices, continue to be closely monitored by the AMA. At the same time, new health care payment and delivery models have led many physicians to engage in pioneering practice transformations that involve integrating a variety of delivery partners, including hospitals. The AMA promotes physician leadership in integrated structures and develops policy and resources intended to help safeguard physicians employed by large systems.

The AMA believes that specific instances of health care entity consolidation must be examined individually, taking into account the case-specific variables of market power and patient needs as determined, in part, by physician input. That said, the AMA strongly supports and encourages competition in all health care markets in order to provide patients with more choices while improving care and lowering the costs of that care. The AMA further maintains that markets should be sufficiently competitive to allow physicians to have adequate practice options.

The most visible AMA competitive analyses have focused on health insurance markets, because the anticompetitive effects of dominant insurers in highly concentrated health insurance markets pose substantial risk of harm to consumers. Analyses prepared by the AMA—based on data from the AMA's *Competition in Insurance: A Comprehensive Study of US Markets*—provide the foundation for the AMA's merger advocacy, which achieved two significant victories this year when a federal judge issued a ruling blocking the proposed merger between Aetna and Humana on January 23 and another federal judge blocked the proposed Anthem-Cigna merger on February 8. AMA analyses had determined that the proposed mergers would significantly diminish market competition. The AMA has been publishing its analyses of health insurance markets for fifteen years, and has long cautioned about the negative consequences of anticompetitive health insurer mergers.

Although the Federal Trade Commission (FTC) has successfully blocked several hospital mergers, many hospital markets are highly concentrated and noncompetitive.¹ In 2016, the AMA conducted its own analysis of hospitals' market shares and market concentration levels using 2013 data from the American Hospital Association (AHA). The AMA looked at 1922 hospitals in 362 metropolitan statistical area-level markets and found that the vast majority (90 percent) of hospital markets are highly concentrated. The analysis also found that 70 percent of hospitals are members of hospital systems.²

The AMA also monitors trends in hospital acquisition of physician practices (vertical hospital consolidation) and physician employment. Data from the AMA's 2012, 2014 and 2016 Physician Practice Benchmark Surveys (Benchmark Surveys), which yield nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week, demonstrate recent stability in the ownership structure of physician practices. Analyses of the surveys found that the share of physicians who worked directly for a hospital or in practices that were at least partially owned by a hospital remained unchanged between 2014 and 2016 at 33 percent both years.³ This percentage represented an increase from 29 percent in 2012. In 2016, 56 percent of physicians worked in practices that were wholly owned by physicians, compared to 57 percent in 2014 and 60 percent in 2012. Although detailed information on practice ownership structure is not available for years prior to 2012, research suggests that in 2007-2008, only 16 percent of physicians worked directly for a hospital or in practices that were at least partially owned by a hospital.⁴

Because the Centers for Medicare & Medicaid Services has taken steps to level the site-of-service playing field between physician offices and off-campus provider-based departments acquired after November 2015, the incentive for hospitals to purchase physician practices in the future has likely been reduced. Vertical consolidation between hospitals and physician practices was the focus of Council on Medical Service Report 2-A-15 (ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/a15-cms-report2.pdf), which described potential benefits of such consolidation, such as increased patient care coordination and operational efficiencies, as well as the potential for increased provider market concentration that could lead to higher prices.

There is also the potential for benefits and harms resulting from hospital mergers (horizontal hospital consolidation). Consolidated hospitals may incur some savings due to economies of scale, and may also increase the volume of specialized services, which may in turn improve quality.⁵ However, hospitals acquiring market power through mergers may also increase prices for hospital care.⁶ Furthermore, highly concentrated hospital markets may lessen the practice options available to physicians in communities dominated by large hospital systems. The AMA is cognizant of the effects of hospital consolidation on physicians and patients, including concerns about loss of physician autonomy in clinical decision-making and also preserving physician leadership in large systems.

The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large hospital systems or hospital-owned practices remains an attractive practice option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls

and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.⁷

AMA ACTIVITY

The AMA strongly supports and encourages competition among all health care entities (e.g., hospitals, health insurers and physician practices) as a means of promoting high-quality, cost-effective health care. A competitive marketplace provides more choices to physicians and patients, and stimulates innovation in health care. The AMA also supports rigorous review and greater scrutiny of proposed health care entity mergers to determine their effects on patients and providers, and has urged Congress and the Administration to take steps to foster competition in health care markets. The AMA has further advocated for clear and commonsense antitrust rules concerning the formation of innovative delivery models so that physicians can pursue integration options that are not necessarily hospital driven.

Physician-Owned Hospitals: The AMA strongly advocates that Congress repeal the ban on expansion and new construction of physician-owned hospitals, which could increase competition in hospital markets. Under current law, physician-owned hospitals are not allowed to expand capacity unless certain restrictive exceptions can be met. The AMA supports HR 1156, “Patient Access to Higher Quality Health Care Act of 2017,” which would repeal limits to the whole hospital exception of the Stark physician self-referral law that essentially bans physician ownership of hospitals and places restrictions on expansion of existing physician-owned hospitals. Because physician-owned hospitals have been shown to provide the highest quality care to patients, limiting their viability reduces access to high-quality care. Limits on existing physician-owned hospitals also put them at a competitive disadvantage, making it difficult for them to respond to their communities’ health care needs.

Working Toward Integrated Leadership Structures: The AMA has always supported the ability of physicians to choose their mode of practice. As greater numbers of physicians became employed by hospitals and health systems, the AMA developed resources for employed physicians and promoted their autonomy and leadership within integrated structures. AMA resources include a new Guide to Selecting a Physician-Led Integrated System, the Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement to assist members in the negotiation of employment contracts. AMA Principles for Physician Employment (Policy H-225.950) were codified to address some of the more complex issues related to employer-employee relationships, and the AMA Physician’s Guide to Medical Staff Bylaws is a useful reference manual for drafting and amending hospital medical staff bylaws.

Notably, the AMA has been working with the American Hospital Association (AHA) to create collaborative and integrated leadership structures for physicians, health care executives, hospitals and health systems. In October 2013, the AMA and the AHA held a joint leadership conference on new models of care to initiate discussions about integrating the administrative and clinical aspects of health care delivery. The conference, which was the first formal meeting between these two organizations in more than 35 years, was an opportunity to better understand how physicians and hospitals interact and the ways in which they can become more collaborative. Conversations centered on the need for greater physician-hospital collaboration to achieve the Triple Aim through new payment and delivery models. These discussions laid the foundation for identifying solutions to aid physicians and hospital executives in working together and in adapting to an ever-changing health care environment.

In 2015, the AMA and AHA jointly released “Integrated Leadership for Hospitals and Health Systems: Principles for Success.” These principles provide a guiding framework for physicians and hospitals that choose to create an integrated leadership structure but are unsure how to best achieve the engagement and alignment necessary to collaboratively prioritize patient care and resource management. A series of collaborative conferences have been held to promote the principles and the AMA’s vision of successful integrated leadership, which requires functional partnership between organized physicians, health care executives, and hospitals.

The structure and function of physician-led health care teams were addressed by the Council in Reports 1-I-13 (ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i13-cms-report1.pdf), and 1-I-15 (ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i15-cms-report1.pdf), and Council on Medical Education and Council on Medical Service Joint Report I-12 (ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i12-cmecms-jointreport.pdf).

AMA POLICY

The AMA's strong support of health care market competitiveness has been reaffirmed by several policies (e.g., Policies H-215.968, H-285.998[1], H-165.985, and H-385.990). The AMA also has longstanding policy on pluralism (Policy H-165.844) and the freedom of physicians to choose their method of earning a living (Policy H-385.926[2]). Policy D-225.995 directs the AMA to continue to monitor hospital mergers. Under Policy H-140.984, the AMA opposes the ban on physician self-referrals because of benefits to patients, including increased access and competition.

Policy H-225.947, which was established with Council on Medical Service Report 5-I-15 (ama-assn.org/sites/default/files/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/i15-cms-report5.pdf), encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy. Policy H-225.947 also encourages continued research on the effects of integrated health care delivery models on patients and the medical profession. Policy H-285.931 adopts principles for physician involvement in integrated delivery systems and health plans, while Policy H-225.957 outlines principles for strengthening physician-hospital relationships. Policy D-225.977 directs the AMA to continue assessing the needs of employed physicians and promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures.

Policy H-215.969 provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve certain issues. Policy H-215.969 further directs the AMA to work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

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 without being employed by a hospital or accountable care organization. Policy H-160.906 defines "physician-led" in the context of team-based health care and outlines guidelines for physician-led health care teams.

DISCUSSION

The Council understands the concerns regarding potential negative consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options). More broadly, the Council believes that highly concentrated markets dominated by any type of health care entity (including a physician practice) may be harmful and, conversely, that competition in the marketplace is essential to a well-functioning health care system.

The Council recognizes that the AMA is a strong advocate for competitive health care markets and antitrust relief for physicians and that existing policy sufficiently supports AMA activity in this regard. The Council recommends reaffirming Policy H-215.968, which supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care, and Policy H-380.987, which maintains antitrust relief as a top AMA priority. The Council also recognizes ongoing AMA efforts to monitor and respond to health care consolidation, including engaging with the FTC and the US Department of Justice as well as state attorneys general and insurance commissioners. AMA advocacy to ensure competitive health care markets is predominantly based on the AMA's own studies, which include the AMA's annual analyses of competition in health insurance markets; biennial Physician Practice Benchmark Surveys; and the 2016 analysis of hospital market concentration. Additionally, the Council values the AMA's strong advocacy to repeal the ban on expansion and new construction of physician-owned hospitals, which could increase competition in hospital markets, and recommends reaffirming the AMA's longstanding policy opposing the ban on self-referrals (Policy H-140.984).

Many hospital markets are already highly concentrated. Accordingly, the Council affirms its support for AMA activity and policy, summarized in this report, which is meant to help mitigate the effects of consolidation. In particular, the Council views active involvement by physicians in integrated leadership structures as an intrinsic countervailing force to dominant hospital systems. The AMA's strategic focus on physician satisfaction and its

collaborative work to foster physician leadership further demonstrate AMA commitment to the needs of physicians working in large systems. The Council recommends reaffirmation of three AMA policies intended to help guide and protect these physicians: Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements that actively involve physicians in integrated leadership and preserve clinical autonomy, and also encourages continued research on the effects of integrated health care delivery models on patients and the medical profession; Policy H-225.950, which outlines AMA principles for physician employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations; and Policy H-160.906, which defines "physician-led" in the context of team-based health care and outlines guidelines for physician-led health care teams.

The Council points to the AMA and state medical associations as resources that AMA members can turn to for information on anticompetitive health care entity mergers as well as assistance with matters related to physician-hospital relations. The Council observed during its deliberations that health system mergers may have positive or negative effects on the availability of graduate medical education positions, depending on the merger. The importance of business education to physicians, which would help ensure that physician leaders have requisite business and management skills, was also discussed. Finally, the Council notes that the impact on patient access to services resulting from consolidation between secular and religiously-affiliated hospital systems is currently under study by the AMA Council on Ethics and Judicial Affairs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 216-A-16 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-215.968, which supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care.
2. That our AMA reaffirm Policy H-380.987, which maintains antitrust relief as a top AMA priority.
3. That our AMA reaffirm Policy H-140.984, under which the AMA opposes an across-the-board ban on self-referrals, because of benefits to patients including increased access and competition.
4. That our AMA reaffirm Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy, and also encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.
5. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations.
6. That our AMA reaffirm Policy H-160.906, which defines "physician-led" in the context of team-based health care and outlines guidelines for physician-led health care teams.

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**6. EXPANSION OF US VETERANS' HEALTH CARE CHOICES
(RESOLUTION 229-A-16)**

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 117 AND RESOLUTION 229-A-16
REMAINDER OF REPORT FILED**
See Policy H-510.983 and H-510.985

At the 2016 Annual Meeting, the House of Delegates referred Resolution 229, "Expansion of US Veterans' Health Care Choices," which was sponsored by the Ohio Delegation. Resolution 229-A-16 asked the American Medical Association (AMA) to:

- (1) adopt policy that the Veterans Health Administration (VHA) expand all eligible veterans' health care choices by permitting them to use funds currently spent on them through the Veterans Affairs (VA) system, through a mechanism known as premium support, to purchase private health care coverage, and for veterans over age 65, to use these funds to defray the costs of Medicare premiums and supplemental coverage; and
- (2) actively support federal legislation to achieve this reform of veterans' health care choices.

The majority of testimony on Resolution 229-A-16 requested referral for study to review the implications of allowing veterans to access health care outside of the VA through premium support, which was viewed as complicated and controversial with implications not only for the VA, but also for Medicare, the private health insurance market and the entire health care system.

This report provides background on the creation of the Veterans Choice Program (VCP); outlines efforts to redesign the veterans' health care delivery system; highlights stakeholder input; explains the difficulty of providing premium support to veterans; summarizes legislative activity; explains how to become a VA provider; summarizes AMA policy, advocacy and resources; discusses avenues to improve access to care for veterans; and proposes a series of recommendations.

BACKGROUND

In 2014, it was discovered that thousands of veterans were waiting excessive amounts of time to access health care through the VA. To address access issues, the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146, "Choice Act") created the VCP, which authorized the VA to contract with physicians in private practice to provide care to veterans who either live too far away from a VA facility or cannot access care in a VA facility in a timely manner. The VCP was set to expire in August 2017.

Implementation of the VCP was challenging. The VA was given just 90 days to fully implement the nationwide program. To achieve this short timeline, the VA modified existing purchased care contracts that were not designed to handle the scope of the VCP. In addition, the VA distributed nine million choice cards, mostly to veterans who were not immediately eligible for the VCP. The VA recognized these problems early in the implementation stage and has been working with stakeholders, including the AMA, to make needed changes.

REDESIGNING THE VETERANS' HEALTH CARE DELIVERY SYSTEM

Blueprint for Excellence

In 2014, the VA issued a "Blueprint for Excellence," which identified strategies to improve the performance of VHA health care, develop a positive service culture, transition from a focus on "sick care" to "health care," and develop business systems and management processes that are efficient, transparent and accountable.¹ In addition to

the VCP, the VA maintains the following community care programs: Emergency Care, Preauthorized Care, Patient-Centered Community Care, State Veterans Home, Indian Health Services/Tribal Health Program and other benefits and services.

The Blueprint for Excellence includes a recommendation to consolidate all of the community care programs into one streamlined program and make improvements to information and billing systems. The VA has decided that maintaining all of the community care programs is unsustainable given the following challenges: varied eligibility criteria; multiple referral and authorization requirements; lack of standard care coordination model; multiple local provider contracting approaches; variable payment rates and structures; and multiple programs that result in confusion for veterans and providers. In 2015, the VA submitted a plan to Congress to consolidate the community care programs into a community care network, which is expected to be fully operational in June 2018.²

Veterans Choice Act Independent Assessment

The Choice Act called for an independent assessment of 12 areas of the VA's health care delivery system and management processes. The "Veterans Choice Act Independent Assessment," issued in 2015, identified the following four systemic problems: a disconnect in the alignment of demand, resources and authorities; uneven bureaucratic operations and processes; non-integrated variations in clinical and business data and tools; and leaders not fully empowered due to a lack of clear authority, priorities and goals. To address these issues, the independent assessment developed recommendations to improve the VHA system.³ A subsequent review found that the VHA is making progress on implementing the suggested changes.⁴

Commission on Care

In accordance with the Choice Act, a "Commission on Care" (the Commission) was also established to evaluate the health care that veterans had been receiving. Released in 2016, the Commission's final report concluded that although care delivered by the VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility. The Commission outlined a series of recommendations, many of which are already being implemented as part of the ongoing "MyVA initiative."^{5,6}

MyVA Initiative

The "MyVA initiative" is considered the largest department-wide transformation in the VA's history and has reportedly been very successful. In 2016, the VHA scheduled about 58 million appointments, which accounts for 1.2 million more than were scheduled in 2015 and almost 3.2 million more than in 2014. In September 2016, about 96 percent of appointments were completed within 30 days of the clinically indicated or veteran's preferred date. About 91 percent of these appointments were scheduled within 14 days, about 85 percent within 7 days and about 22 percent on the same day. The average wait time for primary care appointments was reportedly about five days, for specialty care about six days and for mental health care about two days.⁷

VHA and VCP contractors authorized appointments for more than 3 million veterans to receive care in the private sector from February 1, 2015, through January 31, 2016. The number of authorized appointments represents a 12 percent increase compared to the same time period a year earlier.⁸

STAKEHOLDER INPUT

Many veterans' organizations (i.e., Disabled American Veterans, The American Legion, Military Order of the Purple Heart, Vietnam Veterans of America, Veterans of Foreign Wars, Paralyzed Veterans of America, AMVETS, and Iraq and Afghanistan Veterans of America) have emphasized that reform efforts should focus on strengthening the VA health care system, not dismantling it. These organizations specifically called for reform efforts to be based on veterans' health care needs and preferences, and have voiced concerns about coordination of care, the quality of medical services and the health outcomes for veterans receiving health care in the private sector. The organizations concluded in a statement that "we are confident that any objective, unbiased analysis of all the relevant data and evidence about the VA health care system compared to private sector health care will demonstrate the benefits of maintaining and strengthening a dedicated veterans' health care system."⁹

PREMIUM SUPPORT FOR VETERANS

Suggesting premium support for veterans to purchase health care in the private sector is not a new concept. Proponents have suggested providing veterans with a choice of accessing private health care regardless of the distance from their residence to the nearest VA facility or how long it takes to make an appointment within the VA. Opponents have argued that premium support for veterans would essentially be a voucher and may not cover all necessary services. One proposal has suggested privatizing health care for all veterans by phasing out VA health care facilities over the next 20 years.¹⁰

The VHA is not a health insurance plan with a tangible amount of money to give veterans to purchase private health care. The VHA is the largest integrated health care system in the US, consisting of 150 medical centers, and approximately 1,400 community-based outpatient clinics, community living centers, vet centers and domiciliaries. The VHA medical centers provide a wide range of services including traditional hospital-based services, medical and surgical specialty services, and advanced services such as organ transplants and plastic surgery.

In addition, the VHA provides unique, highly specialized care for many medical conditions, such as spinal cord and traumatic brain injuries, which are not available to the same extent outside of the VHA. The VHA provides a comprehensive, multidisciplinary approach that allows providers to address the full spectrum of veteran needs beyond physical medical care, such as behavioral health care, rehabilitation, vocational training and educational assistance. Some veterans have expressed gratitude for the camaraderie they experience while receiving treatment alongside fellow veterans.

Veterans provided input on privatizing the VHA during the Commission's evaluation. The majority opposed privatizing the VHA, with a minority wanting more access to non-VA providers. The Disabled American Veterans shared with the Commission a compilation of more than 4,000 verbatim comments on veterans' health care experiences, which indicated that approximately 82 percent reported overall positive experiences.¹¹

LEGISLATIVE ACTIVITY

The Administration, Congress and the VA are working together to reform the VCP rather than let it expire or privatize it. Recent legislation was enacted into law to extend the VCP beyond the sunset date of August 2017. The extension allows the program to use the remaining appropriated funds and give Congress and the VA time to work on a comprehensive reform plan.

BECOMING A VA PROVIDER

The AMA encourages physicians to become VA providers. Physicians can sign up on the following website: <https://www.hnfs.com/content/hnfs/home/va/provider/options-for-providers.html>. Interested physicians can register to become a provider for just the VCP or for all the community care programs. Physicians can download a non-VA provider fact sheet at ama-assn.org/sites/default/files/media-browser/public/washington/veterans-affairs-fact-sheet-for-non-va-medical-care-program_1.pdf for a summary of the conditions of participation and other requirements that are included in the VCP application process.

Adequate and prompt payments by the VA have been long-standing problems, which can deter physicians from providing services to veterans. The VCP pays Medicare rates, but the other community care programs pay less. To address payment delays, in 2012 the Veterans Benefits Administration created a new electronic claims processing system, the Veterans Benefits Management System, to process claims faster, more efficiently and more accurately. From 2013-2016, the new system allowed the VA to reduce the backlog of disability claims by 87 percent.¹²

RELEVANT AMA POLICY

The AMA supports providing full health benefits to eligible veterans to ensure they can access the medical care they need outside the VA in a timely manner (Policy H-510.986[2,3]). AMA Policy H-510.990 encourages the VA to continue exploring alternative mechanisms for providing quality health care coverage for veterans.

The AMA supports approaches that increase the flexibility of the VA to provide all veterans with improved access to health care services (Policy H-510.991). Policy H-510.985[1] calls on the AMA to continue advocating for

improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the VA health care system. Policy H-510.985[2] calls on the AMA to monitor implementation of and support necessary changes to the VCP "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the VA health care system.

The AMA urges all physicians to participate, when needed, in providing health care to veterans (Policy H-510.986). AMA Policy H-510.985[4] advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician. The AMA has long advocated that payers should pay for clean claims submitted electronically within 14 days and paper claims within 30 days (Policy H-190.981).

The AMA urges the VA to hire additional primary and specialty physicians as needed and to enhance its loan forgiveness efforts to help with physician recruitment and retention, and to improve patient access in VA facilities (Policies H-510.985[5] and D-510.990).

The AMA supports improved access to health care for veterans, including in the civilian sector, for returning military personnel when their needs are not being met by locally available resources through the Department of Defense or the VA (Policies H-510.985, H-510.990, H-510.991 and D-510.994). Policy H-510.986 encourages state and local medical societies to create a registry of physicians who are willing to provide health care to veterans in their community.

AMA ADVOCACY AND RESOURCES

The AMA strongly supported passage of the Choice Act, which created the VCP, and supports bipartisan efforts to make the VCP permanent, and to streamline the registration process for non-VA providers. The AMA has been actively involved in helping to shape and monitor implementation of the VCP. For example, the AMA sent a letter to the VA in March 2015, urging it to change the way it calculated the 40 mile distance criteria from a straight line to the time it takes for a veteran to travel to the nearest VA medical facility.¹³ AMA advocacy efforts were instrumental in influencing the VA to change the distance criteria in April 2015, which expanded eligibility for the VCP.¹⁴

In addition to meetings and other communications with VA officials, the AMA submitted statements on proposed legislation to improve the VCP to the Senate Committee on Veterans' Affairs in March 2016, and to the House Committee on Veterans' Affairs in May 2016.^{15,16} The AMA continues to work with the Committees on Veterans' Affairs to streamline programs, improve access to care and encourage participation by non-VA physicians and other providers. The AMA has communicated the following to the committees:

Consolidation of Programs: The AMA strongly supports the improvement and consolidation of the VCP to streamline and eliminate confusion and duplication between community care programs. The AMA believes that creating efficiencies and reducing administrative costs will benefit both veterans and physicians and encourage greater participation.

Access to Specialty Care: The AMA recognizes that a lack of access to specialty care in VA-based facilities is further complicated by provisions that require a minimum 40 mile driving distance, in addition to the lack of necessary specialists at VA community-based outpatient clinics.

Agreements/Contracts with Providers: The AMA supports using provider agreements between the VA and private physicians, similar to those for Medicare and Medicaid, which could help alleviate some of the burdensome compliance issues associated with federal contractors.

Billing and Payment: The AMA supports efforts to reform billing and reimbursement, such as to standardize provider payment rates using Medicare rates as a "floor" and not a "ceiling" (especially in regions with high demand and low supply of care specialists). Improving the VA's reimbursement processes would alleviate complaints that physicians and other providers have tied to the VCP in terms of administrative hassles and payment delays.

Electronic Billing: The AMA does not advocate for the strict mandate that all claims should be submitted electronically. Rather, it encourages a system similar to Medicare that allows certain exceptions, especially for smaller practices.

Tiered Networks: The AMA is very concerned about proposed plans to create tiered networks, especially in the absence of clear guidelines about differentiations in “high-value care.” The AMA urges extreme caution that the VCP doesn’t experience problems similar to those sometimes resulting from the Affordable Care Act, in which tiering narrowed networks and reduced access.

Value-Based Payment Modifier: The AMA is strongly opposed to the use of a value-based payment modifier (VBM). Because the VBM was developed to measure hospital populations, it may be inadequate for accurately measuring services provided by physicians’ offices. Reports suggest that practices with the sickest patients fare poorly under the VBM. The AMA believes that more analysis of the VBM and its results are needed before it is applied to programs like the VCP.

The AMA has resources and advocacy materials located at: ama-assn.org/search/ama-assn/veterans. The AMA also has veterans’ health resources for medical professionals located at: ama-assn.org/delivering-care/veterans-health-resources-medical-professionals.

DISCUSSION

Since the access issues in 2014, the VA has made concerted efforts to improve the care it provides to veterans and has made substantial strides, but improvements are still necessary. Given the extensive input the AMA has been providing, and the progress that is being made by the VA, the Council recommends that the AMA continue to work with the VA to provide quality care, support efforts to improve the VCP, and make it a permanent program.

The VA is aware that veterans need to be able to access medical care in the private sector when it is not available through the VHA. The Council suggests reaffirming Policy H-510.985, which supports necessary changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran’s residence outside of the VA health care system. In addition, the Council believes the AMA should encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care.

The Council suggests supporting consolidation of all the VA community care programs to streamline and eliminate confusion and duplication. Creating efficiencies and reducing administrative costs will benefit both veterans and physicians and encourage greater participation.

The VCP has been reviewed by numerous external agencies since implementation. The Council suggests the VA use external assessments as necessary to identify and address systemic barriers to care. The Council also suggests that the AMA support interventions to mitigate barriers to the VA from being able to achieve its mission.

The lack of adequate and prompt payments by the VA has been a long-standing problem that can deter physician participation. The VCP pays Medicare rates, but lower payment rates have been negotiated for the other community care programs by third party administrators based on regional/local trends. Other local contracts between VA medical centers and individual practices have also been negotiated at lower rates. The Council’s recommended reaffirmation of Policy H-510.985 reiterates AMA support for the VA to pay private physicians a minimum of 100 percent of Medicare rates.

While the VA has demonstrated progress in making prompt payments, there is room for improvement. The AMA has long advocated that payers should pay for clean claims submitted electronically within 14 days and paper claims within 30 days (Policy H-190.981). The Council recommends that the VA provide payments within the same timeframe.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 229-A-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. That our AMA continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. That our AMA reaffirm Policy H-510.985, which supports changes to the VCP to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the VA health care system and advocates that the VA pay private physicians a minimum of 100 percent of Medicare rates.
4. That our AMA encourage the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
5. That our AMA support consolidation of all the VA community care programs.
6. That our AMA encourage the VA to use external assessments as necessary to identify and address systemic barriers to care.
7. That our AMA support interventions to mitigate barriers to the VA from being able to achieve its mission.
8. That our AMA advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
9. That our AMA encourage the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.
10. That our AMA encourage the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.
11. That our AMA advocate for new funding to support expansion of the Veterans Choice Program.

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7. RETAIL HEALTH CLINICS (RESOLUTION 705-A-16)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 705-A-16
REMAINDER OF REPORT FILED**

See Policies H-160.921, H-215.981, H-385.926, H-440.877 and D-35.985

At the American Medical Association's (AMA) 2016 Annual Meeting, the House of Delegates referred Resolution 705, "Retail Health Clinics," submitted by the Washington Delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2017 Annual Meeting. Resolution 705-A-16 asked:

That our AMA study retail health clinics, with consideration of patient care delivery to ensure patient safety, the appropriate level of oversight as entities separate from an independent physician's practice and other health care facilities, and potential conflicts of interest where such clinics are located within a store that includes a pharmacy as such co-locations could result in incentives to provide costly, unnecessary, inappropriate, and uncoordinated health related services. The resolution also asks the AMA to consider the merits of pursuing legislation to ensure appropriate oversight.

This report provides an overview of retail health clinics, notes the various retail clinic models in operation, the clinics' extent of physician oversight, explores continuity of care and patient safety, unnecessary or inappropriate care and potential cost savings, outlines the financial impacts of retail clinics, summarizes conflicts of interest and legislative activity pertinent to retail clinics, outlines relevant policy, and proposes new recommendations that build off the current body of policy on store-based clinics.

BACKGROUND

Retail health clinics have been playing a steadily growing role in health care. The first retail clinics opened in 2000. By 2010, there were estimated to be about 1,200 retail clinics in operation, and the most recent estimates predict that there will be more than 2,800 clinics this year.¹ The most important drivers of this growth include convenience, after-hours accessibility, and clear pricing at the point of care.

It is important to note that commercial clinics fall into two main categories: urgent care and retail. The Council limited the scope of this report to retail health clinics as directed by referred Resolution 705-A-16. Retail clinics typically provide basic primary care treatment, screening, and diagnostic services. They focus on providing convenient care for a limited number of acute conditions such as colds, sore throats, and ear infections.² In most instances, retail clinics are staffed by nurse practitioners and physician assistants. However, in some states, nurses work under the remote supervision of a physician.³ In all states except Michigan, physician assistants work under physician supervision; Michigan requires a collaborative arrangement.

Generally, retail clinics follow one of three business models. In the first, the clinic is owned and operated by the parent store that houses it. In the second, the clinic is owned by an independent company that partners with a retail store to house the clinic. In the third model, the clinic is owned by a hospital, a physician group, or another health care provider. Nearly three quarters of clinics follow the first model.⁴

Retail clinic use is heaviest among young adults, minority families, and families with children.⁵ Retail clinic users are generally younger than patients seen in primary care offices and emergency departments.⁶ Only 39 percent of retail clinic users report having an established relationship with a primary care physician, which contrasts to about 80 percent of the general population reporting such a relationship.⁷

Retail clinics have established a niche in the health care system based on their convenience and high levels of patient satisfaction. Convenience is the reason most overwhelmingly cited for visiting a clinic. Retail clinics generally have weekend or evening hours and no need for appointments. The recent proliferation of retail clinics provides many consumers with an alternative source of care for a limited number of routine services at the consumer's convenience. Despite the effort in many physician practices to expand hours, consumers continue to seek care in the retail setting due to perceived preferential wait time and overall convenience.

Nearly all retail clinics accept some form of private health insurance and many accept public health insurance options. Sixty percent of small firms and 73 percent of large firms cover services offering health benefits provided in retail clinics in their largest health plan. Some plans even encourage enrollees to visit retail clinics through reduced or waived copayments, which is a practice AMA policy condemns (H-160.921).

Despite the finding that retail clinic use is more likely among minority families and that retail clinic users are disproportionately likely to live in poorer neighborhoods, thus far, the number of retail clinics that target underserved populations is limited. Retail clinics have not taken up the role of providing care in medically underserved areas and are unevenly distributed across neighborhoods. Specifically, retail clinics are often placed in higher-income, urban and suburban settings with higher concentrations of white residents and fewer black and Hispanic residents and fewer residents living in poverty.⁸ Medicaid payment rates present an obstacle to opening clinics in low-income neighborhoods, and managed care beneficiaries may need to pay out of pocket for care at retail clinics. Accordingly, retail clinics do not seem to be a component of the solution to primary care shortages and access to care disparities in underserved communities.⁹

Retail clinics pose both challenges and opportunities for policymakers and regulators. Supporters of the model point out that retail clinics serve as a lower-cost alternative to emergency departments or physician offices when patients have minor ailments. Others worry that retail clinics serve only as a way to fragment care. Concerns include lack of physician oversight potentially undermining quality of care and disrupting continuity of care and the physician-patient relationship, thereby potentially weakening the medical home. In particular, there are concerns with patient safety and the worry that individuals may try using a retail clinic when they have a problem beyond the scope of the retail clinic's limited services or expertise.

PHYSICIAN OVERSIGHT

Although some retail clinics are staffed by physicians, most are staffed by nurse practitioners and physician assistants.¹⁰ Retail clinic operators claim that these arrangements help sustain their economic viability.¹¹ Direct licensing of health care facilities and providers gives states the ability to monitor and enhance patient safety, so state practices and laws vary on the flexibility of non-physician medical professionals to prescribe drugs and practice.¹² As previously stated, some states allow nurse practitioners to provide care independent of physician involvement while most states require physician supervision and still others mandate collaboration. Again, all states except

Michigan require physician assistants to be supervised by physicians and Michigan requires a collaborative arrangement.

CONTINUITY OF CARE AND PATIENT SAFETY

Particularly for patients with a medical home, there is concern that retail clinics do not communicate with primary care providers about services delivered, thereby potentially undermining the physician-patient relationship or medical home. Moreover, patients rarely receive follow-up care after a visit to a retail clinic, and often, after a patient receives care in a retail clinic, there is no follow-up communication with a patient's primary care provider or usual source of care, exacerbating the concern that retail clinics may fragment care.

Additionally, there is increasing concern with retail clinics expanding their scope to include the screening and treatment of chronic diseases such as asthma and hypertension. Many believe there is a need to distinguish between screening and monitoring disease versus the active management of chronic disease, potentially raising liability concerns.

UNNECESSARY OR INAPPROPRIATE CARE AND COST SAVINGS

Several studies have examined the cost of retail clinic services and compared them with other health care settings. The results show that retail clinics typically offer lower per-episode costs than urgent care centers, emergency departments, and primary care providers. Therefore, retail clinics may reduce overall health spending if patients substitute care at retail clinics for care at more expensive sites of service. However, retail clinics may also increase overall utilization by attracting patients who might not have otherwise sought care, thereby increasing overall health spending.

Recent studies challenge the idea that convenience settings like retail health clinics substitute for emergency department (ED) visits. It is estimated that up to 20 percent of ED visits are for low-acuity conditions, and it is possible to treat many ED patients for low-acuity conditions in low-cost settings such as retail clinics.¹³ However, retail clinics to date have not been associated with a meaningful reduction in low-acuity ED visits.¹⁴ Accordingly, it seems that instead of lower costs associated with ED visits, retail clinics may be substituting for care in other settings, such as primary care practices, or they may be increasing utilization by prompting patients to seek care for minor conditions that patients otherwise would have treated at home. One recent study found that 58 percent of retail clinic encounters were for care that a patient would not have otherwise sought, and not in lieu of care from an outpatient provider like a primary care physician.¹⁵ This new utilization is associated with a modest increase in health care spending of \$14 per person per year.¹⁶ Overall, it seems the predominant effect of retail clinics is "new use," meaning patient visits to these settings are mostly additive rather than substitutive.¹⁷

Retail clinics create new use for a number of reasons: they meet unmet demands for care, the motivations for seeking care differ in retail clinics versus EDs, and groups of people are more likely to use EDs for low-acuity conditions because they have little access to other types of care. Additionally, in some communities, the demand for episodic acute care exceeds the supply of physicians or facilities, and this desire for care is met conveniently by settings such as retail clinics. Retail clinics meet consumer expectations by delivering the desired service, with minimal time investment (e.g., travel, waiting).

FINANCIAL IMPLICATIONS

In economic terms, the increased use of health care services created by retail clinics can be termed "supply-sensitive care," in which the supply of a specific resource and not necessarily the demand for the resource influences utilization.¹⁸ People select the setting they think can best care for them. Most people know that if they are having an emergency, they should not seek care at a convenience setting. Therefore, convenience settings like retail clinics often do not directly compete with EDs. Convenience settings do not save lives in emergencies; rather, they deliver services relating to minor ailments or give people peace of mind and reassurance that they are taking the right steps to get better.¹⁹ Generally, the use of such supply-sensitive care is largely capacity-driven, which makes it potentially inconsistent with the move to value-based care and payment. In many instances, convenience settings simply create new use through improved access.²⁰

Conditions for which patients typically visit retail clinics also constitute a large portion of reasons patients visit primary care providers. Therefore, there is a concern that retail clinics pose a financial threat to primary care providers by treating the latter's most profitable patients.²¹ Others believe that retail clinics may increase primary care revenue by generating referrals to practices and by allowing physicians in practice settings to focus on sicker patients with more complex needs, which generally provides higher payment. This premise is supported by evidence that, while physician office visits for acute minor conditions have declined by 13 percent since the advent of retail clinics, total physician visits have remained steady.²²

Retail clinics may have a role to play in providing timely and affordable access to primary care services. It is estimated that if the 20 percent of ED visits that are for low-level conditions could instead be treated in a retail clinic, the health care system would save an estimated \$4 billion annually.²³

CONFLICTS OF INTEREST

When the retail clinic market began, it was predominantly run by commercial retailers. More recently, traditional health care institutions have entered the market.²⁴ Commercial retailers often affiliate with regional health systems leading to the co-branding of the retail clinic. In such a relationship, the health system affiliate and commercial retailer might develop protocols to support clinical decision-making and patients might be referred to the affiliate health system for primary care or ongoing care.²⁵

Because retail clinics are often located within a store that includes a pharmacy, there is also concern that providers might overprescribe to induce unnecessary purchases at the store or provide discount plans for the pharmacy housing the retail clinic.

Retail clinics may also implicate a number of federal laws and regulations.²⁶ The federal Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving anything of value to induce or reward referrals for any item or service that is reimbursable, in whole or in part, by a federal health care program. The Anti-Kickback Statute may be activated if the retail clinic is owned by a host retailer wherein they refer federal health care program patients to one another. Retail clinics must mitigate this potential risk by structuring an arrangement with the retailer to fit within the safe harbors. Additionally, retail clinics must consider the Stark Law, which prohibits physician self-referral. Specifically, the law prohibits a referral by a physician of a federal health care program patient to an entity providing designated health services (DHS) if the physician has a financial relationship with that entity. While most retail clinics do not offer such DHS and therefore do not implicate the Stark Law, some clinics offering routine lab services, which are DHS, are subject to the Stark Law and must fit within specifically enumerated exceptions.

LEGISLATIVE ACTIVITY

There has been limited restrictive legislation passed regarding retail clinics at either the federal level or state level.²⁷ Aside from licensing the physician assistants, nurse practitioners, and other providers working at retail clinics, most states have not passed legislation specifically addressing retail clinics.²⁸ Rather, the clinics tend to operate within the existing state law framework. Importantly, there have been several noteworthy challenges to retail clinic regulation by the Federal Trade Commission (FTC), which is charged with preventing unfair methods of competition and unfair or deceptive acts of practice in or affecting commerce.²⁹ These FTC challenges expressed concerns over provisions that might cause undue burden to retail health clinics and have the effect of limiting their ability to compete. After the only two states to try and pass legislation imposing requirements specific to retail clinics were struck down by the FTC, there has not been much legislative activity in other states.

RELEVANT AMA ACTIVITY AND POLICY

With respect to scope of practice issues, the AMA has established a Scope of Practice Partnership with members of the Federation as a means of using legislative, regulatory, and judicial advocacy to restrain the expansion of scope of practice laws for allied health professionals that threaten the health and safety of patients.

Store-based health clinics are consistent with long-standing AMA policy on pluralism (Policies H-165.920, H-160.975, H-165.944, and H-165.920). Most notably, the AMA supports free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who

prefer that mode of delivery, and not determined by preferential federal subsidy, regulations, or promotion (Policy H-165.985).

AMA Policy H-160.921, established with Council on Medical Service Reports 7-A-06 and 5-A-07, outlines principles for store-based health clinics. The policy calls for an individual, company, or other entity establishing or operating a store-based health clinic to have a well-defined and limited scope of clinical services; use standardized medical protocols derived from evidence-based practice guidelines; establish arrangements by which their health care practitioners have direct access to and supervision by MDs/DOs; establish protocols for ensuring continuity of care with practicing physicians within the local community; establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic; inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated; establish appropriate sanitation and hygienic guidelines and facilities to insure the safety of patients; use electronic health records as a means of communicating patient information and facilitating continuity of care; and encourage patients to establish care with a primary care physician to ensure continuity of care. Additionally, Policy H-160.921 states that health insurers and other third-party payers should be prohibited from waiving or lowering copayments only for patients that receive services at store-based health clinics.

AMA Policy D-160.986 addresses the alliance of retail clinics with pharmaceutical chains. The policy directs the AMA to ask the appropriate state and federal agencies to investigate ventures between retail clinics and pharmacy chains with an emphasis on the inherent conflicts of interest in such relationships, patients' welfare and risk, and professional liability concerns. Additionally, Policy D-160.986 directs the AMA to continue to work with interested state and specialty societies in developing guidelines for model legislation that regulates the operation of store-based health clinics and to oppose waiving any state or federal regulations for store-based health clinics that do not comply with existing standards of medical practice facilities.

The AMA also has established policy that addresses the physician-patient relationship, physician extenders, and continuity of care. The AMA encourages policy development and advocacy in preserving the doctor-patient relationship (Policies H-100.971 and H-140.920). The AMA has extensive policy on guidelines for the integrated practice of physicians with physician assistants and nurse practitioners (Policies H-160.950, H-135.975, and H-360.987). Policy H-160.947 encourages physicians to be available for consultation with physician assistants and nurse practitioners at all times, either in person, by phone, or by other means. Policy H-425.997 encourages the development of policies and mechanisms that assure continuity and coordination of care for patients. Finally, the AMA believes that full and clear information regarding benefits and provisions of a particular health care system should be available to the consumer (Policy H-165.985). Addressing other possible retail clinic services that might impact continuity of care, Policy H-440.877 states that, should a vaccine be administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and that the administrator of the vaccine should enter the vaccination information into an immunization registry when one exists to provide a complete vaccination record.

Finally, the AMA has extensive policy related to the health care team. Several policies reinforce the concept of physicians bearing the ultimate responsibility for care and advocate that allied health professionals such as nurse practitioners and physician assistants function under the supervision of a physician (Policies H-35.970, H-45.973, H-35.989). Policy H-160.912 advocates that all members of a physician-led team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure, and the discretion of the physician team leader. Policy H-160.906 defines "physician-led" in the context of team-based health care as the consistent use by a physician of the leadership, knowledge, skill, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of those skills.

DISCUSSION

Retail clinics have had a steadily growing role in health care over the past decade. The Council recognizes concerns that the retail clinic model may potentially undermine the medical home and therefore the physician-patient relationship and quality of care. Nonetheless, the Council acknowledges the ease and convenience of retail clinics for minor acute conditions that has increased their prominence in the health care system. As such, the Council believes that, with the appropriate safeguards and guidelines, retail clinics have a complementary place in the

delivery of health care. The following recommendations attempt to strike a balance between the use of retail clinics and traditional physician visits with the patient's best interest of paramount concern.

In 2006, the AMA established Policy H-160.921 regarding store-based clinics, another designation for retail clinics, when it became clear that the clinics were rapidly expanding and spreading across the country. As previously noted, this policy articulates principles for store-based health clinics, and the policy remains highly salient today. Accordingly, the Council recommends reaffirming Policy H-160.921. Additionally, the Council suggests reaffirmation of numerous policies still relevant to the appropriate role of retail clinics and the practice of medicine. The Council recommends reaffirming Policy H-160.921 asserting that health insurers and other third-party payers should be prohibited from waiving or lowering copayments only for patients that receive services at store-based health clinics, and reaffirming Policy H-215.981 recognizing the potentially detrimental effects of the corporate practice of medicine. Further, the Council recommends reaffirming Policy D-35.985 on the physician-led health care team and Policy H-385.926 supporting physician choice of practice, which includes physicians wishing to practice in the retail clinic setting. Further, the Council remains concerned over proper vaccination reporting at retail clinics to avoid duplicative immunizations. To that end, the Council recommends reaffirming Policy H-440.877 stating that, should a vaccine be administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record.

For guidance on additional recommendations, the Council reviewed the American Academy of Family Physicians' (AAFP) position on retail clinics. Most recently, the AAFP developed a set of characteristics designed to guide discussions between the AAFP and retail clinics about how to collaborate for the good of patients.³⁰ The characteristics include using local physician medical directors, the timely transfer of medical records to the patient's primary care physician, and assisting patients in identifying a primary source of care in the community, among others. The Council found many of the articulated characteristics to be relevant and adapted a number of them for recommendation in this report.

The following recommendations build upon the AMA's current policy on store-based health clinics and reflect a cautious acceptance of retail clinics having a role to play in the health care system with the view that they are part of the continuum of care. Additionally, the Council approaches this issue with the belief that continuity of care and quality of patient care and outcomes are of overriding importance.

The Council recognizes that retail clinics have been playing an increasingly important role in the health care system and consequently garnering attention. Therefore, the Council will continue to monitor market-based developments in health care delivery including retail clinics.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 705-A-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-160.921 outlining principles for store-based health clinics and amend all references to "store-based health clinics" to "retail clinics" to reflect the current naming standard.
2. That our AMA reaffirm Policy H-215.981 regarding the corporate practice of medicine.
3. That our AMA reaffirm Policy D-35.985 supporting the physician-led health care team.
4. That our AMA reaffirm Policy H-385.926 supporting physicians' choice of practice and method of earning a living.
5. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and the administrator of the vaccine should enter the vaccination information into an immunization registry, when one exists, to provide a complete vaccination record.

6. That our AMA supports that any individual, company, or other entity that establishes and/or operates retail health clinics adhere to the following principles:
 - a. Retail health clinics must help patients who do not have a primary care physician or usual source of care to identify one in the community;
 - b. Retail health clinics must use electronic health records to transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent;
 - c. Retail health clinics must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
 - d. Retail health clinics should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
 - e. Retail health clinics should use local physicians as medical directors or supervisors of retail clinics; and
 - f. Retail health clinics should neither expand their scope of services beyond minor acute illnesses including but not limited to sore throat, common cold, flu symptoms, cough, and sinus infection nor expand their scope of services to include infusions or injections of biologics; and
 - g. Retail health clinics should have a well-defined and limited scope of clinical services, provide a list of services provided by the clinic, provide the qualifications of the onsite health care providers prior to services being rendered, and include that any marketing materials the qualifications of the onsite health care providers.
7. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed the spending for services that a patient receives at a retail health clinic if the physician could not reasonably control or influence that spending.

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8. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT REFORM (RESOLUTION 820-I-16)

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

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 820-I-16
REMAINDER OF REPORT FILED**

*See Policies H-285.998, H-320.939, H-320.945, H-320.948, H-320.949, H-320.961,
H-330.921, H-335.981, H-335.999 and D-320.991*

At the 2016 Annual Meeting, the House of Delegates adopted Council on Medical Service Report 7-A-16, “Prior Authorization Simplification and Standardization.” The report established the following directives:

Policy D-120.938: That our American Medical Association (AMA) address the negative impact of medication step therapy programs on patient access to needed treatment by supporting state legislation that places limitations and restrictions around the use of such programs and their interference with a physician’s best clinical judgment;

Policy D-320.987: That our AMA, in collaboration with state medical associations and national medical specialty societies and relevant patient groups, create a set of best practices for prior authorization (PA) and possible alternative approaches to utilization control; advocate that accreditation organizations include these concepts in their program criteria; and urge health plans to abide by these best practices in their PA programs and to pilot PA alternative programs; and

Policy D-320.986: That our AMA explore and report on potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures.

Additionally, at the 2016 Interim Meeting, the House of Delegates referred Resolution 820-I-16, “Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing,” which was introduced by the Pennsylvania Delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House of Delegates. Resolution 820-I-16 asked:

That our AMA advocate for legislation to require insurers’ medical policies to reflect current evidence-based medically appropriate studies and treatments including those for rare and uncommon diseases;

That our AMA advocate for legislation to require insurers to implement a streamlined process for exceptions for rare or uncommon disease states; and

That our AMA advocate for legislation to prohibit insurers from using medical coding as the sole justification to deny medical services and diagnostic or therapeutic testing.

This report addresses the directive policies established with the adoption of the recommendations in Council on Medical Service Report 7-A-16 and responds to referred Resolution 820-I-16. It provides an update on current AMA PA-related advocacy efforts, including the Prior Authorization and Utilization Management Reform Principles and state legislative activities; describes AMA research activities aimed at quantifying the burden and negative effects of PA and other utilization management (UM) processes; and discusses the feasibility of physicians obtaining financial compensation for PA. Additionally, this report reviews existing policy and coding guidelines applicable to payment denials.

BACKGROUND

Health plans employ PA, step therapy, and other forms of UM to control their members' access to certain treatments and reduce health care expenses. As detailed in CMS Report 7-A-16, UM requirements often involve very manual, time-consuming processes that can divert valuable and scarce physician resources away from direct patient care. More importantly, PA and other UM methods interfere with patients receiving the optimal treatment selected in consultation with their physicians. At the very least, UM requirements can delay access to needed care; in some cases, the barriers to care imposed by PA and step therapy may lead to the patient receiving less effective therapy, no treatment at all, or even potentially harmful therapies.

The issues discussed in Council on Medical Service Report 7-A-16 and raised in Resolution 820-I-16 both reflect growing concerns over health plans' interference with physicians' clinical judgment and patients' access to prescribed treatment. The increasing patient harms and practice burdens associated with UM requirements necessitate a broad-based, comprehensive advocacy strategy to effect meaningful change in health plans' programs and policies. Given the challenging and multi-faceted nature of these issues, careful examination and evaluation of the suggested approaches is needed to identify the most viable and impactful strategies.

RELEVANT AMA ADVOCACY

PA and other UM programs are a high-priority advocacy target for the AMA. As summarized below, several current AMA initiatives address the directives established with Council on Medical Service Report 7-A-16 and strengthen the AMA's ability to effectively advocate on UM issues.

State Legislative Activity

In response to the numerous concerns raised by AMA members and the Federation of Medicine, the AMA's Advocacy Resource Center works closely with state medical associations and national medical specialty societies to address PA and other UM-related issues through state legislation. The AMA's model bill on PA, the "Ensuring Transparency in Prior Authorization Act," addresses a variety of concerns related to UM programs, including response timeliness, clinical qualifications of health plans' UM staff, duration of authorizations, public reporting of UM program results, and electronic PA. The bill also places limitations on plans' step therapy requirements, consistent with Policy D-120.938.

Through close collaboration and strong efforts of the AMA and state medical associations, several PA/step therapy bills that were based largely on the AMA's model legislation were passed by state legislatures in 2016. Of particular note were comprehensive bills passed by Ohio and Delaware. The Prior Authorization Reform Act of Ohio, signed into law in June 2016, limits retrospective denials, requires advance notification of PA policy changes, mandates timely responses to PA requests, and incorporates several other aspects of the AMA's model bill. Additionally, the Delaware General Assembly passed legislation establishing mandatory reporting of PA statistics to public databases, advanced notice of new PA requirements, mandatory time limits for responses, limits on retrospective denials, and a requirement that pharmaceutical PAs be valid for one year. The AMA intends to build off of these legislative successes and work with the Federation of Medicine to advance additional UM-related state legislation.

Prior Authorization and Utilization Management Reform Principles

To improve care access and reduce practice burdens, and in accordance with Policy D-320.987, the AMA convened a 17 member workgroup of state medical associations and national medical specialty societies, national provider associations, and patient representatives to create a set of best practices related to PA and other UM requirements. The workgroup identified the most common provider and patient complaints associated with UM programs and developed 21 Prior Authorization and Utilization Management Reform Principles (“the Principles”; see ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf) to address these priority concerns. The Principles, which are based on AMA policy, seek to improve PA and UM programs by addressing the following five broad categories of concern:

1. Clinical validity
2. Continuity of care
3. Transparency and fairness
4. Timely access and administrative efficiency
5. Alternatives and exemptions

These “best practice” principles serve as the foundation for an ongoing, extensive, multi-pronged advocacy campaign to reform and improve UM programs. As part of the campaign, workgroup members directly advocate with health plans, benefit managers, and other UM entities to voluntarily adopt these principles; urge accreditation organizations, such as the National Committee for Quality Assurance and the Utilization Review Accreditation Commission, to include these concepts in criteria for utilization review programs; introduce bills based on these principles to state legislatures; encourage technological standards organizations to support improved UM processes; and promote the Principles in a variety of media and communication outlets to raise awareness of the requested reforms. As part of this campaign, the AMA issued a press release publicizing the Principles, which received significant coverage in various media outlets. Additionally, the AMA sent letters to the major national health plans, pharmacy benefit managers, and accreditation bodies that urged alignment of these organizations’ UM programs or accreditation criteria with the Principles.

While the campaign was still in its early stages at the time that this report was written, response to these initial outreach efforts has been promising. Shortly after the release of the Principles, both Blue Cross Blue Shield of Western New York and BlueShield of Northeastern New York announced that they were eliminating PA requirements for more than 200 medical services. The AMA outreach letters have resulted in several meetings to discuss the Principles with national health plans and other key stakeholders. In addition, more than 80 medical societies and other health care organizations have signed on as “supporters” of the Principles. The AMA will continue to engage insurers, employer coalitions, and other relevant organizations in discussions about the Principles and will identify other impactful opportunities to promote the Principles throughout the industry to achieve PA reform.

PA Research

The lack of alignment between physician and health plan interests on PA and other UM programs create significant challenges to achieving meaningful reform on this issue. Recognizing the key role that credible evidence plays in successful advocacy on this topic, the AMA engaged in two research projects to gather data regarding the impact of PA on patients and physician practices. The following research projects are designed to inform and strengthen the AMA’s ongoing efforts to reduce the practice burdens associated with UM programs.

PA physician survey – In conjunction with a market research partner, the AMA fielded a web-based, 24-question survey to 1000 practicing physicians in December 2016. The national sample comprised 40 percent primary care and 60 percent specialty physicians and included only physicians who routinely complete PAs in their practice. The survey provided the following key takeaways:

- Seventy-five percent of physicians reported that the burden associated with PA for their practice is either high or extremely high;
- Practices complete an average of 37 PAs per physician per week, which take the physician and his/her staff an average of 16 hours—the equivalent of 2 business days—to process;
- Ninety percent of physicians reported that PA delays patients’ access to necessary care;

- More than one-third of physicians reported they have staff who work exclusively on processing PAs;
- Nearly 60 percent of physicians reported waiting, on average, at least 1 business day for PA decisions from health plans—and 26 percent of physicians reported waiting at least 3 business days;
- Seventy-nine percent of PA requests are eventually approved (72 percent approved on initial request and seven percent on appeal);
- Eighty percent of physicians reported they are sometimes, often, or always required to repeat PAs for prescription medications when a patient is stabilized on a treatment for a chronic condition; and
- Fax and telephone were the most commonly reported ways for completing both medical and prescription PAs.

The survey results (ama-assn.org/sites/default/files/media-browser/public/government/advocacy/2016-pa-survey-results.pdf) served as a valuable framework for the public release of the Prior Authorization and Utilization Management Reform Principles and have provided a strong evidence base for other AMA advocacy efforts related to PA.

Academic PA research project – The AMA is partnering with the University of Southern California Schaeffer Center for Health Policy & Economics on an academic research project to assess the growing impact of PA on physician practices and patients. Through analysis of both Medicare Part D drug claims and clinical and claims data from a Federally Qualified Health Center, this project seeks to establish the overall impact of PA on factors such as total health care costs and patient outcomes. The current project plan includes a broad analysis of PA trends, as well as a case study examining the impact of PA for a specific class of drugs and disease state on patient outcomes and overall medical costs. The goal of this project is to generate multiple manuscripts for submission to peer-reviewed publications. These anticipated journal articles should make an important contribution to both the scientific literature on UM programs and future AMA advocacy.

PAYMENT FOR PA

In addition to the state legislative activities and PA Principles described above, Council on Medical Service Report 7-A-16 established Policy D-320.986, which directed the AMA to explore “potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures” as another potential strategy for addressing PA burdens. Long-standing AMA policy supports compensating physicians for the time required to complete PAs on behalf of their patients (e.g., Policies H-320.968 and H-385.951). Furthermore, Current Procedural Terminology (CPT) code 99080 supports payment for fulfilling health plans’ administrative requirements such as PA. However, despite the existence of both policy and tools to support payment for PA, the Council testified in the reference committee against pursuing this strategy, noting that it was unaware of any major health plans that are currently compensating physicians for PA work using CPT code 99080 and the unlikelihood that health plans would agree to pay for PA.

Supportive testimony for pursuing the payment-for-PA approach cited the 2008 *Gibson v. Medco* case from the Trumbull County District Court in Ohio.¹ In that case, a judge ruled that the defendant, a pharmacy benefit manager, was required to pay the physician for his time spent completing PA forms for prescription medications. Although there was no contract controlling the judgment, the judge noted that Medco required physicians to pay a \$75 fee for any information requests submitted to Medco, and he concluded that the physician should have the same right to collect fees for information requests that the company requires as part of PA.

While the *Gibson* case may initially seem encouraging to physicians interested in collecting payment for PA, the facts of the case and the decision’s lack of precedential authority (as only appellate courts carry such authority) limit its broad applicability. The court assigned particular importance in the *Gibson* case to the processing fees charged by Medco for physician inquiries and the lack of contractual relationship between the physician and the UM entity. These characteristics are not common traits to most of the PA processes burdening physicians today. The information-request processing fee assigned by Medco is not a standard practice throughout the industry, and terms of network participation almost uniformly require physicians to meet the UM requirements of the health plan or any agents/subcontractors, including benefit managers such as Medco.

Even if the *Gibson* decision were broadly applicable, physicians would face several logistical challenges in obtaining payment for PA from health plans and benefit managers. First, assigning a specific payment amount to CPT code 99080 would be challenging, as time and administrative costs likely vary greatly by the specific PA request. PA denials pose another problem for this compensation model, as it is questionable if health plans would

pay physicians to complete PAs for treatment that the patient never actually receives. Technological issues may also hinder payment for drug PAs, as most physicians are not equipped to create and submit electronic claims to pharmacy benefit managers. Even if physicians were successful in obtaining compensation for PA, the payment rate assigned by health plans would likely be unacceptably low from physicians' perspectives. Indeed, the court awarded only \$187.50 to the physician in the *Gibson* case.

As an alternative to pursuing health plan payment for PAs, physicians could theoretically seek compensation from the patient. While patients are a potential funding source for PA work, there are multiple issues with this approach. Most health plan network participation contracts bar physicians from billing patients for completion of UM processes, and any physician who chose to bill patients for PA would be violating these terms of participation and putting his/her network status at risk. Additionally, by shifting the burden of compensation to the patient, physicians would be introducing a barrier to care for patients who are unwilling or unable to pay the PA rate. Such a scenario also could significantly harm the patient/physician relationship and negatively impact patients' satisfaction with their care.

In its Report 7-A-16, the Council noted that actively pursuing compensation for PA could conflict with the AMA's other advocacy efforts on this issue. As described above, the AMA is vigorously working to reform and reduce health plans' overall use of PA and other UM programs. If the AMA were to undertake and achieve widespread compensation for PA, a perverse and unintended consequence could be an overall increase in PA requirements, as health plans could use payment as justification for additional utilization review. Furthermore, the patient care barriers and delays associated with UM requirements form one of the key persuasive arguments in the AMA's advocacy campaign for PA reform. Pursuing payment for PA suggests that physicians find PA to be an acceptable practice so long as they receive compensation for this administrative work, which could undercut the central message of the AMA's current UM reform efforts.

PAYMENT DENIAL FOR MEDICALLY APPROPRIATE TREATMENT

Referred Resolution 820-I-16 underscores many of the previously discussed concerns regarding health plans' interference with physicians' clinical judgment and patients' access to medically necessary treatment. Specifically, the resolution references health plans' use of outdated policy, improper medical coding edits, or overly rigid medical necessity definitions that fail to take into account complexities caused by comorbidities as causes for payment denials. The resolution cites the example of health insurers' failure to cover payment for dual-energy x-ray absorptiometry (DEXA) scans for patients with sickle-cell disease, despite substantial clinical evidence showing the use of such scans to be medically appropriate for the diagnosis and treatment of these patients. The resolution asks that the AMA work to ensure that health plans have medically accurate and up-to-date payment policies and that there is a streamlined process to ensure payment approval for appropriate treatment of rare diseases. Additionally, the resolution asks that medical coding not be the sole justification for a medical insurer's denial of payment.

AMA policy states that health plans should base coverage decisions on current clinical information and support exceptions processes so that patients may receive needed care. For example, Policy H-320.949 states that UM criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. Policy H-285.998 states that the medical protocols and review criteria used in UM programs must be developed by physicians. In line with the asks of Resolution 820-I-16, Policy H-320.945 states that preauthorization should not be required when a treatment is customary, properly indicated, and supported by peer-reviewed medical publications.

In addition to the above-cited policies, the requests of Resolution 820-I-16 parallel concepts included in the Prior Authorization and Utilization Management Reform Principles created pursuant to Policy D-320.987. The principles related to clinical validity and administrative efficiency capture the resolution's concerns regarding health plan policies being based on clinically appropriate criteria, the availability of an appeal or exception process, and the streamlining of medical necessity determination methods. State legislative activity is one of the advocacy channels for these Principles; the legislative ask of the resolution is therefore included in the PA reform workgroup's ongoing advocacy campaign.

Resolution 820-I-16 also seeks advocacy to prohibit insurers from using medical coding as the sole justification to deny payment for medical services and diagnostic or therapeutic testing. As noted in the I-16 reference committee report, Policy H-70.914 states that the AMA opposes limitations in coverage for medical services based solely on

diagnostic code specificity. The reference committee also correctly reported that traditionally, when a diagnosis has not been established or when a code does not exist for a specific rare disease, general coding guidelines allow for the use of codes that describe signs and symptoms. In addition, prohibiting claim denials based solely on medical coding could have the unintended consequence of undermining the current electronic claims adjudication system, which heavily relies upon medical coding to support automated processing. The use of medical coding in health care payments facilitates machine processing of claims and significantly reduces adjudication and payment time. Elimination of a codified system for payment approval or denial would require manual claim review and result in significant administrative efficiency losses.

While the requests of Resolution 820-I-16 focus on claims and initial payment determinations and are accomplished through existing policy and coding guidelines, these concerns merit further consideration in relationship to appeals. After an initial claim denial, it is reasonable to expect health plans to perform a more comprehensive review upon a physician's appeal. Manual review of appeals by a physician of similar training to the ordering physician can ensure that physicians and patients receive appropriate consideration for coverage of proposed treatment. A detailed, specialty-specific review of appeals that includes consideration of all pertinent facts of the clinical case protects patients' access to medically necessary treatment.

Furthermore, as its title indicates, Resolution 820-I-16 seeks to ensure that physicians are paid for the delivery of medically appropriate care and are not subject to improper retrospective denials. It is important that our AMA underscore its commitment to ensuring that physicians receive payment for services as expected, especially given our proposed changes to UM systems. The AMA's efforts to reform PA programs should not be construed as tacit acceptance of increased post-payment audits or retrospective claim denials by health plans. Existing policy already addresses a variety of concerns regarding post-payment reviews and retrospective denials. For example, Policies H-320.961 and H-320.948 oppose claim denials for previously authorized services and support provision of clinical justification to physicians and patients for any retrospective claim denials. Policies D-320.991, H-330.921, H-335.981, and H-335.999 support transparency, fairness, and limitations in post-payment reviews.

DISCUSSION

The Council recognizes the value and importance of the AMA's current multi-pronged advocacy efforts related to PA. The recent successes in Delaware and Ohio to achieve meaningful reform in health plans' UM programs illustrate the effectiveness of a state approach to this issue and lead the Council to recommend continued activity in this area. The favorable initial response to and media attention from the release of the Prior Authorization and Utilization Management Reform Principles bode well for the ability of the AMA and its coalition partners to effect positive change in PA programs. The Council recommends that the AMA maintain the intensity of the current campaign, continue to follow through with various stakeholders, and reach out to additional potential partners to promote adoption of the Principles. All of these advocacy activities require a solid evidence base to establish the patient impact and practice burden of UM burdens. The Council therefore also recommends that the AMA continue its efforts to promote the results of the Prior Authorization Physician Survey and complete the PA research project with the USC Schaeffer Center for Health Policy & Economics.

Given the substantial practice time burdens imposed by PA programs reported in the Prior Authorization Physician Survey, it is understandable that physicians would desire compensation for PA work. However, after a review of potential funding sources for PA compensation, the Council believes that diverting advocacy resources to focus on this particular endeavor is not in the best interest of physicians. As described in this report, existing policy and CPT coding support payment for PA completion; however, logistical and practical challenges make it unlikely that health plans will routinely compensate physicians for completing UM requirements. While the 2008 *Gibson v. Medco* case may initially seem promising, the Council's close examination of the case specifics reveals a lack of broader applicability. Finally, the Council notes that pursuance of payment for PA may undermine the AMA's other strong and effective activities to reduce PA burdens. To avoid threatening the success of the AMA's current campaign related to the Prior Authorization and Utilization Management Reform Principles and other PA-related activities, the Council believes that the AMA refrain from efforts to seek physician compensation for PA work.

Ensuring that patients have timely access to medically necessary care forms the key underlying concept behind all of the AMA's efforts related to UM reform. The Council notes that existing policy addresses the need for coverage decisions and UM criteria to be based on sound clinical evidence and allows for individual patient differences, as requested in Resolution 820-I-16. Existing policy and general coding guidelines also support the flexibility in coding

referenced in the resolution. However, a strict prohibition of claims denials being based on medical coding alone could have the unintended consequence of interfering with electronic claims processing. As such, the Council recommends reaffirmation of existing policy regarding coverage for medically necessary treatment while refraining from an outright prohibition of payment denials based on coding. The Council also notes that the advocacy campaign associated with the Prior Authorization and Utilization Management Reform Principles will accomplish many of the objectives, including state legislative activity, mentioned in the resolution.

The Council believes that the increased level of review for initial coverage determinations referenced in Resolution 820-I-16 would be more effective for health plans' appeals systems. After an initial coverage denial, health plans should engage in a more detailed level of review for appeals that extends beyond coding and includes consideration of any clinical documentation submitted by the physician. As such, the Council recommends adoption of policy establishing that appeal decisions should not be based solely on medical coding, but rather on the direct review of a physician of the same specialty/subspecialty as the prescribing/ordering physician.

The issues with retrospective denials cited in Resolution 820-I-16 are both long-standing and of particular current relevance given the AMA's extensive activities related to UM. To ensure that any reductions in PA requirements do not result in a subsequent increase in health plan post-payment reviews and audits, the AMA should reiterate its global concern with administrative burdens related to medical necessity reviews, whether these processes occur prior to or after the claim payment. Health plans' post-payment reviews impose many of the same administrative burdens on practices as prepayment UM programs, with the additional potential harm of recoupment of previously paid claims. The Council therefore recommends reaffirmation of policies addressing concerns related to retrospective denials and post-payment audits.

Finally, the Council recommends rescinding the directive policies established with Council on Medical Service Report 7-A-16 (D-120.938, D-320.987, and D-320.986), all of which have been accomplished with AMA advocacy efforts as detailed in this report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 820-I-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. That our AMA oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. That our AMA reaffirm Policies H-320.948 and H-320.961, which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized, and Policies D-320.991, H-330.921, H-335.981, and H-335.999, which address fairness and limitations in post-payment reviews.
4. That our AMA reaffirm Policy H-320.949, which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions, and Policies H-285.998 and H-320.945, which further underscore the importance of a clinical basis for health plans' coverage decisions and policies.
5. That our AMA rescind Policies D-120.938, D-320.987, and D-320.986.

REFERENCES

¹ *Gibson v. Medco Health Solutions*, Trumbull Cnty. C.D. Ct. No. CVF-06-00106 (Mar. 6, 2008).

9. CAPPING FEDERAL MEDICAID FUNDING

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

HOUSE ACTION: REPORT REFERRED POLICY [H-290.963](#) ADOPTED

Expanding Medicaid eligibility to most individuals with incomes up to 138 percent of the federal poverty level (FPL) was a key element of the strategy to expand health insurance coverage under the Affordable Care Act of 2010 (ACA, Public Law 111-148) and made the biggest impact by accounting for 63 percent of coverage gains in 2014.¹ Medicaid expansion resulted in an estimated 11 million newly enrolled beneficiaries in 2015.² The program currently covers approximately 73 million beneficiaries nationwide.³

Proposals are being considered to reform Medicaid from an entitlement program, which covers all eligible individuals and guarantees federal funding for part of the cost of a state's program, to a program with fixed federal funding. The recent proposed reforms would cap federal Medicaid funding either through block grants or per capita caps. The effects that such reforms would have on patient access to care, physician payment, and state Medicaid programs is uncertain and has led the Council to review and identify potential issues that could arise if federal Medicaid funding is capped.

This report provides background on the Council's previous consideration of block grants; explains Medicaid funding; identifies the beneficiaries covered under Medicaid; outlines proposed mechanisms to cap federal Medicaid funding; highlights state and local input to congressional leaders; summarizes American Medical Association (AMA) policy and activity; discusses potential safeguards to ensure that patients have access to care, physicians are adequately paid and states are able to provide care to their Medicaid beneficiaries. The Council proposes a series of recommendations.

BACKGROUND

The Council previously considered Medicaid block grants in Council Report 5-I-11, "Medicaid Waivers and Maintenance of Effort Requirements." The report included a recommendation for the AMA to support giving states the option to convert Medicaid from an entitlement program to a block grant program only if certain safeguards were in place. The reference committee and House of Delegates opposed the recommendation due to concerns about patient access to care and physician payment under a block grant scenario. Testimony focused on the merits of providing states with the option to convert funding for their Medicaid programs into block grants, but did not discuss the recommended safeguards.

In 2011, capping federal Medicaid funding was not being considered by Congress and the Administration as urgently as it has been this year. In March 2017, the American Health Care Act (AHCA), aimed to repeal and replace the ACA, was introduced in the US House of Representatives. The AHCA proposed to discontinue funding Medicaid expansion programs and cap federal Medicaid funding to states. At the time this report was written, there had been no vote on the proposed legislation. With this legislative proposal, in addition to others aimed at capping federal Medicaid funding, the Council believes it is timely to consider how to help ensure that low-income patients have health care coverage, physicians are able to continue to treat them, and states are financially able to pay for services.

MEDICAID FUNDING

The Federal Medical Assistance Percentage (FMAP) determines the amount of money the federal government contributes to a state's Medicaid program and is designed so the federal government pays a larger percent of Medicaid costs in states with overall lower per capita incomes as compared to the national average. The FMAP contributes at least 50 percent of a state's Medicaid expenses and no more than 83 percent. For fiscal year 2017, the District of Columbia and seven states (AL, ID, KY, MS, NM, SC, and WV) are receiving 70 percent or more of their Medicaid funding from the federal government.⁴ Under the ACA, Medicaid expansion states received an enhanced FMAP initially covering 100 percent of states' costs for newly eligible beneficiaries. In 2017, as outlined in the ACA, the enhanced FMAP has phased down to cover 95 percent of expansion states' Medicaid costs for newly eligible beneficiaries and will phase down to 90 percent in 2020. At least eight states (AR, AZ, IL, IN, MI, NH, NM

and WA) that expanded Medicaid have statutory triggers to end their expansion programs if the enhanced federal match rates are decreased or discontinued.⁵

MEDICAID BENEFICIARIES

Medicaid provides coverage to children, pregnant women, elderly adults, people with disabilities, and eligible low-income adults. About one-quarter of Medicaid beneficiaries are elderly and disabled and account for two-thirds of all Medicaid spending.⁶ While children account for about half of Medicaid enrollees, they account for only one-fifth of the program's spending.⁷

Medicaid is the largest insurer for children in the country. From 2013-2015, the rate of uninsured children decreased from 7.1 percent to 4.8 percent, thereby increasing health insurance coverage for children to 95 percent.⁸ The decrease in the number of uninsured children coincided with the implementation of the ACA. Approximately 35.7 million children receive their health care through Medicaid, which provides guaranteed coverage, comprehensive and preventive health care services through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, and cost-sharing protections.⁹ The long-term effects on children covered through Medicaid include better health and lower rates of mortality that last into adulthood.¹⁰

The expansion of Medicaid has been critical in helping many states cope with the increased demand for mental health and substance abuse treatment as a result of the ongoing crisis of opioid abuse and addiction. Low-income adults with serious mental health illnesses are 30 percent more likely to receive treatment if they are enrolled in Medicaid than if they are not enrolled.¹¹ Medicaid expansion has provided an opportunity to improve the health of women, thereby ensuring healthy pregnancies and newborns.¹²

CAPPING FEDERAL MEDICAID FUNDING

Recent proposals to cap Medicaid funding seek to control federal Medicaid costs by providing less financial assistance to states in return for allowing more flexibility in administering their Medicaid programs. Federal savings would come from capping funding to states based on current or historical total spending (i.e., block grants) or per enrollee spending (i.e., per capita caps), multiplied by a predetermined growth rate.

Medicaid enrollment fluctuates and can change dramatically depending on factors outside of a state's control, such as economic downturns, natural disasters (e.g., Hurricane Katrina), epidemics (e.g., HIV), or treatment innovations (e.g., for Hepatitis C). If Medicaid funding is capped through block grants or per capita caps, the unpredictable fluctuations in state enrollment may make it difficult for states to balance their budgets.

Capping federal Medicaid funding may be viewed as advantageous by some states and not by others. While a cap may not provide as much financial support as some states want, other states may welcome the opportunity for more flexibility in managing their programs. The impact of a federal Medicaid funding cap could lead state Medicaid programs to cap enrollment, implement wait lists, restrict eligibility, eliminate or restrict benefits, or decrease provider payment rates. States could be permitted to impose work requirements, terminate coverage for beneficiaries who are considered non-compliant, or begin charging significant cost-sharing amounts that may cause low-income individuals to forgo coverage entirely or go without needed care.

STATE AND LOCAL INPUT

Governors, Medicaid directors, and mayors have all expressed concerns to Congress about the potential change in Medicaid financing. The National Governors Association (NGA) has requested that Congress maintain an open dialogue with governors and incorporate their suggestions throughout the legislative process. Specifically, the NGA requested that a meaningful federal role in the federal-state partnership be maintained and that costs do not shift to states.¹³ The National Association of Medicaid Directors has requested that the Trump Administration and congressional leaders form an expert workgroup of Medicaid Directors to provide technical expertise on any Medicaid proposals.¹⁴ The United States Conference of Mayors has urged Congress to take into consideration the impact that a repeal of the ACA would have on their residents and expressed their opposition to converting Medicaid to block grants.¹⁵

RELEVANT AMA POLICY

The AMA continues to assign a high priority to the problem of the uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all (Policy H-165.904[3]). The AMA supports continuous, affordable coverage and minimal, if any, copays for low-income individuals (Policies H-165.920, H-165.855, H-290.982, and H-165.845) and advocates for coverage that allows individual choice of health plans and benefits (Policies H-165.845, H-165.855, and H-290.985).

Long-standing AMA policies support maintaining Medicaid as a safety net program for the nation's most vulnerable populations and eligibility expansions of Medicaid with the goal of improving access to health care coverage to otherwise uninsured groups (Policies H-290.974 and H-290.986). The AMA advocates that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients (Policy H-290.982).

The AMA opposes payment cuts in Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; advocates that Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the population, and the cost of new technology; and supports a mandatory annual "cost-of-living" payment increase to Medicaid providers (Policy H-330.932).

The AMA advocates that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, such as converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need. The AMA supports changes in federal rules and financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds (Policy D-165.966). The AMA encourages state waiver demonstrations for low income adults living between their state's Medicaid income eligibility and 138 percent FPL (Policies H-290.966, H-165.855, D-165.966, and D-290.979).

Physician participation in the Medicaid program is encouraged by the AMA in order to support access to care (Policy H-290.982[12]). The AMA has long advocated that Medicaid payment rates for physician providers should be at minimum 100 percent of Medicare rates to increase and maintain access to health care for all (Policy H-385.921). The AMA will continue to advocate that the Centers for Medicare & Medicaid Services (CMS) provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services (Policy H-290.965[8]).

The AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements as outlined in the ACA and American Recovery and Reinvestment Act, which mandate that states maintain eligibility levels for all children in Medicaid until 2019 (Policy H-290.969). The AMA recognizes the importance of the EPSDT program and advocates that children qualified for Medicaid receive benefits with no cost-sharing obligations (Policies H-165.855, D-290.987, D-290.985, and H-290.987).

Policy H-290.965[10] supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016 and supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the ACA's Medicaid expansion exists.

AMA ACTIVITY

In January 2017, the AMA sent its health system reform objectives to members of Congress. Key objectives include ensuring that individuals currently covered do not become uninsured; that low/moderate income patients are able to secure affordable and adequate coverage; and that Medicaid and other safety net programs are adequately funded.¹⁶

In response to the March 2017 release of the AHCA, the AMA sent a letter to congressional leaders outlining reasons for not supporting the proposed legislation as written. With respect to proposed changes to the Medicaid program, the AMA emphasized support for increased flexibility in the Medicaid program so that states may pursue innovations that improve coverage for patients with low incomes. The AMA indicated its concern with the proposed rollback of the Medicaid expansion under the ACA. Medicaid expansion has proven highly successful in providing

coverage for lower income individuals. Beyond the expansion, the underlying structure of Medicaid financing ensures that states are able to react to economically driven changes in enrollment and increased health care needs driven by external factors. The Medicaid program, for example, has been critical in helping many states cope with the increased demand for mental health and substance abuse treatment as a result of the ongoing crisis of opioid use. Changes to the program, therefore, that limit the ability of states to respond to changes in demand for services threaten to force states to limit coverage and increase the number of uninsured.^{17,18}

The AMA has encouraged state medical associations to share their perspectives with their governors. The AMA is working with states to identify common priorities across the Federation and coordinate related advocacy activities.

DISCUSSION

Since capping federal Medicaid funding is being considered by Congress, the Council reviewed its previously proposed, but not adopted, recommendation on capping federal Medicaid funding and reconsidered it in the current context. Consistent with policy supporting state flexibility without capping federal funds (D-165.966), the Council recommends that safeguards be established in the event that federal funding is capped so that patients have access to care, physicians are adequately paid, and states are able to sustain their Medicaid programs.

The Council believes that individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced. This recommendation is aimed to help ensure that all eligibility groups (low-income adults, children, pregnant women, elderly adults, and people with disabilities) continue to receive the same level of services if federal Medicaid funding is capped.¹⁹ Of importance, the positive impact that Medicaid has on children's access to health care needs to be preserved.

The Council believes that the amount of federal funding available to states must be sufficient to ensure adequate access to all Medicaid statutorily required services, which include: hospital care; nursing home care; physician services; laboratory and x-ray services; immunizations and other EPSDT services for children; family planning services; federally qualified health center and rural health clinic services; and nurse midwife and nurse practitioner services. In addition, the ten essential health benefits the ACA requires for health plans are statutorily required for the Medicaid expansion population.²⁰

The Council believes that any cost savings mechanisms that are implemented due to capping federal Medicaid funding should not decrease patient access to quality care or physician payment. Section 1902(a)(30)(A) of the Social Security Act, also known as the "equal access" provision of Medicaid, requires that states have procedures in place to ensure that provider payment rates are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The AMA has advocated that CMS should provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can access necessary services in a timely manner.²¹

The Council believes that the methodology for calculating the federal funding amount should take into consideration the state's ability to pay for health care services, the rate of unemployment, the concentration of low income individuals, population growth, and overall medical costs. Currently, the FMAP determines the amount of money the federal government contributes to a state's Medicaid program and is designed so the federal government pays a larger percent of Medicaid costs for states with poorer populations. For fiscal year 2017, the District of Columbia and seven states are receiving 70 percent or more of their Medicaid funding from the federal government. If federal Medicaid funding is capped, states will still need adequate federal financial assistance to provide care to their residents and some states will need more assistance than others. The FMAP is able to respond to fluctuations in the financial needs of state Medicaid programs, whereas block grants and per capita caps are not.

The Council believes that the federal funding amount should be based on the actual costs of health care services for each state. The federal government should continue to fund the ACA Medicaid expansion populations in states that have expanded Medicaid. States that have not expanded Medicaid should be given the opportunity to do so with additional federal funding to cover their newly eligible populations. To date, 31 states and the District of Columbia have expanded Medicaid, which has resulted in approximately 11 million newly insured individuals who are now able to access health care – some for the first time. Even with this coverage gain, approximately three million

uninsured adults in non-expansion states fall into the “coverage gap” of earning too much to qualify for Medicaid in their states, but too little (i.e., less than 100 percent of the federal poverty level) to qualify for subsidies to purchase health insurance through the health insurance marketplace.^{22,23}

The Council believes that the federal funding amount should be indexed to accurately reflect changes in actual health care costs or state-specific trend rates, not on a preset growth index such as the consumer price index (CPI). Historically, US health care spending has grown faster than most other sectors of the economy. Some proposals to cap federal Medicaid funding suggest using the CPI to determine the yearly increase in federal funding to states. The CPI is the most widely used measure of inflation and represents goods and services purchased for consumption, such as medical care; but it also includes food and beverages, housing, apparel, transportation, recreation, education, communication, and additional goods and services.²⁴

The Council believes that maximum cost-sharing requirements should not exceed five percent of family income. Current federal regulations stipulate that Medicaid premiums and cost-sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent of the family’s income applied on either a quarterly or monthly basis, as specified by the relevant agency.²⁵ Medicaid coverage should be affordable and cost-sharing mechanisms, such as premiums, deductibles and co-payments, should be calculated according to a sliding scale based on income.

The Council believes that the federal government should monitor the impact of capping federal Medicaid funding to ensure that patient access to care, physician payment, and the ability of states to provide health care to their residents has not been compromised.

Finally, the Council suggests urging Congress and the Department of Health and Human Services to take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders in the process of developing federal legislation, regulations, and guidelines on capping federal Medicaid funding.

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) advocate for the following safeguards if federal Medicaid funding is capped:
 - a. Individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced;
 - b. The amount of federal funding available to states must be sufficient to ensure adequate access to all statutorily required services;
 - c. Cost savings mechanisms should not decrease patient access to quality care or physician payment;
 - d. The methodology for calculating the federal funding amount should take into consideration the state’s ability to pay for health care services, rate of unemployment, concentration of low income individuals, population growth, and overall medical costs;
 - e. The federal funding amount should be based on the actual cost of health care services for each state;
 - f. The federal funding amount should continue to fund the Affordable Care Act (ACA) Medicaid expansion populations in states that have expanded Medicaid and provide non-expansion states with the option to expand Medicaid with additional funding to cover their expansion populations;
 - g. The federal funding amount should be indexed to accurately reflect changes in actual health care costs or state-specific trend rates, not on a preset growth index (e.g., consumer price index);

- h. Maximum cost-sharing requirements should not exceed five percent of family income; and
- i. The federal government should monitor the impact of capping federal Medicaid funding to ensure that patient access to care, physician payment and the ability of states to sustain their programs has not been compromised.

2. That our AMA advocate that Congress and the Department of Health and Human Services take into consideration the concerns and input of the AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on modifications to Medicaid funding.

The following policy was adopted after which Council on Medical Service Report 9 was referred.

H-290.963, FEDERAL MEDICAID FUNDING

- 1. That our American Medical Association (AMA) oppose caps on federal Medicaid funding.
- 2. That our AMA advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on Medicaid funding.

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10. PHYSICIAN-FOCUSED PAYMENT MODELS: REDUCING BARRIERS

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

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

See Policies H-385.908, H-385.913, H-450.933, H-478.984 and D-478.972

At the 2016 Annual Meeting, the House of Delegates adopted the recommendations of Council on Medical Service Report 9-A-16, “Physician-Focused Alternative Payment Models,” which created guiding foundational policy to support the appropriate shift to physician-focused Alternative Payment Models (APMs) (see Policy H-385.913). As payment models take effect and evolve, the American Medical Association (AMA) must focus not only on physician awareness and understanding of APMs but also on their implementation and sustainability. To that end, this report identifies current barriers to the development and implementation of APMs including the limitations of existing health information technology (IT) capabilities, a dearth of valid and reliable resource use measures, and current challenges such as risk adjustment, attribution, and performance target setting.

This report, initiated by the Council, provides an overview of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provisions; outlines a number of barriers preventing the development and implementation of APMs; details the work of the Physician-focused Payment Model Technical Advisory Committee (PTAC) to the Secretary of the US Department of Health and Human Services (HHS); highlights a number of Physician-Focused Payment Model (PFPM) proposals submitted to the PTAC; describes an APM being implemented across the country; summarizes relevant policy; and presents policy recommendations to help alleviate the enumerated barriers.

BACKGROUND

MACRA repealed the Sustainable Growth Rate (SGR) formula and the constant threat of payment cuts to which physicians were subject under the SGR. MACRA is separate from yet builds upon the Affordable Care Act’s (ACA) focus on the shift to value-based payment. Of note is that MACRA not only repealed the SGR but also changed the way Medicare would link physician payments to quality improvement and use of technology moving forward. It creates new ways for the Medicare program to adjust physician payments for the care they provide to Medicare beneficiaries through MACRA’s Quality Payment Program (QPP). The QPP has two participation tracks: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).¹

The first QPP track, MIPS, will provide annual updates to physicians starting in 2019 based on their performance in four categories: quality (replaces the Physician Quality Reporting System), cost (replaces the Value-Based Modifier), improvement activities (new), and advancing care information (replaces Meaningful Use of an electronic health record system).² Instead of three separate programs, MIPS is intended to be one cohesive program to incentivize and reward physicians who meet or exceed performance thresholds and improve care.

The second QPP track is participation in Advanced APMs. APMs are intended to fundamentally change how care is delivered and paid for. Examples of APMs include accountable care organizations (ACOs) and other demonstration programs that have been created under the Centers for Medicare & Medicaid Services' (CMS) Center for Medicare & Medicaid Innovation (CMMI).³ In addition to the models that are currently available, MACRA encourages the development of PFPMs, which are the focus of this report. PFPMs are an APM wherein Medicare is the payer, physician group practices or individual physicians are APM participants, and the focus is on the quality and cost of physician services.⁴

MACRA established the PTAC, an 11-member independent federal advisory committee, to review, assess, and potentially recommend PFPM proposals submitted by stakeholders to the committee based on certain criteria defined in regulations. After reviewing the PTAC's recommendations, CMS is required to post a detailed response on its website. After providing an opportunity for public comments on a draft Request for Proposals (RFP) in August 2016, the PTAC issued an RFP and guidance on the types of proposals it is seeking in November and has been accepting PFPM proposals for its review since December 2016.

OPPORTUNITIES

Although the ACA and MACRA set goals to accelerate the development and implementation of innovative payment and delivery models, the majority of physicians do not yet have the tools and opportunities necessary to participate in APMs that support their efforts to improve care while reducing costs. For example, it is estimated that only 26 percent of physicians are part of a medical home, and 32 percent of physicians are part of a Medicare ACO.⁵ Despite numerous demonstration projects, most physicians, including primary care and other specialists, still lack access to APM participation.

MACRA's focus on PFPMs creates an opportunity to accelerate the implementation of APMs by expanding the number of eligible APMs and imparting them with the flexibility physicians need to help drive the shift toward improved value. Having several common frameworks for new APMs will not only make it easier for particular specialties to create payment models that match their needs, but should also make it easier for payers to implement payment models for multiple specialties and various practice types and settings. With the first APM performance period under the MACRA final rule starting in January 2017, now is a critical time for physicians to design and implement APMs in their practices. PFPMs provide a unique opportunity for physician organizations, including group practices and specialty and state medical societies, to have a key role in the development of new APMs, and for the AMA to aid members of the Federation in taking advantage of this opportunity.

BARRIERS

The overarching goal of payment reform is widely agreed to be delivery of high quality care in a cost efficient manner to improve patient outcomes. However, there are currently significant challenges to achieving that goal. APMs can only achieve their desired objective if the multitude of issues impeding their development and adoptability are addressed. Health IT capabilities and measurement challenges such as appropriate risk stratification and adjustment methods, attribution, and performance targets may inhibit APM development and discourage participation. The Council intends to address these barriers in the report to enable widespread development and adoption of PFPMs across physician practice size, specialty, and geographic location.

Health IT

Poorly functioning health IT continues to be one of the greatest drags on efficiency and satisfaction in the practice of medicine and is therefore a significant barrier to the development and implementation of care delivery and payment reform. PFPMs depend on access to high quality, real-time actionable data at the point of care. Physicians' readiness to participate in PFPMs hinges on health IT systems that support and streamline participation. The availability and affordability of electronic health information that tracks and informs care has been a challenge since the advent of

health IT. Without the appropriate tools, physicians will continue to struggle to track the metrics necessary to inform and improve care delivery. Physicians must have the guidance and technical assistance to meaningfully participate in PFPMS.

Lack of interoperability also hinders value-based care through PFPMS. Electronic health record (EHR) systems should facilitate connected health care across settings and enable the exporting of data and the ability to properly incorporate data from other systems. Connecting EHRs to external registries is one possible barrier due to backend technology that is often necessary for connectivity and may not exist, or in cases where it does exist, is often cost prohibitive.⁶ Clinical registries and Qualified Clinical Data Registries (QCDRs) have the potential to promote quality improvement and enhance patient safety and care. QCDRs are platforms that collect clinical data, calculate performance on quality measures and submit results to entities such as CMS with the overarching goal of improving the quality of care provided to patients. Since the passage of MACRA, CMS has encouraged reporting through QCDRs given their potential for advancing quality care. QCDRs enable physicians to report on quality measures that are outcomes oriented and may be more relevant to a physician's patient population as compared to traditional PQRS measures. However, to achieve the shared goal of greater QCDR participation, QCDRs need flexibility to incorporate measures that are tailored to their participating specialties. QCDRs are a fundamental aspect of a learning-based care environment since they allow tracking of measures, learning from the performance results in real-time, and adjusting clinical practice accordingly.

Data blocking, a sub-component of interoperability, continues to be an obstacle to the meaningful use of health IT. PFPMS only work efficiently when physicians have access to health information in real-time and in a coordinated manner. However, physicians continue to experience difficulties in transmitting and sharing patient health information. Barriers to interoperability and access to patient data must be overcome if APMs, including PFPMS, are to enjoy widespread acceptance and participation.

In order to realize the benefits of a learning-based health care system, patients and physicians must have access to their complete patient record. The 21st Century Cures Act, which was signed into law in December 2016, aims to address some of the health IT challenges outlined above and to promote information sharing and interoperability.⁷ Among other things, the 21st Century Cures Act calls for the creation of a reporting system to gather information about EHR usability and interoperability; supports the creation of a digital health care directory to facilitate exchange; encourages the exchange of health information between registries and EHR systems; and grants the HHS Office of the Inspector General authority to assign penalties for blocking the sharing of electronic health records.⁸ If properly implemented, the 21st Century Cures Act provides a path forward for increased interoperability and clinician access to useable data to inform care.

Risk Adjustment

The resources needed to achieve appropriate patient outcomes during an episode of care depend heavily on the individual needs of the patient as well as their ability to access care and properly adhere to prescribed treatment plans.⁹ Many risk adjustment methods only explain a small percent of the total variation, and they are focused on variation in spending, not on patient factors. Current risk adjustment methods are designed for a health plan's entire covered population, not the subpopulations of patients with a particular condition. Moreover, cost measures and benchmarks are often based on historical information on patient characteristics, not the most current information on health problems that affect the services patients need. As a result, risk adjustment based on prior claims data may not account for significant changes in the patient's health status. Further exacerbating data deficiencies is that most risk adjustment systems give little or no consideration to the factors other than health status that can affect patient needs, such as functional limitations and access to health care services.

Some risk adjustment methods do not take into account disease stages, such as cancer or kidney disease or glaucoma, or functional status, nor do they account for the factors that affect whether a particular patient is a favorable or poor candidate for a particular treatment. An additional concern is that most risk adjustment methods do not adequately account for socio-demographic factors. Research is emerging demonstrating the influence of socio-demographic factors, such as community supports, on the cost and outcomes of care. Flawed risk adjustment methods have the unwanted effect of inappropriately penalizing the physicians and health systems caring for sicker patients and individuals with socio-demographic challenges while rewarding those who do not care for these patients. As an unintended consequence, it may be harder for higher-need patients to access care and for physicians caring for these patients to maintain a sustainable practice.¹⁰

Attribution

Current retrospective statistical attribution methodologies often fail to accurately assign to physicians the services they delivered.¹¹ The purpose of attribution and corresponding performance measures is to ensure that physicians are held accountable for the costs they can control but not for costs they cannot. Use of an attribution method that assigns total costs to physicians regardless of their contributions to those costs is improper. Spending on complications and preventive conditions may be improperly assigned to the physicians who treated the problems.

Attribution methods that rely solely on claims are problematic. For example, in the Comprehensive Primary Care Plus (CPC+) APM, a patient can be attributed to a physician if the physician is billing for Chronic Care Management (CCM), which is a non-face-to-face service. However, physicians participating in CPC+ generally cannot bill for CCM for a CPC+ beneficiary. Accordingly, if physicians provide more non-face-to-face services and fewer visits, it is possible that patients will be inappropriately attributed to different physicians.

Various attribution methods could provide mixed signals to physicians as to who is actually responsible for delivering efficient care. The concern regarding accountability is exacerbated if some of the clinicians caring for a CPC+ participant's patients are unaffiliated with CPC+ and lack the same incentives to coordinate care and making care coordination more challenging. The delay in providing physicians with lists of attributed patients in real-time also stifles timely care coordination.

Performance Targets

Performance targets refer to quality metrics upon which physicians are measured. It is a priority to ensure performance targets are not unduly burdensome for physicians, particularly those in small practices and solo physicians, as they transition to value-based care and try implementing APMs. Unachievable performance targets may discourage physicians from developing and implementing PFPMs. Therefore, performance targets must be set reasonably such that Medicare savings may be realized while practice risk is reasonable. Payment rates for services should be set so that practices have the resources necessary to meet performance targets and are able to succeed under a new model. Importantly, physicians must receive data on how much is currently being spent on a particular condition and how much spending is potentially avoidable through the APM. Developing PFPMs is impossible without answering these questions so that realistic performance targets can be set.

WORK OF THE PTAC

The PTAC serves an important advisory role in the implementation of PFPMs, and will be instrumental in achieving the goal of developing more PFPMs. The PTAC is charged with seeking the following types of models for recommendation to the Secretary of HHS:

- Payments designed to enable an individual, eligible professional, or group of eligible professionals to improve care for patients who are receiving a specific treatment or procedure. These “treatment-based payments” could focus only on services delivered on the day(s) of treatment or on services delivered during a longer episode of care;
- Payments designed to enable an individual, eligible professional, or group of eligible professionals to improve care during a period of time for patients who have a specific health condition or combination of conditions. These “condition-based payments” could focus on either acute conditions or chronic conditions;
- Payments designed to enable teams of eligible professionals to deliver more coordinated, efficient care for patients who have a specific condition or are receiving a specific treatment or procedure;
- Payments designed to improve the efficiency of care and/or outcomes for patients receiving both services delivered by physicians or other eligible professionals and related services ordered by eligible professionals that are delivered by other providers;
- Payments designed to enable physicians or other eligible professionals to improve care for particular subgroups of patients (e.g., patients with a severe form of a condition, patients who have an early stage of a condition where progression can be more easily prevented, patients who need special services after treatment, or patients living in frontier or rural communities);
- Payments designed to enable a primary care physician or a multi-specialty group of eligible professionals to improve care for most or all of the health conditions of a population of patients, or to prevent the development of health problems in a population of patients with particular risk factors;

- Revisions to the codes and fee levels for a broad range of services delivered by physicians and other eligible professionals that are designed to support delivery of a different mix of services in conjunction with accountability for measures of utilization, spending, or outcomes for a group of patients; and
- Payments in which the amount of payment depends on patient outcomes, with or without changes to the units of payment for individual physicians or other eligible professionals.

Pursuant to MACRA, the Secretary was required to establish criteria for PFPMs, and these criteria, which were included in the MACRA final regulations, will be used by the PTAC to evaluate the proposals it receives:

- *Value over volume*: Provide incentives to practitioners to deliver high-quality health care;
- *Flexibility*: Provide the flexibility needed for practitioners to deliver high quality health care;
- *Quality and Cost*: PFPMs are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost;
- *Payment methodology*: Pay APM participants with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM participants, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies;
- *Scope*: Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM participants whose opportunities to participate in APMs have been limited;
- *Ability to be evaluated*: Have evaluable goals for quality of care, cost, and any other goals of the PFPM;
- *Integration and Care Coordination*: Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM;
- *Patient Choice*: Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients;
- *Patient Safety*: Aim to maintain or improve standards of patient safety; and,
- *Health Information Technology*: Encourage use of health IT to inform care.¹²

The PTAC intends to evaluate the degree to which stakeholder's proposed models satisfy the Secretary's criteria and make recommendations regarding the proposed model including whether to test on a limited scale, implement, implement with high priority, or not recommend. Proposed PFPMs may be submitted to the PTAC on an ongoing basis.

PTAC PROPOSALS

As previously stated, the PTAC began accepting PFPM proposals on December 1, 2016. At the time that this report was written, seven proposals and numerous letters of intent have been submitted to the PTAC and are available on its website (<https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee>) for public comment. At its April meeting, the committee reviewed three of the proposals and recommended two of the proposals for limited-scale testing. These two proposals are briefly discussed below: the American College of Surgeons-Brandeis proposal and Project Sonar, a model submitted by the Illinois Gastroenterology Group and SonarMD, LLC.

American College of Surgeons-Brandeis

The ACS-Brandeis APM is an episode-based payment model. The model is built on an updated version of the episode grouper for Medicare software currently used by CMS for measuring resource use. The grouper processes Medicare claims data using clinical specifications to create condition-specific episodes to assess utilization and costs. The patient-focused philosophy of both the grouper and APM recognizes that surgical care is team-based, and that coordination with medical specialists, primary care and all the other segments of the delivery system involved plays an important role in improving outcomes. The model does not require hospitalization, which allows for inclusion of procedures performed in the outpatient setting and possible expansion to include acute and chronic conditions.

Project Sonar

The 20 gastroenterology practices that have participated in the Project Sonar model to date have achieved significant improvements in quality and outcomes for patients with Crohn's disease while also lowering costs. The health plan has stated that the model is saving significant amounts of money due to decreased hospitalizations. Project Sonar achieved these improvements using a care pathway and clinical decision tool developed by the American Gastroenterological Association. Project Sonar's innovative technical solutions engage patients in a monthly process of reporting to their gastroenterologist on their symptoms and feelings, and they then receive an immediate action-focused response if indicated by the reported symptoms. The project has been effective in reducing hospital admissions and emergency department visits for patients with Crohn's disease, especially those who demonstrate the most engagement in their own health care by responding to the monthly "pings." Project Sonar is more than a model way of improving care for patients with Crohn's disease. It also has the potential to support better care for patients with other kinds of chronic health problems that require close monitoring to avoid hospitalizations and therefore demonstrates a means for specialist physicians who have had very few opportunities to participate in APMs to date to effectively do so.

EXAMPLE OF AN APM: CPC+

As previously noted, CPC+ is an example of an Advanced APM already implemented in practices across the country. CPC+ is a primary care medical home model that aims to strengthen primary care through payment reform coupled with delivery transformation. The CPC+ model focuses on strategies to promote population health and chronic disease management techniques to encourage more coordinated care. There are two tracks of the CPC+ program with different levels of risk and potential upside. In both tracks, CPC+ includes three payment elements. First, practices receive a risk adjusted non-visit-based care management fee paid per beneficiary per month, which is intended to pay for services that fall outside the traditional physician visit such as patient education and medication management and adherence support. Second, CPC+ uses a performance-based incentive payment that is based on how well a practice performed on patient experience of care measures, clinical quality measures, and utilization measures that drive total cost of care. Finally, practices receive a payment under the Medicare Fee Schedule. In CPC+ Track 1, practices continue to bill and receive fee-for-service (FFS) payments as usual. However, in CPC+ Track 2, practices receive a hybrid payment meaning they receive a Comprehensive Primary Care Payment (CPCP) and a reduced FFS payment. This hybrid model is intended to account for CMS shifting a portion of Medicare FFS payments into CPCP, which are paid in a lump sum on a quarterly basis. Because it is the expectation that Track 2 practices will increase the breadth and depth of services offered, the CPCP amounts will be larger than the FFS payment amounts they are intended to replace.

RELEVANT AMA POLICY

At the 2016 Annual meeting, the House of Delegates adopted the recommendations of Council on Medical Service Report 9-A-16, "Physician-Focused Alternative Payment Models," which created guiding foundational policy (H-385.913) to support the appropriate shift to physician-focused APMs. Policy H-385.913 promulgated goals for physician-focused APMs, developed guidelines for medical societies and physicians to begin identifying and developing APMs, and encouraged CMS and private payers to support assistance to physician practices working to implement APMs. The policy has been influential in related AMA advocacy thus far, which has included development of extensive comments on the MACRA proposed and final rules and responding to draft documents from the PTAC and proposed models from CMMI. The AMA has a key role in helping physicians develop and participate in PFPMs.

The AMA has extensive policy related to physician-led payment reform models. AMA policy is committed to promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs (Policy D-385.963). Policy H-390.844 emphasizes the importance of physician leadership and accountability to deliver high quality and value to patients. In transitioning from the SGR, the AMA advocates for providing opportunities for physicians to determine payment models that work best for their patients, their practices, and their regions (Policy H-390.844). Policy D-390.953 directs the AMA to advocate with CMS and Congress for APMs developed in concert with specialty and state medical organizations. Policy H-450.931 recognizes that physicians will need assistance transitioning to APMs.

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

The AMA also has significant and comprehensive policy on health IT. Policy D-478.972 calls for efforts to accelerate development and adoption of universal, enforceable EHR interoperability standards for all vendors; supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; eliminate pricing barriers to EHR interfaces and connections to health information exchanges; and continue to promote interoperability of EHRs and clinical registries. Policies D-478.995 and D-478.996 echo this commitment to work towards interoperability while mitigating the financial burden on physicians. Policy H-450.933 encourages efforts to develop and fund clinical data registries; supports flexibility in the development and implementation of clinical data registries; encourages physicians to participate in clinical data registries; and advocate for and support initiatives that minimize the costs of physician participation in clinical data registries. Policy H-478.984 directs the AMA to advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data.

AMA ACTIVITY

The AMA continues to work to prepare physicians for the implementation of MACRA. The AMA has been active in educational activities including webinars and regional conferences for physicians and staff and will be continuing these activities. Recent AMA advocacy activity has called for improvements in the methodologies behind APMs to reduce practice barriers and enable more physicians to participate. Such areas for improvement in methodology include performance targets, risk adjustment, and attribution. The AMA recognizes that proper methodologies ensure that the appropriate patients are participating in APMs and that the APM is designed in such a way that prioritizes the patient's needs. Improving resource use (cost) measurement is an important focus moving forward to ensure that the measures used compliment and support APMs.

The AMA has released new tools and resources to help physicians prepare. One important aim of the new tools is to ease the transition of qualified physicians to the QPP and ensure their practices remain sustainable moving forward. The new resources include the AMA Payment Model Evaluator, AMA Steps Forward™ modules, and a series of ReachMD podcasts.

The AMA Payment Model Evaluator (<https://apps.ama-assn.org/pme/#/>) is an innovative tool offering initial assessments to physicians so they can determine how their practices will be impacted by MACRA and QPP, and how they can prepare for the 2017 performance year and beyond. Developed with the expertise of physicians and input from partners, the tool gives physicians and their staff a brief assessment of their practices, as well as relevant educational and actionable resources. Once physicians and medical practice administrators complete the online questionnaire, they receive an individualized practice profile that provides guidance on what QPP path appears to be best for them (MIPS vs Advanced APMs) and how they can best succeed. The AMA will continually update the Payment Model Evaluator to respond to regulatory changes and to keep practices up to date throughout the new payment and care delivery reform process. The tool is free to all physicians and their practice administrators.

The AMA STEPS Forward™ (<https://www.stepsforward.org/>) collection of practice improvement modules has new MACRA-specific tools. Accurate and successful reporting on quality metrics is crucial to the new Medicare payment system, both in the current Physician Quality Reporting System program and under MACRA's new QPP. Effectively leveraging health IT to track practice metrics is crucial in the evaluation of proposed PFPMs to ultimately improve care. Each STEPS Forward module focuses on a specific challenge and offers real-world solutions, steps for implementation, case studies, downloadable tools and resources and an opportunity for continuing education credit. Physicians and their practice staff can use these to improve practice efficiency and ultimately enhance patient care, physician satisfaction and practice sustainability. The full collection, which now includes more than 40 modules, has a variety of tools that will help physicians and their practices, including:

- Implementing team-based care;
- Electronic health record selection and implementation;
- Preparing practices for value-based care;
- Implementing team documentation; and
- Quality Reporting and the importance of Qualified Clinical Data Registries (QCDRs) in maximizing your success.

The AMA launched a ReachMD podcast series titled *Inside Medicare's New Payment System* (<https://reachmd.com/programs/inside-medicares-new-payment-system>). Several physicians who have been instrumental in developing and implementing APMs are featured. The series also includes podcasts with former CMS acting administrator Andy Slavitt; 2016-2017 AMA President Dr. Andrew Gurman; and AMA staff experts.

Additionally, the AMA is undertaking significant work to improve health IT interoperability. The AMA is working to convene the industry around a solution for interoperability that will support data access to empower patients and clinicians.

AMA ADVOCACY ON MACRA APMs

The biggest APM problem in the proposed regulations for the QPP was the proposed definition of “more than nominal financial risk,” which was set at four percent of total Medicare spending on the APM’s patients. As spending on physician services is a small fraction of total spending, this definition would have required physicians in APMs to take risk for hospital and other costs that are outside their control and for which many practices receive no revenues. Instead, the AMA successfully urged CMS to allow APM financial risk to be defined as a percentage of the APM practices’ revenues. The final rule set the standard at eight percent of revenues. In APMs that define financial risk as a percentage of total spending, the final regulation lowered the minimum percentage from four to three.

AMA comments also addressed the need to provide more credit for APM participation in the improvement activities (IA) component of MIPS. While the proposed rule would have allowed full credit for medical home participation, as required by MACRA, it only would have provided 50 percent IA credit for other APMs. As the AMA advocated, other APMs will also now provide full credit in IA. Additionally, CMS responded to AMA comments by expanding the number of medical homes that can be recognized under IA. Finally, whereas the proposed rule indicated that the requirement for APM participants to use certified EHRs would increase from 50 to 75 percent in future years, the final rule maintained the 50 percent requirement.

Comments on the final rule sought additional APM policy changes in future MACRA rulemaking. For example, while the final rule set the revenue threshold at eight percent to meet financial risk requirements, it indicated that it could be increased to 15 percent in 2019 and later years. The AMA is advocating that the standard remain at eight percent. The AMA is also calling for the lower financial risk requirements available for patient-centered primary care medical homes be extended to specialty medical homes.

AMA advocacy efforts are also focused on the PTAC and PFPMs. The AMA attends and makes public comments at meetings of the PTAC, submits comments on its draft documents and stakeholder proposals, and works with specialty societies developing PFPM proposals to help address challenges they face in APM design. To that end, the AMA convened an APM workshop in Washington DC on March 20, 2016 to bring together many of the leading physicians who are working on PFPM proposals to discuss potential solutions to these issues.

DISCUSSION

With the publication of the MACRA final rule, now is a critical time for physicians to implement APMs as MACRA begins to take effect. While APMs have the potential to shape the future of health care delivery and drive innovation, many obstacles to participation remain. The challenges identified in this report are ripe for improvement. The AMA has a key role in helping physicians navigate toward full and efficacious implementation of APMs, and helping physicians tackle these obstacles is critical to physicians’ success in new payment models. By addressing process barriers, the AMA can help physicians work within the rules in MACRA legislation and regulations to develop and implement new and feasible payment models tailored to their practices and patient populations.

As MACRA implementation moves forward, it is vital for physicians to take a leadership role to ensure that future changes fulfill the promise of delivering better care at lower costs in ways that are financially viable for physician practices that vary in size and by specialty. The AMA is uniquely qualified to help physicians shape this transition and ensure sustainable success through targeted advocacy efforts and creation of physician-specific resources and tools. Major challenges remain on the path to achieving value-based care, and the AMA and physicians must remain at the forefront.

Health IT has the capacity to yield great change in health care that delivers improved health outcomes. However, while it promises a future of connectedness and improved quality, challenges remain in bridging the gap between data silos and full interoperability. The Council believes that CMS must expand technical assistance for practices, ensure that the complex backend IT systems required to receive clinician data are available and affordable, and enable systems to participate in data exchange and provide physicians with useful reports and analyses based on the data provided. Additionally, although the 21st Century Cures Act includes numerous provisions intended to improve health IT, the Council believes that physicians must be diligent in ensuring such provisions are promptly implemented.

Flawed risk adjustment methods can have the effect of inappropriately penalizing physicians who care for sicker patients or those caring for patients whose socio-demographic status makes it difficult to achieve the health outcomes they deserve. As such, the Council suggests alternative approaches be explored in which the physician managing a patient's care can contribute additional information that may not be available in existing risk adjustment methods and that can help risk stratify patients appropriately. Additionally, to mitigate the possibility of physicians being inappropriately penalized for caring for patients with socio-demographic challenges, the Council suggests urging CMS to identify new data sources to enable adequate consideration of non-clinical (e.g., socio-demographic) factors that contribute to a patient's state of health and account for treatment success.

Attribution is intended to ensure that physicians are held accountable for the costs that they can control. However, current attribution methods often fail to properly assign accountability for a service to the appropriate physician, and the Council suggests policy to alter attribution methods so that accountability for spending and quality is accurate. Attribution methods must complement and support APMs by being based on the actual nature of the relationship between physician and patient.

It is important that performance targets do not prevent physicians, particularly those in small, solo, and rural practices, from participating in an APM. There is concern that stringent performance targets may be unduly burdensome to physicians, particularly because not all consequences, intended or not, of MACRA are yet known. Therefore, the Council suggests policy ensuring performance targets are set reasonably. As a prerequisite to realizing Medicare savings, physicians must receive data on how much is currently being spent on a particular condition and how much of that spending is potentially avoidable through an APM. Such information is critical both to physicians designing PFPMs and to those considering whether participation is appropriate for their practice.

Though the transition to value-based payment may be difficult, the Council believes that with a united physician voice and strong leadership, payment reform will allow physicians to provide higher quality care to patients and have sustainable practices. In this report, the Council offers a set of recommendations intended to address some of the barriers that interfere with the shift to value-based payment. These recommendations are consistent with AMA policy and significant ongoing advocacy efforts. The Council recognizes that the need for technical assistance and health IT functionality and affordability place enormous stress on physicians and inhibit PFPM participation. Additionally, the Council identifies resource use measurement, including risk adjustment, attribution, and performance targets, as areas where improvements can be made. Physicians must be equipped to shape payment reforms appropriately, and the Council is hopeful that its recommendations will help physicians as they develop and participate in value-based payment and delivery reform.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-385.913 promulgating goals for physician-focused alternative payment models (APMs), developing guidelines for medical societies and physicians to

begin identifying and developing APMs, and encouraging the Centers for Medicare & Medicaid Services (CMS) and private payers to support technical assistance to physician practices working to implement APMs.

2. That our AMA reaffirm Policy D-478.972 on electronic health record (EHR) interoperability calling for the elimination of unjustified information blocking and excessive costs which prevent data exchange and continuing efforts to promote interoperability of EHRs and clinical registries.
3. That our AMA reaffirm Policy H-478.984 advocating for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data.
4. That our AMA reaffirm Policy H-450.933 encouraging efforts to develop and fund clinical data registries and supporting flexibility in the development and implementation of clinical data registries.
5. That our AMA encourage physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
6. That our AMA continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
7. That our AMA continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
8. That our AMA work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance;
 - b. Develop IT systems that support and streamline clinical participation;
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
9. That our AMA work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
 - a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;
 - b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and
 - c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
10. That our AMA work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
 - a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
 - b. Distinguish between services ordered by a physician and those delivered by a physician;
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patient's and physician's responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.

11. That our AMA work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
 - a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.

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