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* Contained in Handbook Addendum
At the 2015 Interim Meeting, the House of Delegates referred Resolution 819, “Physician and Medical Staff Member Bill of Rights.” Resolution 819 was introduced by the Florida Delegation and asked that our AMA:

1. Support and adopt the following medical staff member bill of rights in order to be able to carry out professional obligations and to clearly define the rights which we hold to be self-evident and inalienable:
   a. The right to care for patients without compromise;
   b. The right to freely advocate for patient safety;
   c. The right to be compensated for providing care;
   d. The right to be evaluated by unbiased peers who are actively practicing physicians in the community and specialty;
   e. The right to care for our own well-being;
   f. The right to full due process when privileges are challenged;
   g. The right to privacy;
   h. The right of medical staffs to be self-governed and independently advised;
   i. The right of freedom from personal loss or liability for adverse outcomes relating to medical practice based on compassion and good judgment within community standards; and
   j. The right to fair market and transparent economic competition in our communities between hospitals with or without employee physicians and other allied health care professionals and independent physicians and groups in the delivery of health care services and compensation based on appropriate community need; and

2. Encourage state medical associations to promote the formation of medical staff advocacy committees throughout these states; and

3. Provide support for state medical associations in their efforts to aid medical staff advocacy committee’s role with medical staff issues and communications between physicians and hospitals and any other appropriate agency.

Testimony on Resolution 819 was mixed. Some members favored adoption while others suggested that the proposed bill of rights is not something that should be adopted without a thorough review of each component, especially given the large volume of existing AMA policy on these and related topics.
DISCUSSION

Medical staff rights and responsibilities

Resolution 819 asks the AMA to adopt a “medical staff bill of rights.” A comprehensive review of more than 160 AMA policies and directives on medical staff topics reveals that the medical staff-related rights espoused in the first resolve clause are already addressed by existing AMA policy, albeit often in a nuanced fashion. Recognizing that the complexity of this body of policy makes it difficult to summarize in a useful manner, your Board believes the AMA should establish a high-level abridgement of these existing policies in order to provide more practical guidance for medical staffs and their advocates. As implied by the resolution, any such enumeration of medical staff rights—whether attributed to individual members or the organization as a collective—ought to be framed in terms of the responsibilities that give rise to these rights.

Your Board therefore proposes the adoption and widespread distribution of a concise series of fundamental medical staff rights and responsibilities based on existing AMA policy. Additionally, to improve the usability of the rich body of underlying AMA policy, we suggest that the AMA undertake a review and consolidation as necessary of its policies on medical staff topics.

AMA and state medical associations

Resolution 819 also asks the AMA to “encourage state medical associations to promote the formation of medical staff advocacy committees” and “provide support for state medical associations” in these efforts. Existing AMA policy already directs the AMA to take such action. Specifically, the AMA “supports efforts to foster more effective liaison between state and local medical societies and organized medical staffs, and better coordination of their activities,” and will work “with county medical societies and state medical associations to provide the counsel and services necessary to strengthen local organized medical staffs” (AMA Policy G-620.080). In furtherance of these goals, the AMA, through its Organized Medical Staff Section (OMSS) and a variety of related resources, supports physicians affiliated with medical staffs in their efforts to cultivate high-functioning medical staffs and improve patient safety and quality of care in their health care organizations. Physicians interested in representing the interests and concerns of their medical staffs at the local, state, and national level are encouraged to visit ama-assn.org/go/omss to learn more about and become involved with OMSS.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 819-I-15 and that the remainder of the report be filed:

1. Our AMA adopt and distribute the following Medical Staff Rights and Responsibilities:

   a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization’s governing body.

   b. The responsibility to provide leadership and work collaboratively with the health care organization’s administration and governing body to continuously improve patient care and outcomes.
c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.

f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.


II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:

   a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules, and regulations (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, and (iv) being advised by independent legal counsel.

   b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.

   c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

   d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.

   e. The right to be represented and heard, with or without vote, at all meetings of the health care organization’s governing body.

   f. The right to engage the health care organization’s administration and governing body on professional matters involving their own interests.


III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

   a. The responsibility to work collaboratively with other members and with the health care organization’s administration to improve quality and safety.

   b. The responsibility to provide patient care that meets the professional standards established by the medical staff.

   c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.

   d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.

   e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.

   f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment or contractual status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization’s administration or governing body.

d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

f. The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities.


(New HOD Policy)

2. That our AMA reaffirm Policy G-620.080, “Federation Organizations and Organized Medical Staff.” (Reaffirm HOD Policy)

Fiscal Note: Less than $500
At the 2016 Annual Meeting, the House of Delegates (HOD) referred Resolution 717-A-16, “Unforeseen Consequences of Core Measures,” for report back at the 2017 Annual Meeting. This resolution was introduced by the Young Physicians Section and asked that:

Our AMA call for the immediate suspension of the SEP-1 core measure and any financial incentives or penalties relating to compliance with it;

Our AMA strongly discourage the implementation of further protocols, core measures, or directives concerning the care of patients in the outpatient or inpatient setting without structured trials designed to identify unforeseen costs and potential patient harms;

Our AMA strongly discourage the implementation of indiscriminant and not medically indicated screening or testing for “pre-existing” infection in patients in order to avoid financial penalties; and

Our AMA supports any physician who refuses to perform testing or treatment that they feel is not medically indicated or potentially harmful to patients.

BACKGROUND

At the 2016 Interim Meeting, the HOD referred for decision Resolution 811-I-16, “Opposition to Centers for Medicare & Medicaid Services (CMS) Mandating Treatment Expectations and Practicing Medicine.” This resolution was introduced by the Texas Delegation and asks that:

Our AMA oppose CMS creating mandatory standards of care that may potentially harm patients, disrupt the patient-physician relationship, and fail to recognize the importance of appropriate physician assessment, evidence-based medicine and goal directed care of individual patients; communicate to hospitals that some CMS mandatory standards of care do not recognize appropriate physician treatment and may cause unnecessary harm to patients and communicate to members, state and specialty societies, and the public the dangers of CMS’ quality indicators potentially harming the patient-physician relationship.

Given that there is significant overlap between Resolutions 811-I-16 and 717-A-16, at the 2016 Interim meeting members from the Board of Trustees (BOT), Council on Medical Service, and...
Council on Legislation noted that a resolution addressing the unintended consequences of the Hospital Inpatient Quality Reporting (IQR) program measures was referred at the 2016 Annual Meeting. Therefore, a report on the issues raised in Resolution 811-I-16 was already being developed. However, several speakers noted the urgency of this resolution since implementation of the problematic measure has already begun. There were calls to refer Resolution 811-I-16 for decision, since members felt action might need to be taken prior to the 2017 Annual Meeting. Therefore, Resolution 811-I-16 was referred for decision even though this report was already in development.

In addition, since the time Resolution 811-I-16 and 717-A-16 were introduced, several changes have been made to the severe sepsis and septic shock measure which addresses the issues that were referenced in the resolutions. Therefore, the BOT acted on Resolution 811-I-16 in February 2017 by adopting the below general policy in lieu of Resolution 811-I-16 (Policy H-450.927, “Development of Quality Measures with Appropriate Exclusions and Review Processes” and Policy D-450-953, “Development of Quality Measures with Appropriate Exclusions and Review Processes”):

Our AMA advocate for quality measures, including those in the Hospital Inpatient Quality Reporting Program, to have appropriate exclusions to ensure patient and clinical differences are accounted for and do not interfere with clinical decision making, and for denominators of quality measures to be appropriately defined to ensure patients for whom the treatment may not be appropriate are adjusted for or excluded.

Our AMA advocate for CMS to allow for any proposed quality measures to be reviewed by the appropriate medical specialty societies prior to adoption.

Our AMA provide input on the Severe Sepsis and Sepsis Shock: Management Bundle measure during the National Quality Forum’s (NQF) review of the measure in 2017, and ask the Centers for Medicare & Medicaid Services to redesign the measure.

Given that general policy has already been issued, and the specific issues addressed in this resolution have been resolved, no additional action is needed. This report provides information on the Hospital IQR program, including specific analysis of the sepsis measure.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 mandated the Hospital Inpatient Quality Reporting program. The statute authorized CMS to pay hospitals that successfully report designated quality measures a higher annual payment update. Initially, the MMA provided a 0.4 percentage point reduction in the annual market basket update for hospitals that did not successfully report the required quality measures. Section 5001(a) of the Deficit Reduction Act of 2005 provided new requirements for the Hospital IQR program and increased the possible payment reduction to two percentage points. Section 1886(d) of the Social Security Act requires CMS to make data collected under the Hospital IQR program available to the public on Hospital Compare.

Measures included in the Hospital IQR program are designed to standardize practices among hospitals and improve patients’ quality of care. The measures range from reporting whether stroke patients with an abnormal heartbeat received anti-coagulation therapy to whether a heart failure patient received proper discharge instructions.
Addressing the issue of appropriate care for patients with severe sepsis and septic shock is vital to improving health care quality and reducing health care costs. Sepsis represents the most expensive condition treated in United States hospitals, and was the second most common principal diagnosis for hospitalization in the United States in 2013.1 In addition, the Agency for Healthcare Research and Quality (AHQR) found that the sepsis mortality rate is more than eight times higher than mortality rates among patients admitted for other conditions. From 1999 to 2014, the annual number of reported sepsis-related deaths (primary and secondary diagnosis combined) increased 31 percent, from 139,086 in 1999 to 182,242 in 2014.2

The “whereas” clauses in Resolution 811-I-16 and Resolution 717-A-16 both discuss physicians’ concerns with a particular Hospital IQR program measure, Severe Sepsis and Septic Shock: Management Bundle (Composite Measure) (SEP-1), NQF 0500. The SEP-1 measure was included as a Hospital IQR program measure on October 1, 2015, as one of the 2015 Hospital IQR program measures that will apply to Fiscal Year 2017 payment determinations for hospitals.

Measure Description

The SEP-1 composite process-of-care measure focuses on adults ages 18 and older with a diagnosis of severe sepsis or septic shock. SEP-1 assesses the timely measurement of lactate levels, the timely collection of blood cultures, the administration of broad spectrum antibiotics, fluid resuscitation, vasopressor administration, timely reassessment of volume status and tissue perfusion, and a repeat lactate measurement. The measure calculates the percentage of patients with severe sepsis or septic shock for whom all of the relevant and recommended bundles have been completed, within the required timeframe, as a single composite measure. All bundles must be completed in order for a case to pass the measure. Results of the SEP-1 measure are then reported as an aggregate rate generated from all the cases assessed and reported as a proportion. Hospitals with five or fewer discharges (both Medicare and non-Medicare combined) in a measure set (SEP-1) within a quarter are not required to submit patient-level data for that measure set for that quarter.

The intent of the SEP-1 measure is an effort to lower complication and mortality rates, while making sepsis care more affordable by focusing on early intervention. However, the new measure has created some controversy within the medical community, which is referenced in Resolutions 811-I-16 and 717-A-16. Specifically, these two resolutions raise concerns that SEP-1 fails to adequately account for individual patient circumstances. Physicians have reported that while there are benefits for some patients to receive the treatments required by this measure, there are also numerous situations where patients should be exempt from receiving this treatment. Many of these concerns have been addressed in later versions of measure specifications and release notes.

Measure Calculation

The denominator of the SEP-1 measure includes patients with an inpatient hospital stay, ages 18 and older, with an ICD-10-CM principal or other diagnosis code of sepsis, severe sepsis, or septic shock. The numerator for this measure includes patients from the denominator who meet the requirements and have the characteristics listed below:
• Within three hours of presenting with severe sepsis: their lactate levels were measured, their blood cultures were obtained before antibiotics were administered, and they were given broad spectrum antibiotics.
• Within six hours of presenting with severe sepsis, the patients’ lactate level was drawn again if the initial lactate level was elevated.
• Within three hours of presenting with septic shock, the patients’ received 30 ml/kg of crystalloid fluids.
• And only if hypotension does not respond to the initial fluid resuscitation within six hours of presentation of septic shock, then vasopressors were given.
• And only if hypotension persists after fluid administration of the initial lactate level is >= 4 mmol/L, the volume status was reassessed, and tissue perfusion was performed, within six hours of presentation of septic shock.

Currently the following patients are excluded from SEP-1:

• Severe sepsis is not present;
• Directive for comfort care or palliative care within three hours of presentation of severe sepsis;
• Directive for comfort care or palliative care within six hours of presentation of septic shock;
• Administrative contraindication to care within six hours of presentation of severe sepsis;
• Administrative contraindication to care within six hours of presentation of septic shock;
• Length of stay greater than 120 days;
• Transfer in from another acute care facility;
• Patients with severe sepsis who are discharged within six hours of presentation;
• Patients with septic shock who are discharged within six hours of presentation;
• Patients receiving intravenous antibiotics for more than 24 hours prior to presentation of severe sepsis; and
• Patients included within a Clinical Trial (Note: This exclusion will be removed from the list in 2018).

Resolutions 811-I-16 and 717-A-16 noted that there were circumstances, in addition to those listed above, which may create issues for physicians attempting to adhere to the SEP-1 measure requirements. Specifically, if a patient has severe systolic dysfunction (LVSD), a physician may determine that treating the patient with the amount of fluids required under the SEP-1 measure would be harmful to the patient, possibly causing fluid overload. Some research shows that this can be harmful to patients with septic shock and increase mortality, and more than 60 percent of patients who present with septic shock have LVSD. If a physician provides the appropriate care to the patient in this circumstance (limiting the fluids), it would impact their ability to comply with the SEP-1 measure. This concern was addressed in the CMS July through December 2016 measure specification updates. Specifically, the developer added a new element to the measure on “initial hypotension” to better identify patients who should receive crystalloid fluids. The new element should help ensure that physicians will not be penalized for failing to provide fluids to patients for whom those fluids may be harmful in the SEP-1 measure calculation.

In addition, the measure required that blood cultures be completed prior to starting a patient on antibiotics, which is common clinical practice. In some situations, this requirement was problematic, as the Surviving Sepsis Campaign guideline recommendation states “we recommend obtaining appropriate cultures before anti-microbial therapy is initiated if such cultures do not cause significant delay (> 45 minutes) in the start of antimicrobial(s) administration (grade 1C).” It was possible that if this delay occurred, a physician would have no way to indicate that he or she
prioritized giving the patient a broad-spectrum antibiotic over waiting for the cultures to be drawn. Due to these concerns over the requirement for blood cultures prior to administering antibiotics, in
the updated release for 2017 specification release notes from CMS, an additional data element was
added that allows a physician to document if there was an acceptable delay in drawing blood
cultures. This new element alleviates physicians’ concerns and illustrates that there may be times
when prioritizing the administration of antibiotics over the blood culture is appropriate.

Physicians also questioned whether the definitions that were used to define the population of
interest (denominator) in this measure were too broadly defined. Specifically, with the inclusion of
organ dysfunction in the severe sepsis definition, patients with end-stage renal disease or cirrhosis
may be counted in the denominator. This inclusion of false positives paired with the inability to
exclude patients beyond what is currently outlined could have had unintended negative
consequences and directly affected the validity of the measure. In the 2017 updated specification
release notes, CMS added an additional data element requiring documentation of severe sepsis by
the physician. This requirement addresses the concern that the measure may not be defined
precisely enough to capture the correct patients and allows individual patient circumstances to be
considered.

Current NQF Review

SEP-1 was developed by the Henry Ford Health System in collaboration with leadership and
representatives from the Society of Critical Care Medicine and the Infectious Diseases Society of
America based on the Surviving Sepsis Campaign guidelines. Some changes have been made to
the measure based on new randomized controlled trial data, such as the ProCESS trial. The results
of this trial led to NQF’s ad hoc review of the measure in 2013. SEP-1 is also currently undergoing
maintenance review of its endorsement status with NQF as part of the Infectious Disease Project
2016-2017. Outside stakeholders, such as the AMA, will have the opportunity to provide input to
NQF during this review process.

CONCLUSION

Many of the specific concerns noted in Resolution 717-A-16 have been resolved in later updates to
the SEP-1 measure specifications and release notes. In addition, Resolution 717-A-16 should not be
adopted on the grounds that the Board of Trustees already acted on this issue in February 2017 by
adopting a substitute resolution in lieu of Resolution 811-I-16 which states:

Our AMA advocate for quality measures, including those in the Hospital Inpatient Quality
Reporting program, to have appropriate exclusions to ensure patient and clinical differences are
accounted for and do not interfere with clinical decision making, and for denominators of
quality measures to be appropriately defined to ensure patients for whom the treatment may not
be appropriate are adjusted for or excluded.

Our AMA advocate for CMS to allow for any proposed quality measures to be reviewed by the
appropriate medical specialty societies prior to adoption.

Our AMA provide input on the Severe Sepsis and Sepsis Shock: Management Bundle measure
during National Quality Forum’s (NQF) review of the measure in 2017, and ask CMS to
redesign the measure.
Resolution 717-A-16 has already been addressed by the Board of Trustees at the direction of the House of Delegates through action on Resolution 811-I-16. Therefore, the Board of Trustees recommends that Resolution 717-A-16 not be adopted.

RECOMMENDATION

The Board of Trustees recommends that resolution 717-A-16 not be adopted and the remainder of this report be filed.

Fiscal Note: Less than $500.
REFERENCES

2 Ibid.
7 Boyd et al 259-265; Kelm et al 68-73; Pulido et al 620-628.
8 CMS Fact Sheet SEP-1: Early Management Bundle, Severe Sepsis/Septic Shock.

EXISTING AMA POLICY

AMA Code of Medical Ethics, Chapter 1, Opinion 1.1.6 – Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

(a) Keeping current with best care practices and maintaining professional competence.
(b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
(c) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.
(d) Demonstrating commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.
(e) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

Policy D-225.977, “Physician Independence and Self-Governance”

Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (Res. 801, I-11; Modified: BOT Rep. 6, I-12)
REPORT OF THE BOARD OF TRUSTEES

Subject: Eliminate the Requirement of H&P Update (Resolution 710-A-16)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee G (J. Clay Hays, MD, Chair)

INTRODUCTION

At the 2016 Annual Meeting of the House of Delegates (HOD), Resolution 710-A-16, “Eliminate the Requirement of H&P Update,” was referred. Resolution 710-A-16, sponsored by the Ohio Delegation, asks our American Medical Association (AMA) to work to change the Centers for Medicare & Medicaid Services’ (CMS) Medicare conditions of participation regulations governing the medical history and physician examination update and documentation requirements (H&P update) prior to surgery or a procedure as follows:

Change regulation 42 C.F.R. section 482.24 (c)(4)(i)(B) to read as follows:

When the medical history and physical examination are completed within thirty days before admission or registration, documentation of an updated examination of the patient must be placed in the patient’s medical record within twenty-four hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, only if any changes have occurred in the patient’s condition.

Change regulation 42 C.F.R. section 482.51(b)(1)(ii) to read as follows:

When the medical history and physical examination are completed within thirty days prior to admission or registration, an updated examination of the patient must be completed and documented within twenty-four hours of admission or registration only if any changes have occurred in the patient’s condition.

The HOD supported referral of Resolution 710-A-16 because testimony was mixed and the topic involved clinical, legal, and regulatory considerations. The sponsoring delegation testified that physicians should not have to document “no change” in the patient’s H&P update on the day of a procedure or surgery. Other testimony emphasized the importance of documenting updates on the date of surgery and potential risks associated with not documenting changes or “no change” in the patient’s condition. One speaker noted that H&P update requirements are not particularly burdensome to physicians. Additional speakers noted the complexity of the issues brought up by Resolution 710-A-16, and that patient needs may differ depending on their health and the procedures they are receiving.
AMA POLICY

The AMA does not have policy that is directly applicable to whether the documentation requirements of the H&P update are appropriate. There is, however, policy that is germane to the issue of medical record authentication in the context of physical examinations, though it provides for a streamlined approach—namely a single signature to authenticate a host of services and procedures provided to a patient. Policy H-225.965, “Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record,” provides:

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.

DISCUSSION

In order to participate in the Medicare program, health care providers, such as hospitals, must comply with statutory and regulatory Conditions of Participation (COPs) requirements. The COPs are established through notice and comment rulemaking and represent Medicare’s minimum health and safety standards. CMS ensures compliance by conducting (or contracting with state health survey agencies to conduct) scheduled or unscheduled investigations (called surveys) to assess compliance. These surveys will include sampling and review of patients records, standard operating procedures, and associated documentation among other survey activities. Alternatively, hospitals may also receive certification to participate in the Medicare program by obtaining accreditation from an accrediting body approved by CMS. Accredited institutions are deemed to meet all of the Medicare COPs, with some exceptions. Currently, CMS-approved accrediting bodies for hospitals include, but are not limited to, The Joint Commission and the American Osteopathic Association.

In 2006, CMS issued as a final rule: The Medicare and Medicaid Programs; Hospital Conditions of Participation: Requirements for History and Physical Examinations; Authentication of Verbal Orders; Securing Medications; and Postanesthesia Evaluations. The final rule incorporated requested changes that reduced compliance burdens on patients and physicians. Among other things, the final rule expanded the timeframe for completion of the pre-operative H&P to 30 days and expanded the number of permissible professional categories of individuals who may perform the history and physical examination. The final rule also required that all orders, including verbal orders, be dated, timed, and authenticated by a practitioner responsible for the care of the patient. The proposed rule would have required the pre-operative H&P to be completed only by a physician credentialed by the medical staff at the admitting hospital. This would have excluded for many patients their primary care provider who may not necessarily be credentialed and privileged at the admitting hospital. CMS struck this requirement and put an alternative requirement in place as outlined below:

If a patient’s H&P is completed before admission to the hospital, an updated examination must be completed and documented in the patient’s medical record within 24 hours after admission, but before a surgical procedure. This update to the H&P would be completed after the patient is admitted to the hospital by a physician, oral-maxillofacial surgeon or other qualified individual who has been granted these privileges by the medical staff in accordance with State law. Therefore, if the H&P was completed by the patient’s primary care provider, the H&P would be reviewed, the patient would be examined, and the H&P would be updated by an individual
who has been credentialed and privileged by the medical staff to conduct an H&P. If upon review, the H&P done before admission is found to be incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P, and conduct and document a new H&P within 24 hours after admission, but before a surgical procedure. The practitioner completing the update is responsible for ensuring that the H&P documented in the medical record is complete and accurate.

While this documentation requirement was established as an alternative to a more onerous proposed Medicare requirement that would have hindered patient access to care, it is possible to forgo this requirement while still ensuring an updated H&P exam is conducted by qualified individuals with privileges. Specifically, an alternative requirement could still mandate such a review is conducted, but establish a legally enforceable conclusion that the H&P remained unchanged when no documentation is submitted to the contrary. Furthermore, the new Trump Administration has expressed strong support for reducing regulatory burdens and the AMA is engaged in efforts to identify a wide range of administrative burdens that do not enhance patient care and that re-direct physician time away from patient clinical care.

CONCLUSION

The H&P update requirement constitutes a compliance burden for physicians when a patient’s health status remains unchanged without a direct clinical benefit. It is reasonable to create a regulatory presumption that the H&P update was performed and remained unchanged if documentation to the contrary is not provided. Qualified individuals with privileges would still have to document when changes have occurred; thereby, safeguarding patient safety and ensuring a basic standard of care is met.

RECOMMENDATION

The Board of Trustee recommends that Resolution 710-A-16 be adopted and the remainder of the report be filed.

Fiscal Note: Less than $500.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-17

Subject: Study of Minimum Competencies and Scope of Medical Scribe Utilization

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee G
(J. Clay Hays, MD, Chair)

INTRODUCTION

At the 2016 Interim Meeting, Policy D-478.976, “Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians,” was amended by the House of Delegates. This report serves as a summary of the medical scribe industry, training requirements, scope of work, utilization in various specialties, and potential benefits and drawbacks of medical scribe utilization in health care.

BACKGROUND

It is widely accepted practice for healthcare professionals in advanced team-based models of care, such as medical assistants, nurses, nurse practitioners or physicians assistants, to assist with visit note documentation while performing clinical tasks commensurate with their level of training. It is also recognized that medical students and residents may document as part of their training. It is important to distinguish these individuals from unlicensed clerical scribes whose only responsibility is documentation. For the purposes of this report, the term “medical scribe” refers only to the unlicensed individuals hired in a medical practice to enter information into electronic health records (EHR) or chart at the direction of a physician or practitioner. Medical scribes work in a variety of practice settings, including hospitals, emergency departments, physician practices, long-term care facilities, ambulatory care centers and others. Medical scribes always work with a practitioner and are not permitted to make independent decisions about patient care or translations during data entry.

With new regulatory requirements comes a growing dependence on EHRs throughout the health care industry. The time expenditure required to maintain compliant records has resulted in increased utilization of medical scribes to assist with this work. Poor usability of EHR systems has led to increases in the amount of time spent completing entries in an EHR, and has significantly affected the amount of clinical face time physicians spend with patients. For every hour of clinical face time with patients, physicians spend nearly an additional two hours doing EHR and desk work. It has been found that access to documentation support, such as that of a medical scribe, can increase the amount of direct face time with patients during a visit. It was estimated in 2014 that 10,000 medical scribes were employed. The American College of Medical Scribe Specialists (ACMSS) estimated there were 20,000 medical scribes in employment in 2016 and projects this will reach 100,000 in 2020. The nation’s largest professional scribe training and management company organization currently (2017) employs over 13,000 medical scribes.
AMA POLICY

Our AMA recognizes the importance of EHR technology and through its policy commits to advocating for research and physician education on EHR adoption, and to design best practices concerning key features to improve the quality, safety, and efficiency of health care (Policy D-478.976, “Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians”). The AMA also acknowledges the important role allied health professionals, such as medical scribes, have in the practice of medicine in today’s health care environment. The AMA endorses a principle on health manpower that recognizes the legal and ethical responsibilities both physicians and allied health professionals have for patient care (Policy H-200.994, “Health Workforce”). It is AMA policy that the services of new health professionals may be made available for patient care within the scope of their authorized practice, and that medical staff bylaws should establish procedures to determine and specify the functions of and services provided by such professionals (Policy H-35.996, “Status and Utilization of New or Expanding Health Professionals in Hospitals”). It is also AMA policy to continue working with state and specialty medical societies to collect, analyze, and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access, quality, and cost (Policy H-35.966, “Protecting Physician Led Health Care”).

MEDICAL SCRIBE TRAINING AND CERTIFICATION REQUIREMENTS

The minimum requirements to enter into a medical scribe training program, whether it is onsite at a hospital or in a private organization, are a high school diploma and basic computer skills. The coursework in a typical training program covers the following minimum competencies:

1. Medical terminology
2. Medical note structure
3. EHR navigation
4. History of present illness

Licensure or certification is not required for medical scribes to find employment, however several organizations have developed certification programs for individuals interested in obtaining the credential. The Medical Scribe Certification & Aptitude Test (MSCAT) is the most widely used certification and is offered by ACMSS. Full recognition of this certification is awarded only after 200 hours of employment experience are completed. Many practices employ medical scribes who are students either preparing for or in medical or nursing school. This can be a great fit for both physician and student, but is not necessarily a long-term solution for an employer since most students will move on after one or a few years. Physicians and practices seeking long-term investment in a medical scribe staff may choose to employ those not seeking a medical or nursing degree.

MEDICAL SCRIBE SCOPE OF WORK

Physician organizations that use or plan to use medical scribes must clearly define responsibilities for the role and document set policies and procedures which can help optimize the use of the medical scribe and minimize risks and challenges. The predominant responsibilities of medical scribes include performing documentation in the EHR, gathering information for the patient’s visit, and assisting with the physician’s delivery of efficient patient care. The Joint Commission states the scope of work and responsibilities of a medical scribe can be to:

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• Document the previously determined physician’s or practitioner’s dictation and/or activities.
• Assist practitioners in navigating the EHR and in locating information such as test results and lab results.
• Support work flow and documentation for medical record coding.
• Accompany the physician or practitioner and record information into the medical record.

One set of established standards, from ScribeMD, states that medical scribes do not act independently of a physician or licensed practitioner, or participate in other tasks associated with patient care such as transporting specimens, answering phones, or assisting patients.

MEDICAL SCRIBE UTILIZATION IN VARIOUS HEALTH CARE SETTINGS

Medical scribe services can be implemented in many practice settings, from solo or small practices to large hospitals or health systems. Medical scribes may be directly employed by the practice or hospital, or contracted through a third party. Use of a medical scribe can be beneficial to a solo or medium-sized practice by helping to bridge volume gaps resulting from increased patient loads and enabling the physicians to focus more on the patient during a visit. In a large hospital system, medical scribes can potentially improve efficiency in workflow and increase revenue, and larger systems are more likely to have the resources available to invest in medical scribe services.

A systematic review of studies identified some of the different ways in which medical scribes can operate within a medical practice depending on a variety of factors. “In some settings medical scribe services may be contractually arranged with an independently operated scribe company, whereas in other settings scribes may be direct employees of the health system or clinic. Likewise, the tasks performed by the scribe can vary from setting to setting. In settings with fully functional EHRs the scribe might actively participate in the clinical encounter, serving as an interface between the EHR and the clinician; for example, the scribe could communicate to the clinician information generated by the EHR such as automatic warnings, prompts, or reminders. In other settings, the scribe’s role could be essentially invisible, where direct interactions with the clinician or patient are kept to a minimum.”

MEDICAL SCRIBE UTILIZATION IN VARIOUS SPECIALTIES

Research on the scope or specific effects of medical scribe use within a variety of specialties is limited. One such review identified five studies, including three that measured medical scribe use in emergency departments, one in a cardiology practice and one in a urology clinic. It was concluded that although the limited evidence suggests the use of medical scribes may improve clinician satisfaction, productivity, time-related efficiencies, revenue, and patient-clinician interactions, more robust study on the subject is needed.

A member survey conducted by the American Society of Cataract and Refractive Surgery demonstrated that 88.4 percent of ophthalmologists have an EHR and of those, 86.6 percent utilized medical scribes in practice. The practices with 5 to 15 physicians on staff were most likely to use scribes, and solo practices were least likely. On average, practices employed 9 medical scribes, and over 84 percent of respondents indicated they were satisfied with their use of medical scribes. Some ophthalmologists remarked that while they are satisfied with their medical scribes, they would prefer not to have to use them, and many indicated they have their technicians scribe during patient visits.
A majority of hematologists polled by the American Society of Hematology reported they do not use medical scribes. Reasons for low utilization among this specialty included cost, doctor or patient discomfort, lack of necessity for younger physicians more agile in the EHR, or employment of voice to text technology. Twenty percent of dermatologists reported in the 2014 Practice Profile Survey that the use of medical scribes increased after the implementation of an EHR in their practice.

Physiatrists and psychiatrists are among specialists who report rare use of medical scribes. Another small study of 40 Federally Qualified Health Centers—practices that typically provide primary care in medically underserved urban and rural communities—indicated that only 7.5 percent of those centers reported using a medical scribe.

More research is available on the broader topic of team documentation, but it primarily includes measures of documentation completed by other members of the health care team such as physician assistants, nurse practitioners and medical assistants, all of whom perform tasks outside the scope of work of a medical scribe. This may be a beneficial view of how other health professionals on the whole have an effect on patient care and other aspects of medical practice, but it does not provide a focused observation of medical scribe utilization.

**REPORTED BENEFITS OF MEDICAL SCRIBE USE**

In a 2015 retrospective comparative study, physicians with medical scribes saw 9.6 percent more patients per hour than physicians without a medical scribe. The increased productivity resulted in over 3,000 additional relative value units (RVUs) and more than $1.2 million in revenue. Another study demonstrated a nearly 60 percent increase in physician productivity (patients per hour) with the use of a medical scribe. With the use of medical scribes, patient visits were on time as scheduled, documentation was mostly or completely finished within the clinic time frame, and physicians were not working after clinic hours to complete documentation.

Physicians who use medical scribes say they “feel liberated from the constant note-taking that modern [EHRs] demand” and they can “think medically instead of clerically.” When face-to-face time with the patient increases, physicians are able to listen and respond more thoroughly without the distraction of entering data into the EHR, giving patients a better experience. Physicians are in turn able to provide the level of care they find the most satisfying.

Improved case mix index and increased revenue have been reported after the introduction of medical scribes into a health care setting. Additionally, inpatient physicians also experience a reduction in the amount of time required to update patient charts (10 minutes on average).

**POTENTIAL DRAWBACKS OF MEDICAL SCRIBE USE**

Medical scribes are not required to complete rigorous or comprehensive training, and although some medical scribes are pre-med students or students seeking other healthcare related careers, most are only high school educated. There is no required certification for medical scribes, and the profession is largely unregulated by state or federal governments.

The scope of work for medical scribes is intentionally limited. The Health Information Technology for Economic and Clinical Health (HITECH) Act, as well as The Joint Commission standards, restrict the types of tasks medical scribes are permitted to perform, prohibiting them from assisting with or performing x-rays, tests or order entry for prescriptions. When compared with other health
care team members who are permitted to assist with more tasks, a medical scribe may fall short of a medical practice’s needs.

Health information management experts list other workflow challenges that may arise with the use of medical scribes:

- Medical scribes in the exam room may cause patients to be less honest or withhold important personal information necessary for treatment.
- Use of a medical scribe will change existing documentation processes and workflows for multiple members of the health care team, necessitating a full-scale review and possible revision of processes.
- Provider verification and authentication of scribed documentation for accuracy may slow down overall workflow.
- An inexperienced medical scribe who does not have medical terminology and clinical workflow knowledge may cause documentation errors leading to liability and other risks.
- Utilizing a medical scribe does not completely eliminate the risk of error or documentation mistakes.

One expert opines that the use of medical scribes may stifle improvements to EHR technology. By providing a workaround to EHRs, thus decreasing reported physician dissatisfaction with EHR technology, pressure on the industry to continue developing improvements may recede, slowing or preventing necessary improvements.

DISCUSSION

The widespread use of medical scribes could impact healthcare delivery on several levels including patient care, patient and physician satisfaction, organizational structure and operations, costs and expenditures (both in private and public sectors), and others. While there are some drawbacks to utilization of medical scribes, according to some experts, they may be favorably outweighed by its benefits.

Given the evidence that physicians are increasingly dissatisfied in practice, burnout is on the rise, health care costs continue to increase, and patients are left to bear the brunt of the other things that demand their doctor’s time, it is clear that relief is needed. Based on the published evidence, team documentation, including the use of medical scribes, is useful for some physicians and medical practices to improve the environment of healthcare delivery as well as patient and physician satisfaction. It is apparent that as usability issues in EHRs persist the use of medical scribes will continue to grow, suggesting that sustained attention to medical scribe use may be of benefit. In addition, continued focus on improving the usability of EHRs will be important to assist physicians with documentation and over the long run may reduce the need for medical scribes.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed:

2. That our AMA monitor the medical scribe industry periodically to identify important trends. (Directive to Take Action.)
3. That our AMA continue to review and promote strategies that help improve physician practice workflow. (Directive to Take Action.)

4. As this report has provided the requested study, that Policy D-478.976, “Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians” be amended by rescission of the fourth paragraph to read as follows:

   1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs.

   2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs—open source and proprietary—to create more transparency and formulate more formal decision making in the selection of EHRs.

   3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.

   4) Our AMA will study medical scribe utilization in various health care settings.

   5) Our AMA will make available the findings of the AmericanEHR Partners’ survey and report back to the House of Delegates. (Directive to Take Action.)

Fiscal note: Within current budget.
REFERENCES

8. Lombardi, R., Medical scribes are coming to Canada, in Technology for Doctors Online. 2014, Canadian Healthcare Technology.
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 (https://www.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 https://www.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 ([https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator](https://www.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](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 SAMSHA’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](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/](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](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/](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 ([http://www.aaap.org/patient-resources/find-a-specialist/](http://www.aaap.org/patient-resources/find-a-specialist/)), as does the American Society of Addiction Medicine (ASAM) ([https://asam.ps.membersuite.com/directory/SearchDirectory_Criteria.aspx](https://asam.ps.membersuite.com/directory/SearchDirectory_Criteria.aspx)). ASAM has conducted payer surveys in the past including research on Medicaid coverage of addiction treatment by state. A review of addiction coverage benefits in Affordable Care Act plans was conducted by the National Center on Addiction and Substance Abuse. 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/](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/](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, 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.
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” (New HOD Policy); and

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” (New HOD Policy).

Fiscal Note: Less than $500

REFERENCES


4 American Medical Association. Letter to Kana Enomoto, Principal Deputy Administration, SAMHSA.

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
browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/a15cms-
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
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.


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-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. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-380.987, which maintains antitrust relief as a top AMA priority. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)


Fiscal Note: Less than $500
REFERENCES

6 Ibid.
REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-17)
Retail Health Clinics
(Resolution 705-A-16)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2016 Annual Meeting, the House of Delegates referred Resolution 705, “Retail Health Clinics,” sponsored by the Washington Delegation. Resolution 705-A-16 asked the American Medical Association (AMA) to 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 asked the AMA to consider the merits of pursuing legislation to ensure appropriate oversight.

In this report, the Council notes that retail health clinics have been playing a steadily increasing role in the health care marketplace since they first opened in 2000. Convenience, accessibility, and clear pricing seem to be the largest drivers of their growth. Nonetheless, the Council acknowledges and agrees with concerns that the retail clinic model may have the effect of fragmenting care delivery by potentially undermining the medical home and the patient-physician relationship. When considering the appropriate role of retail clinics, the Council believes that the patient’s best interest is of paramount concern.

The Council believes that, with the appropriate safeguards and guidelines, retail clinics have a place in the delivery of health care and that they may serve as a complement to, rather than a substitute for, the primary care physician or usual source of care. The Council recommends the adoption of additional safeguards and guidelines to encourage value in retail health clinics consistent with current AMA policy on store-based health clinics.
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. 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.

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. 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.

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.\textsuperscript{10} Retail clinic operators claim that these arrangements help sustain their economic viability.\textsuperscript{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.\textsuperscript{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.\textsuperscript{13} However, retail clinics to date have not been associated with a meaningful reduction in low-acuity ED visits.\textsuperscript{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.\textsuperscript{15} This new utilization is associated with a modest increase in health care spending of $14 per person per year.\textsuperscript{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.\textsuperscript{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. 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. 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.

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. 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.

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.

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. 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.

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. 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-
referrer. 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. 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. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-215.981 regarding the corporate practice of medicine. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-35.985 supporting the physician-led health care team. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-385.926 supporting physicians’ choice of practice and method of earning a living. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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 make provisions for all appropriate follow-up patient care;

   e. Retail health clinics should work with primary care physicians and medical homes to support continuity of care;

   f. Retail health clinics should use local physicians as medical directors or supervisors of retail clinics; and

   g. Retail health clinics should not expand their scope of services beyond minor acute illnesses including but not limited to sore throat, common cold, flu symptoms, cough, and sinus infection. (New HOD Policy)

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. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES

4 Id.
5 supra note 2.
6 Id.
7 Id.
8 Retail Clinics Drive New Health Care Utilization and That is a Good Thing. Health Affairs. Available at http://healthaffairs.org/blog/2016/05/20/retail-clinics-drive-new-health-care-utilization-and-that-is-a-good-thing/
9 supra note 8.
12 supra note 8.
14 Id.
15 Id.
16 Retail Clinic Visits for Low-Acuity Conditions Increase Utilization and Spending. Health Affairs. Available at http://content.healthaffairs.org/content/35/3/449.abstract
17 supra note 11.
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21 supra note 2.
23 supra note 2.
24 supra note 9.
27 Ollove, supra note 3.
28 Id.
EXECUTIVE SUMMARY

At the 2016 Annual Meeting, the House of Delegates adopted Council on Medical Service Report 7-A-16, “Prior Authorization Simplification and Standardization,” which established directives (See Policies D-120.938, D-320.987, and D-320.986) for the American Medical Association (AMA) to support state legislation to restrict use of medical step therapy programs; establish a set of best practices regarding utilization management requirements and advocate with health plans, accreditation organizations, and other relevant stakeholders to adopt these principles; and explore and report on potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures. Additionally, at the AMA 2016 Interim Meeting, the House of Delegates referred Resolution 820-I-16, “Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing.” 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 the AMA to advocate for legislation to require insurers’ medical policies to reflect current evidence-based medically appropriate studies and a streamlined process for exceptions for rare or uncommon disease states, as well as prohibit insurers’ use of medical coding as the sole justification to deny payment for medical services and testing.

In its study of these issues, the Council highlights the AMA’s work with state medical associations and national medical specialty societies to address utilization management issues, including step therapy, with state legislation. As directed by Policy D-320.987, the AMA, in partnership with a coalition of 16 other organizations representing physicians, hospitals, pharmacists, and patients, released the Prior Authorization and Utilization Management Reform Principles (the “Principles”) in early 2017. The Council believes that the early response to the advocacy and outreach campaign associated with the Principles has been promising and notes that the AMA’s research efforts to quantify prior authorization burdens have provided important support to these efforts. In exploring the potential sources of physician payment for the completion of prior authorization, the Council considers a variety of logistical and practical factors related to pursuing this strategy. The Council also recognizes the importance of health plans’ medical policies and coverage criteria being based on sound clinical evidence and examines the need for intensive health plan clinical review of claims.

The Council recommends that the AMA continue its extensive advocacy campaign based on the Principles and complete ongoing research on prior authorization burdens to further support this work. While recognizing the associated administrative hassles and clinical burdens, the Council proposes that the AMA refrain from actively seeking physician compensation for prior authorizations due to logistical and practical challenges, as well as the risk of undermining the collaborative outreach efforts associated with the Principles. The Council also recommends reaffirmation of existing policy regarding coverage for medically necessary treatment and creation of new policy supporting increased review of appeal determinations (beyond medical coding alone) by health plans. Finally, the Council recognizes that the AMA’s work to reduce prior authorization requirements could lead to the unintended and undesired consequence of increased post-payment reviews and therefore suggests reaffirmation of policy addressing concerns related to retrospective payment denials and review.
REPORT OF THE COUNCIL ON MEDICAL SERVICE

Subject: Prior Authorization and Utilization Management Reform (Resolution 820-I-16)

Presented by: Peter S. Lund, MD, Chair

Referred to: Reference Committee G (J. Clay Hays, MD, Chair)

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.

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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 https://www.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 (https://www.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. 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
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. (New HOD Policy)

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. (New HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

5. That our AMA rescind Policies D-120.938, D-320.987, and D-320.986. (Rescind AMA Policy)

Fiscal Note: Less than $500

REFERENCES

The Council on Medical Service initiated this report to provide an overview of challenges facing physicians in the transition to value-based payment models and particularly to Physician-Focused Payment Models (PFPMs). This report follows from Council on Medical Service Report 9-A-16, “Physician-Focused Alternative Payment Models,” which was adopted at the 2016 Annual Meeting of the House of Delegates and created guiding foundational policy to support the appropriate shift to physician-focused Alternative Payment Models (APMs).

While the Council recognizes that APMs have potential to provide higher quality care at lower costs, physicians often face barriers in the current payment system that prevent them from seizing upon new opportunities. Specifically, this report attempts to address some of the barriers in the current payment system that preclude or hamper the ability of physicians to adopt innovative payment models. Shifting the health care payment and delivery system requires not only uprooting and changing current aspects of the system but also additional technical assistance and capabilities to support such a shift. To that end, this report focuses on barriers to the development and implementation of APMs including the limitations of existing health information technology (IT) capabilities, resource use measures, and resource use challenges including risk adjustment, attribution, and performance target setting.

With the completion of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule, now is a critical time for physicians to implement APMs as MACRA begins to take effect. Accordingly, the Council offers a set of recommendations intended to address the barriers that interfere with the shift to value-based payment. The 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 and suggests a set of recommendations to address these issues. Additionally, the Council recommends working with stakeholders to bring about changes to resource use measurement, including risk adjustment, attribution, and performance targets in order to better support improved care delivery and patient outcomes delivered at a lower cost. 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.
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).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). 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.

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. 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. 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. 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. 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. 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.

Attribution

Current retrospective statistical attribution methodologies often fail to accurately assign to physicians the services they delivered. 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.

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
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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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. (Reaffirm HOD Policy)

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). (New HOD Policy)

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. (New HOD Policy)

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. (New HOD Policy)

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. (Directive to Take Action)

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.

(Directive to Take Action)

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. (Directive to Take Action)

Fiscal Note: $5,000
REFERENCES


3 Id.


5 2016 AMA Physician Benchmark Survey.


10 Id.

11 Id.

12 Supra note 4.
Whereas, Third party payers can change pharmacies in their retail pharmacy network. For example, on December 1, 2016 Tricare dropped CVS and added Walgreens to its network of pharmacy providers; and

Whereas, Doctors and patients are responsible for the timely and accurate transfer of these prescriptions to the new in-network retail pharmacy; and

Whereas, With government mandated electronic interfaces between health care providers, this transfer of prescription information should occur seamlessly without the need for direct doctor/patient intervention; therefore be it

RESOLVED, That our American Medical Association advocate that insurers or other third party payers must provide 60 days advance notice of changes in retail pharmacy networks to both patients and all physicians treating these patients (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription to the patient’s pharmacy of choice without the need for the patient/physician to initiate such transfer. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 02/10/17
Whereas, Reviewing of hospital medical records is often complicated by difficulty determining the credentials/specialty of involved or consulted physicians/practitioners; and

Whereas, With the near universal usage of electronic medical records, “e-signatures” could easily add the specialty/credentials of the signing physician/practitioner; therefore be it

RESOLVED, That our American Medical Association work collaboratively with appropriate national and state hospital associations and other appropriate organizations to encourage those entities, when feasible, to provide the treating practitioner’s specialty/credentials to signed progress/consult/operative notes. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/20/17
Whereas, Many patients in the United States who do not speak English (or for whom English is not their first language) seek medical care; and  
Whereas, Many patients may be hearing impaired and unable to communicate with physicians or staff; and  
Whereas, Many physician offices are not equipped to communicate with patients with communication or language barriers; and  
Whereas, Physicians recognize the importance and necessity of providing translation services for their patients; and  
Whereas, It is currently the financial responsibility of the physician to provide translation services as a result of Medicare or Medicaid participation and other insurance organizations; therefore be it  

RESOLVED, That our American Medical Association work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act. (Directive to Take Action)  

Fiscal Note: Modest – between $1,000 - $5,000  

Received: 04/25/17  

RELEVANT AMA POLICY  

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924  
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients’ choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools’ limitations--to aid LEP patients’ involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services’ policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.  
Whereas, H.R. 2 (to amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access) allows Medicare to require prior authorizations for physicians with low adherence to guidelines; and

Whereas, H.R. 2 identifies physicians based on low adherence to applicable guidelines or appropriate use criteria based on two years of data and mandates that no more than five percent of ordering physicians can be subject to prior authorization; and

Whereas, Physicians identify prior authorization as a major administrative burden; and

Whereas, Total administrative burden for all 835,000 physicians who practice in the United States is 868,000,000 hours, or $69 billion annually (Bendix J. The prior authorization predicament. Med Econ. 2014;91(13)29-30,32,34-35); and

Whereas, The AMA convened a workgroup of state and specialty medical societies, national provider associations and patient representatives to create a set of best practices related to prior authorization and other utilization management requirements; and

Whereas, The AMA has model legislation that aims to reduce the administrative burden prior authorizations place on practices and streamline the process to prevent delays in care; and

Whereas, The AMA has advocated extensively with NCVHS to streamline the prior authorization process; therefore be it

RESOLVED, That our American Medical Association Board of Trustees continue proposing improvements to the prior authorization process to make it as efficient as possible and that prior authorization is only used for “outlier” medications, tests or treatments. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/25/17
RELEVANT AMA POLICY

Preauthorization D-320.988
1. Our AMA will conduct a study to quantify the amount of time physicians and their staff spend on nonclinical administrative tasks, to include (a) authorizations and preauthorizations and (b) denial of authorization appeals.
2. There will be a report back to the House of Delegates at the 2015 Annual Meeting
3. Our AMA will utilize its advocacy resources to combat insurance company policies that interfere with appropriate laboratory testing by requiring advance notification or prior authorization of outpatient laboratory services.

Abuse of Preauthorization Procedures H-320.945
Our AMA opposes the abuse of preauthorization by advocating the following positions:
(1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen.
(2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial.

Preauthorization for Payment of Services H-320.961
Our AMA supports legislation and/or regulations that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained.

Reasonable Charge for Preauthorization H-385.948
The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients.

Standardized Preauthorization Forms H-320.944
Our AMA: (1) supports the simplification and standardization of the preauthorization process for physicians and patients; (2) supports the adoption of a standardized paper preauthorization form by health plans for those physicians who choose to submit paper preauthorization forms; (3) will publicize and support the legislatively mandated adoption of HIPAA electronic standard transactions by health plans and encourage adoption of HIPAA electronic standard transactions by physicians; and (4) supports efforts to develop clear and complete requirements for each HIPAA electronic standard transaction.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-17)

Introduced by: Washington

Subject: Regulating Health Plans Medical Advice

Referred to: Reference Committee G
(J. Clay Hays, MD, Chair)

Whereas, Health plans typically provide, operate, and/or contract for telephone medical advice services to its enrollees and subscribers; and

Whereas, Such medical advice may be considered the practice of medicine when it is specific to an individual person’s illness or injury; and

Whereas, The primary purpose of medical advice should be to foster patient autonomy and provide patients with information that enhances their ability to make appropriate health care choices and/or receive medical care with an enhanced sense of confidence about risks, benefits and responsibilities; and

Whereas, Health plans’ primary purpose is to manage patient costs and expenses; and

Whereas, California has effectively regulated medical advice from health plans in its CA Health & Safety Code § 1348.8 (2016); therefore be it

RESOLVED, That our American Medical Association define when medical advice is the practice of medicine (New HOD Policy); and be it further

RESOLVED, That our AMA study options for regulating medical advice given by health plans.

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/25/17
RELEVANT AMA POLICY

Patient Navigation Programs H-373.994
1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:
   a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.
   b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
   c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.
   d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.
   e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.
2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care.
3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers.
Whereas, The issues of “concurrent surgery” (critical portions of more than one procedure happening simultaneously) and “overlapping surgery” (noncritical portions of more than one procedure happening simultaneously) have come to the forefront of public awareness recently; and

Whereas, Many institutions and specialty societies are developing policies determining physician responsibility related to this issue with extensive variability in detail; and

Whereas, The Senate Finance Committee has published a report promising further national governmental involvement in the issues related to concurrent and overlapping surgery with minimal focus on stakeholder involvement; and

Whereas, The Centers for Medicare and Medicaid Services issued interpretive guidelines that explain surgical services, whether performed on an inpatient or outpatient basis, must be provided in accordance with acceptable practice, which includes Federal and state laws, and any standards established by nationally recognized professional associations; and

Whereas, These issues raise complex concerns related to patient safety, physician-patient communication, informed consent, medical training, physician wellness and risk of burnout, access to care, and reimbursement; therefore be it

RESOLVED, That our American Medical Association advocate for physicians to have an opportunity to engage in policy development related to concurrent and overlapping surgery (New HOD Policy); and be it further

RESOLVED, That our AMA recommend that any new policies be based on best available evidence (Directive to Take Action); and be it further

RESOLVED, That our AMA participate in efforts to educate physicians on various issues associated with concurrent and overlapping surgery, such as quality of care, patient safety, and medical liability (Directive to Take Action); and be it further

RESOLVED, That our AMA work with key entities to explore the potential impacts of changing policies regarding concurrent and overlapping surgeries on the future of medical education, physician reimbursement and productivity, physician wellness, and patient access to care. (Directive to Take Action)

Fiscal note: Modest – between $1,000 - $5,000

Received: 04/27/17
References
Whereas, The Centers for Medicare & Medicaid Services (CMS) has developed various models of Accountable Care Organizations (ACO) for optimal Population Health management under the Affordable Care Act (ACA); and

Whereas, CMS has created the ACO Investment Model (AIM) to facilitate new ACOs to form in rural and underserved areas by prepayment of shared savings which alleviates the financial burden of creating new ACOs in such markets; and

Whereas, Long-term care (LTC) and Continuing Care Retirement Centers (CCRC) are ideal candidates for patient centered medical homes (PCMH) and ACOs due to the congregate living arrangement for frail elderly residents and the presence of medical directors and practitioners on site, but they lack the financial wherewithal to successfully create and implement such programs; and

Whereas, Any such financial support from the federal government in the form of advance payment of shared savings is impactful in allowing LTC, CCRC and practitioners in such settings to successfully implement Electronic Health Records (EHR) and Data Analytics programs that are essential for participation in Population Health programs; therefore be it

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services to enable Continuing Care Retirement Centers and long-term care facilities and physicians working in those settings to initiate ACO Investment Models. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/01/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-17)

Introduced by: AMDA-The Society for Post-Acute and Long-Term Care Medicine

Subject: Removing ‘Three Star Minimum’ Requirement for Skilled Nursing Facilities to Participate in Next Gen Accountable Care Organizations & Bundled Payments for Care Improvement Programs and Care for Patients with Waiver of Three Night Hospital Stay Requirement

Referred to: Reference Committee G
(J. Clay Hays, MD, Chair)

Whereas, The Centers for Medicare & Medicaid Services (CMS) is in charge of implementing the national quality strategy that involves developing a number of value-based purchasing (VBP) programs including Next Gen Accountable Care Organizations (ACOs) and the Bundled Payments for Care Improvement (BPCI) programs; and

Whereas, Next Gen ACOs and BPCI conveners will evaluate eligible skilled nursing facilities (SNFs) based on their quality measures, outcomes as well as cost measures for their attributed patients before contracting with them and this represents ‘free market’; and since any savings generated by these programs depend on quality care provision, they are incentivized to choose partners that provide quality care; and

Whereas, CMS has stipulated a minimum of three star rating for SNFs to be eligible to receive patients with waived three night stay requirement; and

Whereas, The five star ratings for SNFs can fluctuate widely based on multiple variables not measured in real time nor always reflective of perceived quality; and this can wreak havoc on VBP programs, practitioners, facilities and patients alike, as facilities could lose their contracts with VBP programs abruptly and patients could be liable for unanticipated costs from nonwaiver of their three night stay requirement--if the SNF star ratings were to drop below three stars; and

Whereas, For many hospitals and patients in rural thinly populated areas, there may not be a choice to utilize a SNF with a waived hospital stay if the three star requirement is mandated; therefore be it

RESOLVED, That our American Medical Association advocate to the Centers for Medicare & Medicaid Services to remove the three star quality requirement for skilled nursing facilities to participate in Next Gen Accountable Care Organizations and the Bundled Payments for Care Improvement programs with waiver of three night hospital stays for patients. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/01/17
Whereas, Physicians are generally resourceful people who cope effectively with a myriad of stressors while continuing to perform effectively in their work; and

Whereas, Because of a high stress load, physicians have always been at risk of succumbing to the effects of stress in various ways, including burning out; and

Whereas, There appears to have been an increase in physician stress, burnout, depression and suicide in recent years; and

Whereas, Much of the increase in physician burnout has coincided with an increase in the administrative and regulatory burden forced upon physicians by insurers and others; and

Whereas, Studies have demonstrated that the administrative and regulatory burden has, in fact, increased the incidence of physician burnout; and

Whereas, Addressing the symptoms of a problem is more effective when the underlying causes are also addressed; and

Whereas, Patient health outcomes, patient satisfaction, physician productivity, physician satisfaction, and practice sustainability have been demonstrated to be significantly reduced by physician stress and burnout; and

Whereas, It is widely believed that optimal physician health crosses over state boundaries and licensing agencies; and

Whereas, The stated goals and vision of our AMA are to redesign and improve medical education, improve health care outcomes, and create an environment of personal and professional satisfaction for our members and all physicians; therefore be it

RESOLVED, That our American Medical Association produce a report summarizing current research and efforts to address physician practice sustainability and satisfaction. (Directive to Take Action)
Whereas, The federal government requires physicians to provide interpreter services for Medicaid patients including sign language and translator services; and

Whereas, This requirements places an untenable burden on physicians to arrange and pay for the costs of interpreter services; and

Whereas, Many state Medicaid programs and managed care plans do not arrange and cover the costs for such services; therefore be it

RESOLVED, That our American Medical Association support 1) access to interpreters for limited English proficient and hearing-impaired Medicaid patients; 2) regulations that require the Medicaid program and Medicaid managed care plans to arrange and pay for the services to relieve the burden on physicians; and 3) regulations that require physicians to be fully paid by the Medicaid program and Medicaid managed care plans for such services. (New HOD Policy)
Whereas, Healthy People 2020 defines social determinants of health (SDOH) as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks”, and identifies economic stability, education, health and health care, neighborhood and built environment, and social and community context as five key areas of SDOH;¹ and

Whereas, The World Health Organization’s Commission on Social Determinants of Health declared the need to “measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health” as a major principle of action;² and

Whereas, Disparities in SDOH, including food and housing insecurity, have been correlated with negative health outcomes, particularly in infants and children;³,⁴,⁵,⁶,⁷ and

Whereas, Validated, standardized SDOH screening tools and resources have been developed, evaluated and implemented into clinical practice across the country by organizations such as the U.S. Department of Agriculture, the U.S. Veterans Administration, Children’s HealthWatch, the National Center for Medical-Legal Partnership, Health Leads, and Oregon Health Authority;⁸,⁹,¹⁰,¹¹,¹²,¹³,¹⁴ and

Whereas, A recent *Journal of the American Medical Association* article concluded that responsible screening for SDOH has “the potential to significantly improve the health and well-being of all patients”, and research has shown that addressing SDOH can lessen healthcare costs and improve health outcomes;₁⁻⁻⁻⁻ and

Whereas, Professional societies such as the American Academy of Pediatrics and American Academy of Family Physicians recommend screening for and identifying SDOH in clinical practice;₁⁻⁻⁻⁻ and

Whereas, The Institute of Medicine reported that “Standardized data collection and measurement are critical to facilitate use and exchange of information on social and behavioral determinants of health” and established twelve specific measures addressing social and behavioral domains of health to be readily incorporated into electronic medical records and electronic health records (EMR/EHR);₂⁻⁻⁻⁻ and

Whereas, Health systems and organizations including Kaiser Permanente Colorado, the Johns Hopkins Children’s Center, and the Veterans Affairs Greater Los Angeles Healthcare System have established models that include SDOH screening via patient or medical team-administered instruments within the EMR/EHR to populate appropriate service referrals to existing system resources;₂⁻⁻⁻⁻ and

Whereas, Centers for Medicare & Medicaid Services initiatives such as the Accountable Health Communities Model and the Health Care Innovation Awards are exploring payment models for SDOH screening/intervention;₂⁻⁻⁻⁻ and

Whereas, The AMA “encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources” (H-160.909) and supports “adoption and use of health information technology for quality improvement” (H-160.919); therefore be it

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RESOLVED, That our American Medical Association provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources (Directive to Take Action); and be it further

RESOLVED, That our AMA support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record (New HOD Policy); and be it further

RESOLVED, That our AMA support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings. (New HOD Policy)

Fiscal Note: not yet determined

Received: 05/03/17

RELEVANT AMA POLICY:

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909 – Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources. Res. 404, A-13

Payment Terminology H-385.922 – It is AMA policy to change the terminology used in compensating physicians from "reimbursement" to "payment." Res. 138, A-07; Reaffirmation A-12

Electronic Health Records and Meaningful Use D-478.971 – Our AMA: (1) will continue to work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to allow for partial credit for eligible professionals in the Meaningful Use and Merit-Based Incentive payment programs; and (2) will compile and continue to educate physicians on the available guidance related to different types of EHRs, system downtime, and technology failures, including mitigation strategies, continuity training solutions, and contracting solutions. BOT Rep. 10, A-16

Redefine “Meaningful Use” of Electronic Health Records D-478.982 – 1. Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation. 2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare &amp; Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria. Res. 222, A-10 Reaffirmation I-10; Reaffirmation A-14; Appended: Res. 210, I-14; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15

Make Simplicity the Foremost Criteria for Any CMS Program H-155.956 – Our American Medical Association will: (1) continue to advocate for simplicity in any current or future programs initiated by the Centers for Medicare and Medicaid Services (CMS) that impact physicians; and (2) continue to advocate by all means necessary that any current or future programs initiated by the Centers for Medicare and Medicaid Services be summarized into an executive summary format or other format that is easily comprehensible to physicians, medical staff and administration in a medical office. Res. 225, A-15

See also:
Principles of the Patient-Centered Medical Home H-160.919
AMA Endorsement of Screening Tests or Standards G-600.064
Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Whereas, “Pay for performance,” is a term defined by payers and physicians first, to optimize self-care by patients and second, to support screening, education, oversight, and continuity of care for patients by physicians such that both physicians and patients “perform” to promote the best clinical outcomes as determined by clinical guidelines; and

Whereas, The practice of primary care medicine is an adult-to-adult relationship or an adult-to-parent relationship, and reviewers and payers must recognize that patients and/or their parents have the freedom to choose from a number of goal-oriented health choices meant to custom design a personalized health care program; and

Whereas, Patients and/or their parents sometimes fail to make the best health care choices, including the possibility that their choice may even lead to self-harm of the patient; and

Whereas, The widespread use of electronic health records allows clearer documentation of both the advice given to patients and the clinical outcomes rather than relying on claims data; and

Whereas, While physicians pledge to do their best for their patients by recommending the best preventative actions and disease treatments, patients may fail to comply or to pursue their physician’s advice even when it is delivered repeatedly in the most thoughtful manner and in a supportive environment; and

Whereas, The “Pay-for-Performance” approach has led to physicians being held responsible for the patient’s and/or parent’s action(s) while obviating the patient’s need for personal responsibility and, thus, has compromised the integrity of the physician-patient relationship; and

Whereas, Performance incentives should be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents; and

Whereas, Such performance incentives earned through delivery and documentation of appropriate advice should be considered equal to performance incentives based on clinical outcomes, (e.g., a physician’s recommendation to obtain a screening colonoscopy would earn a performance incentive whether or not the patient completed the colonoscopy); therefore be it
RESOLVED, That our American Medical Association advocate with payers and other physician performance review organizations a new standard whereby performance incentives would be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents and applicable incentives would be earned through delivery and documentation of appropriate advice that are considered equal to the performance incentive based on a clinical outcome (New HOD Policy); and be it further

RESOLVED, That our AMA work with any organization measuring physicians through incentive or performance programs to adopt standards that do not penalize physicians for the actions of patients who cannot or who will not comply with excellence in clinical recommendations. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/11/17

RELEVANT AMA POLICY

Physician Pay-for-Performance Programs H-140.872
Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients' well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
(c) be aware of evidence-based practice guidelines and the findings upon which they are based;
(d) always provide care that considers patients' individual needs and preferences, even if that care conflicts with applicable practice guidelines;
(e) not participate in PFP programs that incorporate incentives that conflict with physicians' professional values or otherwise compromise physicians' abilities to advocate for the interests of individual patients.


See also: Pay-for-Performance Principles and Guidelines H-450.947
Introduced by: Michigan
Subject: Urge AMA to Release a White Paper on ACOs
Referred to: Reference Committee G
(J. Clay Hays, MD, Chair)

Whereas, Accountable Care Organizations (ACO) have been touted as a remedy for saving health care costs while preserving or improving quality of care and access to care; and
Whereas, There is a need to ensure that studies evaluating ACO metrics, outcomes, and impact on patient experience of care, quality, cost, and clinician experience are conducted in an objective manner and by independent sources; and
Whereas, There is no current consensus on whether ACOs have proven to be successful in meeting quality and cost goals, as well as patient and clinician experience expectations; therefore be it
RESOLVED, That our American Medical Association seek objective, independent data on Accountable Care Organizations and release a whitepaper regarding their effect on cost savings and quality of care. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Studying Physician Access to ACO Participation D-160.930
Our AMA will study: (a) the criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO; (b) the criteria and processes by which physicians can be de-selected once they are members of an ACO; (c) the implications of such criteria and processes for patient access to care outside the ACO; and (d) the effect of evolving system alignments and integration on physician recruitment and retention. The results of this study will be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting.
Res. 736, A-14

Health Care Reform Physician Payment Models D-385.963
1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work
with Congress and the appropriate governmental agencies to change existing laws and regulations (e.g., antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.

2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.

3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.

4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.

5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.

6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.

8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.

9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.

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

See also: Accountable Care Organization Principles H-160.915
Whereas, Patients often struggle with pain for years prior to being referred by their primary care physician to a pain management specialist; and

Whereas, Pain can become its own disease state rather than a symptom of an underlying disorder; and

Whereas, “Conservative” treatment is often required by third-party payers prior to evaluation by a pain management specialist; and

Whereas, “Conservative” treatment often includes expensive and time-consuming modalities such as physical therapy and advanced imaging; and

Whereas, Pain management specialists are the only physicians trained to utilize the full array of pain management modalities and interventions in order to address the full biological, psychological and social impact pain has on a patient; and

Whereas, Pain management specialty care has an opioid-sparing effect that reduces the risk of opioid morbidity and mortality for the patient; and

Whereas, Pain management specialty care may reduce the societal burden of opioids, including risk of harm to those in the community who may gain access to non-prescribed opioids causing further harm beyond the scope of the patient; therefore be it

RESOLVED, That our American Medical Association urge the Centers for Medicare and Medicaid Services and the Medicare Contractor Advisory Committee to endorse and adopt evidence-based clinical practice guidelines on the management and treatment of pain including but not limited to timely and appropriate referral to pain management specialists. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic; and (c) will participate in the International Association for the Study of Pain (IASP) International Pain Summit to be held in Montreal, Canada, on September 3, 2010; and encourages the participation of affiliate pain specialty societies, the American Board of Medical Specialties, the Accreditation Council for Graduate Medical Education, the Association of American Medical Colleges, and other relevant organizations in the IASP Pain Summit.
2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.
4. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.


Pain Control in Long-Term Care H-280.958
Our AMA will work: (1) to promulgate clinical practice guidelines for pain control in long term care settings and support educational efforts and research in pain management in long term care; and (2) to reduce regulatory barriers to adequate pain control at the federal and state levels for long term care patients.


Coverage for Chronic Pain Management H-185.931
1. Our American Medical Association will advocate 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.
2. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
3. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process.

Introduced by: Michigan

Subject: Prescription Availability for Weekend Discharges

Referred to: Reference Committee G
(J. Clay Hays, MD, Chair)

Whereas, Many hospital or nursing home patients may be stabilized on new medications prescribed during their admission; and

Whereas, Certain medications may or may not be covered under the insurance company formulary; and

Whereas, Many patients may be discharged on a weekend or holiday; and

Whereas, Most insurance companies do not have staff available on weekends and holidays to confirm or deny coverage of a medication; and

Whereas, There is no way for a prescribing physician or facility to know if a medication is covered or not without access to the insurance company staff; and

Whereas, Patients discharged on vital new medications may be denied access to these medications and suffer harm because of it; therefore be it

RESOLVED, That our American Medical Association work with pharmacy benefit managers (PBMs), health insurers, and pharmacists at a national level to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient’s health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
RELEVANT AMA POLICY

Expanded Use of the AMA's Principles of a Sound Drug Formulary H-125.985
Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.

Health Plan Coverage of Prescription Drugs D-125.995
In consultation with pharmacy benefit managers (PBMs), public and private sector payers, as well as other appropriate entities, our AMA will continue to pursue the development of model procedures for prescribing non-formulary prescription drugs and promote these procedures to PBMs, public and private sector payers, as well as other appropriate entities.
CMS Rep. 6, A-03 Reaffirmation I-04 Reaffirmation A-08
Introduced by: Michael M. Miller, MD, Delegate

Subject: Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records

Referred to: Reference Committee G
(J. Clay Hays, Jr., MD, Chair)

1. Whereas, The health care industry, among other sectors of the economy (e.g., compared to banking, media and journalism, engineering, and legal services) has been one of the later adopters of the transformation from paper documentation to electronic data entry, storage, and retrieval; and

2. Whereas, Electronic health records provide major advances over paper records with respect to legibility, portability, and the ability to audit and mine data for quality analysis; and

3. Whereas, The electronic health record (EHR) industry has itself become a huge sector of the economy and expenditures on EHRs are among the most massive consumers of capital investment in the health care industry; and

4. Whereas, The transformation to the use of EHRs has proven stressful for physicians and other health professionals, has been documented to be a major contributor to physician practice dissatisfaction and physician burnout, and has changed how physicians spend their time each and every practice day; and

5. Whereas, Physicians are intensely trained and highly educated and skilled members of the health care team, and their years of undergraduate and graduate medical education can be put to optimum use on behalf of patients when physicians spend time with patients, collect data from the history and physical and from diagnostic tests, and engage in medical decision-making in the service of well-designed and well-implemented treatment plans on behalf of patients; and

6. Whereas, The last decade has seen a transformation in the workdays of physicians, such that they are spending less time with patients, more time with computer keyboards and monitors, less time with medical decision-making, and more time with basic data entry tasks, contributing to diminished satisfaction with their professional roles and even an acceleration of physician retirement rates, adversely impacting the physician workforce; and

7. Whereas, If an industrial engineer were to arrive in the United States during this decade and examine the U.S. health care delivery system from a high-altitude perspective, what would be found is a system in which the most highly trained and skilled members of the delivery system and the most highly compensated clinicians in the delivery system – physicians – were devoting a disproportionate amount of their time performing data entry tasks, and that significant amounts of work had shifted from clerical staff such as unit clerks, medical transcriptionists, and billers, to physicians; and
Whereas, Using physicians to do data entry tasks, and compensating them at physician salary rates to do such tasks, is remarkably inefficient and leads to a massive misallocation of financial resources in the industry responsible for the health status of all workers in the economy and all citizens, an industry that contributes to 1/6 of the gross domestic product of the world’s largest economy; and

Whereas, It is not just that the daytime hours of physicians are compensated by health systems for physicians doing tasks that much lower paid members of the health care team could, and arguably should, complete, but the “after-hours” time of physicians that should be devoted to personal, family, recreational, and restorative pursuits is spent completing the voluminous non-direct-patient-care clerical-type tasks of clinical data entry and charge entry that the physician “didn’t get around to completing” in the daytime, and these hours are completed uncompensated; and

Whereas, Every stakeholder in the health care system would benefit if financial resources and physician time were not allocated to having physicians do tasks related to the EHR that would more efficiently be performed by others on the health care team; and

Whereas, Our AMA has devoted significant resources to studying and improving physician professional satisfaction and practice sustainability, and has documented the contribution of the EHR to these areas, and the American College of Physicians has recently published a Position Paper addressing imbalances within physician work each day wherein administrative tasks have taken on too large of a position; therefore be it

RESOLVED, That our American Medical Association work with leaders of the health care delivery system (clinics, hospitals and health systems) and federal governmental leaders at the highest level to use industrial engineering and quality improvement principles and practices to examine the imbalances that have evolved in the time allocation of physician work in order to propose systematic reforms that will reduce the amount of a physician’s time in data entry tasks and allow physicians to maximize the time available in their daily work to interact directly with patients and families and maximize the time available for them to design and implement treatment plans within health care teams and to be able to do what they are uniquely trained to do: make appropriate evidence-based medical decisions on behalf of patients. (Directive to Take Action)

Fiscal Note: Not yet determined

References:
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-17)

Introduced by: Texas

Subject: Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit

Referred to: Reference Committee G
(J. Clay Hays, MD, Chair)

1 Whereas, A longstanding and widespread practice exists for a physician to retain a substitute physician (locum tenens) to take over his or her professional practice when the regular physician is absent for reasons such as illness, pregnancy, family emergency, or vacation, and for the regular physician to bill and receive payment for the locum tenens’ services as though the regular physician performed them; and

2 Whereas, The regular physician generally pays the locum tenens a fixed amount per diem, as allowed by the Social Security Act Amendments of 1994; and

3 Whereas, The Centers for Medicare & Medicaid Services (CMS) allows regular physicians to bill for locum tenens services for up to 60 consecutive days during the absence of the regular physician; and

4 Whereas, Circumstances can occur, such as serious illness, physical impairment, or family emergency, that could require regular physicians to be out of the office for more than 60 consecutive days; and

5 Whereas, Those regular physicians should be able to apply for an exception to allow them to continue billing for locum tenens services beyond the 60-day limit; and

6 Whereas, CMS has made exceptions before as documented in Section 116 of the “Medicare, Medicaid, and SCHIP Extension Act of 2007” (MMSE), enacted on Dec. 29, 2007, which provided for an exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces for services furnished Jan. 1, 2008, through June 30, 2008, and in Section 137 of the “Medicare Improvements for Patients and Providers Act of 2008”, enacted on July 15, 2008, which made this exception permanent; therefore be it

7 RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services (CMS) create an exception process to the 60-day locum tenens limit for those physicians with unforeseen circumstances, such as serious illness, physical impairment, or family emergency (Directive to Take Action); and be it further

8 RESOLVED, That our AMA ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000
Received: 05/11/17