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Subject: Physician Burnout and Wellness Challenges, Physician and Physician Assistant Safety Net, Identification and Reduction of Physician Demoralization (Resolution 601-I-17; Resolution 604-I-17; Resolution 605-I-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, three resolutions (601-I-17, “Physician Burnout and Wellness Challenges,” 604-I-17, “Physician and Physician Assistant Safety Net,” and 605-I-17, “Identification and Reduction of Physician Demoralization”) with shared components of a central issue were referred for report back together at the 2018 Annual Meeting. This report addresses the overarching topic and each resolution as it relates to the issue, and presents recommendations accordingly.

Resolution 601-I-17, “Physician Burnout and Wellness Challenges,” was introduced by the International Medical Graduates Section and the American Association of Physicians of Indian Origin. Resolution 601-I-17 asks the American Medical Association (AMA) to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness.

Resolution 604-I-17, “Physician and Physician Assistant Safety Net,” was introduced by the Oregon Medical Association and asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Such safety net services would be provided by doctorate level mental health clinicians experienced in treating physicians. Resolution 604-I-17 also directs the AMA to advocate that funding for such safety net programs be sought from such entities as foundations, hospital systems, medical clinics, and donations from physicians and physician assistants.

Resolution 605-I-17, “Identification and Reduction of Physician Demoralization,” was introduced by the Organized Medical Staff Section and asks that the AMA: (1) recognize that physician demoralization, defined as a consequence of externally imposed occupational stresses, including but not limited to electronic health record (EHR)-related and administrative burdens imposed by health systems or by regulatory agencies, is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness.
BACKGROUND

Today’s physicians are experiencing burnout at increasing rates, expressing feelings of professional demoralization, professionally under-valued and overburdened by an ever-changing health care system. Over 54 percent of practicing physicians report experiencing at least one symptom of burnout, a near 10 percent increase in three years. Practicing physicians are not alone in reported symptoms of burnout; resident and medical student burnout is also on the rise. It is recognized that with growing numbers of physicians, residents and medical students experiencing burnout, health care costs will continue to rise and patient safety will suffer. Stress, depression and burnout can lead to suicidal ideation and sometimes suicide. While no resolute number has been verified, it is estimated and often cited that 300 to 400 physicians per year die by suicide, and physician suicide rates are historically higher than the general population. Resources such as safety nets and hotlines exist for individuals experiencing suicidal ideation and are available from a number of national and reputable sources.

AMA POLICY

Our AMA recognizes the importance of addressing and supporting physician satisfaction as well as the impact physician burnout may have on patient safety, health outcomes and overall costs of health care. This commitment to physician satisfaction and well-being is evidenced by AMA’s ongoing development of targeted policies and tools to help physicians, residents and medical students, and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars.

The AMA supports programs to assist physicians in early identification and management of stress. The programs supported by the AMA concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, as well as when to seek professional assistance for stress-related difficulties (Policy H-405.957, “Programs on Managing Physician Stress and Burnout”). AMA policy and the Code of Ethics acknowledge that when physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided (Code of Ethics 9.3.1, “Physician Health & Wellness”). Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (Policy H-405.961, “Physician Health Programs”). Educating physicians about physician health programs is greatly important to the AMA. The AMA will continue to work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members about the availability of and services provided by state physician health programs to ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. Our AMA will continue to collaborate with other relevant organizations on activities that address physician health and wellness. Our AMA, in collaboration with the FSPHP, develops state legislative guidelines to address the design and implementation of physician health programs, as well as messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training (Policy D-405.990, “Educating Physicians About Physician Health Programs”).

The AMA recognizes physical or mental health conditions that interfere with a physician’s ability to engage safely in professional activities can put patients at risk, compromise professional relationships and undermine trust in medicine. While protecting patients’ well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care (Code of Ethics 9.3.2, “Physician Responsibilities to Impaired Colleagues”).
AMA policy defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities. The AMA in the same policy encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians and to develop case finding mechanisms for all types of physicians (Policy H-95.955, “Physician Impairment”). Access to confidential health services for medical students and physicians is encouraged by the AMA to provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services. Our AMA will continue to urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, only focus on current impairment by mental illness or addiction, and to accept “safe haven” non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (a) be available to all medical students on an opt-out basis; (b) ensure anonymity, confidentiality, and protection from administrative action; (c) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (d) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and, (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education (Policy H-295.858, “Access to Confidential Health Services for Medical Students and Physicians”).

The AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem not only with practicing physicians, but among residents, fellows, and medical students. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets. In addition, our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students. The AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community. Finally, our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements (Policy D-310.968, “Physician and Medical Student Burnout”).

DISCUSSION

Our AMA is committed to upholding the tenets of the Quadruple Aim: Better Patient Experience, Better Population Health, Lower Overall Costs of Health Care, and Improved Professional
Satisfaction. This is evidenced by AMA policy supporting the “Triple Aim” and requesting that it be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers (Policy H-405.955, “Support for the Quadruple Aim”). In order to achieve the fourth aim, the AMA acknowledges that interventions at both system and individual levels are necessary for enhancing physician satisfaction and reducing burnout. The work carried out through the AMA’s Professional Satisfaction and Practice Sustainability strategic focus area is dedicated to this objective.

Resolution 601-I-17 asks the AMA to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. The AMA has been actively and directly engaged with health care organizations, including state and county medical societies, to build awareness and support for addressing physician burnout. The AMA partnered with the RAND Corporation in 2013 to identify and study the factors that influence physician professional satisfaction, as well as understand the implications of these factors for patient care, health systems, and health policy. This seminal work informed subsequent initiatives and a long-term strategy for AMA’s Professional Satisfaction and Practice Sustainability unit. Key accomplishments and offerings have been realized through launching the free, online, STEPS Forward™ practice transformation platform. This online resource offers over 50 modules of content developed by subject matter experts and is specifically designed for physicians, practices, and health systems. The STEPS Forward platform has been openly shared with leadership of many state and specialty societies, as well as presented to their membership in various forums. In addition, the AMA has partnered with health systems, large practices, state medical societies, state hospital associations and graduate medical education programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment. The assessment offers organizations a validated instrument that provides an organizational score for burnout, along with two subscale measures for “Supportive Work Environment” and “Work Pace and EMR Frustration.” In addition to the organizational dashboard, the assessment is able to provide a comprehensive data analysis complete with medical specialty and clinic level benchmarking. The trends and findings from the assessment are shared and targeted interventions are recommended to the surveying organization. The interventions and suggested solutions are curated from existing STEPS Forward content and through specific best practices identified through AMA collaborators.

Resolution 604-I-17 asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Testimony heard in the reference committee hearing further clarified the request for a task force to research, collect, publish and administer a repository of information about programs and strategies that optimize physician wellness. The AMA, through its ongoing work in the Professional Satisfaction and Practice Sustainability strategy unit, acknowledges the importance of addressing and supporting physician mental health and has developed and published resources to help physicians manage stress and prevent and reduce burnout. The AMA supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, and when to seek professional assistance for stress-related difficulties.

In addition, our AMA will review relevant modules of the STEPS Forward program and also identify validated student-focused, high-quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these
resources to medical students. The STEPS Forward platform currently provides relevant modules
to address physician well-being, specifically the modules “Preventing Physician Distress and
Suicide,” “Improving Physician Resiliency” and “Physician Wellness: Preventing Resident and
Fellow Burnout.” In conjunction with STEPS Forward modules, the Mini-Z Burnout Assessments
provide participating organizations the option to embed the PHQ-2 Depression Screening Tool.
This allows organizations to gain a deeper understanding of those physicians experiencing more
severe levels of depression and disinterest and correlate those responses to burnout. The survey
also offers a free text section for physicians in need of services to self-identify and receive direct
outreach and support. Additionally, the Mini-Z tool provides information on the National Suicide
Prevention Lifeline for organizations to utilize in their physician wellness and burnout efforts.

It is demonstrated through current efforts and strategic priorities that the AMA recognizes the
importance of assessment and attention to depression in physicians, residents and medical students,
as well as the relationship that depression can have with suicidal ideation. Current AMA research
and strategic initiatives are focused on enhancing workflows within the system and clinical setting
with the intent to scale efficiency and reduce feelings of burnout amongst physicians. The AMA’s
role in sharing burnout and depression screening data is to assist physician employers in
understanding individual physician burnout and connecting physicians with employee assistance
resources. Considering the AMA’s current efforts and ongoing commitment to providing resources
on the topics of burnout, distress and suicide prevention, stress reduction, and wellness, convening
an exclusive task force separate from the AMA staff already dedicated to this work would be
duplicative. While an online search indicates there is no current, easily identifiable suicide
prevention line exclusively for physicians or health care workers, there are hotlines available that
are open to all individuals regardless of profession. Studying these hotlines as described in the
resolution would be resource intensive and the results of such study may not prove applicable to
the AMA’s primary audiences; however, making existing relevant AMA resources available to
physicians seeking help can be accomplished, and is part of current AMA practices. The AMA will
continue to direct physicians to our current resources to learn about strategies, programs and tools
related to this topic, and will further explore options for providing more direct assistance for
physicians in need.

Resolution 605-I-17 asks the AMA to (1) recognize that physician demorlization is a problem
among medical staffs; (2) advocate that hospitals be required by accrediting organizations to
confidentially survey physicians to identify factors that may lead to physician demorlization; and
(3) develop guidance to help hospitals and medical staffs implement organizational strategies that
will help reduce the sources of physician demorlization and promote overall medical staff
wellness. Testimony in the reference committee hearing recognized that “burnout” is a commonly
used term favored by many physicians, and while there is some preference for the use of another
term instead of “burnout,” there was no consensus on what that term should be. Our AMA
recognizes that burnout is characterized by emotional exhaustion, depersonalization, and a reduced
sense of personal accomplishment or effectiveness. These feelings can manifest as a result from a
multitude of driving factors, such as administrative burden, excessive EHR documentation and
systemic cultural deficiencies leading to demorlization of physicians. The term “burnout” is often
used to encompass the multiple driving factors of physician dissatisfaction as well as the resultant
feelings and behaviors associated with being overworked, excessively scrutinized and
overburdened with unnecessary tasks. As the term “burnout” is used broadly, this allows for many
variations in the interpretation of its meaning. Our AMA does not define the term “burnout” as an
individual “resilience deficiency” or character flaw. Our AMA supports and voices a position that
burnout is derived from system and environmental issues, not from the individual physician. This
position is evidenced by AMA resources and services targeted at system-level approaches to
intervention.
In addition, the AMA will continue to advocate for organizations to confidentially survey physicians to understand local levels of burnout and opportunities for strategic improvement. It should be noted that the AMA’s Mini-Z Burnout Assessment is deployed confidentially and takes protective safeguards very seriously to ensure accurate and safe reporting of results. Through leveraging ongoing AMA media channels, hosting educational webinars, live speaking engagements, and the Transforming Clinical Practices Initiative (TCPI) grant through the Centers for Medicare and Medicaid Services (CMS), the AMA is striving to scale awareness and intervention to advance physician satisfaction and help address the burnout epidemic.

CONCLUSION

The AMA is committed to enhancing joy in practice for physicians, residents and medical students. Our AMA will continue its focus on research, advocacy and activation to address the issues presented in each of the resolutions discussed herein. The AMA will continue to work diligently to address the issues through our existing work, partnerships, resource development and policies. We present the following recommendation to not only emphasize the work already being done, but also to further address the issues brought forth in these three resolutions.

RECOMMENDATION

The AMA Board of Trustees recommends that the following recommendations be adopted in lieu of Resolutions 601-I-17, 604-I-17 and 605-I-17, and that the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
   a. H-405.957, “Programs on Managing Physician Stress and Burnout;”
   b. H-405.961, “Physician Health Programs;”
   c. D-405.990, “Educating Physicians About Physician Health Programs;”
   d. H-95.955, “Physician Impairment;” and
   e. H-295.858, “Access to Confidential Health Services for Medical Students and Physicians.”

2. That our AMA amend existing Policy D-310.968, “Physician and Medical Student Burnout,” to add the following directives (Modify Current HOD Policy):

   1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.

   2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

   3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.

   4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage hospitals to confidentially survey physicians to identify factors that may lead to physician demoralization.

8. Our AMA will continue to develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (2) develop and promote mechanisms by which organizations and physicians can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being at the system level.

Fiscal note: Minimal – less than $1,000
REFERENCES


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

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Board of Trustees (BOT) Report 18-A-17, "Eliminate the Requirement of H&P Update," was referred for report back at the 2018 Annual Meeting. BOT Report 18-A-17 concerned Resolution 710-A-16, “Eliminate the Requirement of H&P Update,” which was referred during the 2016 Annual Meeting. Resolution 710-A-16, sponsored by Ohio Delegation, asked our American Medical Association (AMA) to work to change the Centers for Medicare & Medicaid Services’ (CMS) Medicare Conditions of Participation (COP) 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.

At the 2016 Annual Meeting, 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.

BOT Report 18-A-17 recommended that Resolution 710-A-16 be adopted and noted that:
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.

At the 2017 Annual Meeting, the HOD supported referral of BOT Report 18-A-17 because testimony was mixed—but mostly negative. While there was some support for the report’s recommendations, a preponderance of the testimony expressed concerns about adopting Resolution 710-A-16. Testimony emphasized the importance of documenting the H&P updates on the day of a procedure or surgery and the potential risks associated with not documenting these encounters. A speaker noted that failing to document the H&P update would be a violation of conventional risk management practices. Others questioned whether the documentation is in fact an H&P update. The importance of pre-operative visits was also emphasized, and it was noted that patients can change their minds about surgeries at the last minute. Because a preponderance of the testimony was in opposition to the report’s recommendation, the Reference Committee believed clarification was needed and recommended that it be referred for decision at the 2018 Annual Meeting.

AMA POLICY

The AMA does not have policy that is directly applicable to whether the documentation requirements of the H&P update are appropriate or not. 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,” reads:

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

Although H&P update requirements constitute a small administrative burden for physicians when a patient’s health status remains unchanged, it is good medical practice and risk management. Also, the current regulatory requirement was issued as an alternative to a more onerous proposed Medicare requirement that would have hindered patient access to care. (See discussion below.) Furthermore, if there is a poor patient outcome, the H&P update provides compelling evidence that an H&P update (even if there is no change in status) was performed and demonstrates compliance with Medicare COP during an investigation.

In order to participate in the Medicare program, health care providers, such as hospitals, must comply with statutory and regulatory COP requirements. The COP 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 patient records, standard operating procedures, and associated documentation among other survey activities. Alternatively, hospitals may 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 COP, with some
exceptions. Currently, CMS-approved accrediting bodies for hospitals include, but are not limited

In 2006, CMS issued a final rule, titled: 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. For many patients, this
would have excluded their primary care provider, who may not 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, oromaxillofacial 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.

CONCLUSION

The H&P update documentation requirements are utilized to ensure that the physician performing
the procedure or surgery attests that the H&P was performed properly, is accurate and up-to-date,
and that the patient is deemed to be safe for the planned surgery or procedure. Seeking to reverse
this regulatory concession would invite a return to the original proposed rule that the pre-operative
H&P must be performed by a physician credentialed and privileged in the admitting hospital. In
addition, physicians would no longer have the legal benefit that extends to physicians who are able
to demonstrate through documentation that they complied with Medicare COP and accepted
standards of care.

RECOMMENDATION

The Board of Trustees recommends that Resolution 710-A-16 not be adopted and the remainder of
the report be filed.

Fiscal Note: None.
INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates, Resolution 711-A-17, “Expanding Access to Screening Tools for Social Determinants of Health,” was referred for report back. Resolution 711-A-17, which was introduced by the Medical Student Section, asks that the “AMA provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.” At the 2017 Interim Meeting of the House of Delegates, Resolution 816, “Social Determinants in Health in Payment Models,” was referred. Resolution 816-I-17, which was introduced by the American College of Preventive Medicine, asks that the “AMA support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems.”

Resolution 711-A-17 was referred for report back at the 2018 Annual Meeting and Resolution 816-I-17 was referred for report back at the 2018 Interim Meeting. As the referred resolves in each resolution deal with components of a common issue, this report will address the topic as a whole, and present recommendations accordingly.

BACKGROUND

Defining Social Determinants of Health

The World Health Organization defines social determinants of health (SDH) as “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” There is a national emphasis in the United States on addressing the SDH by creating “social and physical environments that promote good health for all.” There are five key areas of SDH: economic stability; education; social and community context; health and health care; and neighborhood and built environment. Within each of these areas, there are key issues that contribute to the underlying factors of SDH. For example, economic stability examines the impact of employment, food insecurity, housing instability and poverty on a patient’s ability to access health care and adhere to treatment.
Recognition of the role SDH play in influencing health outcomes is growing in the health care field, and many physicians are developing strategies to effectively address these conditions which impact every patient. Care models are currently being refined to include selection and implementation of SDH assessment tools; collection of patient-level information related to SDH; creation of workflows to track and address patient needs; and identification of community-based social service resources and tracking referrals.

Evidence-based Screening Tools for Evaluating and Assessing Social Determinants of Health

There presently are several tools available for screening of risks or issues related to SDH. Most tools, including those described here, are free to use. The Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE) Implementation and Action Toolkit, sponsored by the National Association of Community Health Centers, was designed to create and implement a national standardized patient risk assessment protocol to assess and address patients’ SDH as well as tools to respond to SDH data. The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. The full question set can be administered in nine minutes or less. A recent study in the Journal of the American Board of Family Medicine found that standardizing SDH data collection and presentation in electronic health records (EHRs) could lead to improved patient and population health outcomes in community health centers and other care settings. As of July 26, 2016, the National Association for Community Health Centers reported that only 4 EHR vendors (EPIC, NEXT GEN, eClinical Works, and GE Centricity) currently support the PRAPARE electronic templates.

Another tool, the Patient Centered Assessment Method (PCAM), assesses a patient’s lifestyle behaviors, mental well-being, social environment, health literacy, and communication and care coordination needs. This resource contains a section focused on actions that can be taken to address the needs and issues identified in the assessment as well as the level of service coordination needed to ensure referrals can be practically accessed by the patient. A 2015 study found that while PCAM did not impact patient satisfaction or perception of practitioners’ empathy, it did increase both the number of onward referrals per referred patient and the proportion of referrals to non-medical services addressing psychological, social, and lifestyle needs.

The American Academy of Family Physicians (AAFP) released an initial screening toolkit for SDH in 2018 to help physicians recognize and respond to various social factors that affect their patients’ health. The toolkit includes both a short and long screening tool that includes questions that have been tested, validated, and purposefully assembled to reveal the health hurdles that patients are facing and a sample patient action plan for staff to indicate what types of referrals are needed for patients. As of the time of this report, there are no studies available on the effectiveness of this toolkit. The aforementioned resources indicate there are evidence-based tools to screen for SDH which are accessible and free for physicians to use.

OCHIN, a nonprofit health information and innovation network, integrated SDH screening tools into leading electronic health records (and released an evidence-based set of SDH domain areas for inclusion in EHRs, which was piloted among EPIC users). The integration of the SDH screening tools into the EHR among EPIC user has the potential to reach 25.8 percent of the U.S. physician practice market share. The SDH flowsheet developed by OCHIN provides several means for easily entering patient-reported SDH information that is not already collected in other places in the EHR, such as demographics or social history. Additionally, the data collection tools were designed to be flexible so that anyone on the care team could enter data.
In addition, in 2017 our AMA in collaboration with Lucro launched a platform that streamlines the ability for physicians and health systems to find a number of tools/solutions available on the market, including screening tools for SDH. The platform allows physicians to request information on the clinical validation for a tool, how the tool fits into a workflow/integrates with an EHR, etc., and compares tools to other options available. The Lucro platform is available at app.lucro.com. Also, AMA is currently developing a STEPS Forward™ module to address SDH which will provide physicians with tools, curriculum, and templates to assist in measuring and addressing SDH. The module will also provide strategies for intervention and resources to assist in the understanding of SDH and implementation of tools in practice. Our AMA expects to release this new module in May 2018.

Incentives for Use of Evidence-Based Social Determinants of Health Screening Tools and Interventions in Clinical Settings

Public payers, such as Medicaid and Medicare, may provide financial incentives to encourage providers to address the social needs of their patients as well as the social conditions in the communities in which they serve. For example, Medicare’s Comprehensive Primary Care Plus (CPC+) model, which is a multi-payer, patient-centered primary care medical home, requires participating clinicians to risk-stratify patients based on health-related social needs and other factors. CPC+ provides extra payments to participating practices to cover non-face-to-face services and allows practices to provide intensive care management and other supportive services to patients with complex needs. According to the 2016 Kaiser Family Foundation 50-state Medicaid budget survey, states are using managed care and alternative payment models to improve quality and to help screen for social factors impacting health outcomes. In Fiscal Year 2016, 26 states reported requiring or encouraging managed care organizations to screen for social needs and provide referrals to services, and four states intended to do so in FY 2017.8

AMA POLICY

AMA Policy H-160.909, “Poverty Screening as a Clinical Tool for Improving Health Outcomes,” encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

Policy H-160.919, “Principles of the Patient-Centered Medical Home,” outlines the principles of the patient-centered medical home (PCMH), one which states that care is to be coordinated and/or integrated across all elements of the complex health care system and the patient’s community. This policy further calls for care that is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The policy asserts that the payment structure should appropriately recognize the added value of the PCMH and pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources, and recognize case mix differences in the patient population being treated within the practice.

Policy D-478.995, “National Health Information Technology,” directs AMA advocacy in the health IT arena, and specifically calls for continued research and physician education on EHR design and features that can improve health care quality, safety and efficiency.

Policy H-295.874, “Educating Medical Students in the Social Determinants of Health and Cultural Competence,” states that our AMA: (1) Supports efforts designed to integrate training in SDH and cultural competence across the undergraduate medical school curriculum to assure that graduating
medical students are well prepared to provide their patients safe, high quality and patient-centered care; (2) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of SDH and cultural competence in the undergraduate medical school curriculum; and (3) Recommends studying the integration of SDH and cultural competence training in graduate and continuing medical education and publicizing successful models.

DISCUSSION

Screening for SDH does not need to be administered by a physician and it can be performed upon check in, or while rooming the patient, so that it does not disrupt the flow of the visit while promoting more comprehensive care. Screenings are most frequently conducted by the other members of the care team such as the registration staff, medical assistants, and care coordinators. Having knowledge about a patient’s SDH may help physicians understand barriers patients face in adhering to recommended treatments. For example, if a patient screens food insecure, they may not be able to fill prescriptions or take medication as recommended. Knowing such information in advance, may help physicians engage in collaborative discussions with their patients regarding treatment options that make sense for the patient.

Key principles for expanding access to screening tools for SDH are reflected in existing AMA policy. Several tools for screening are publicly available for physician and care team use and have been incorporated into some EHR products. Furthermore, our AMA is developing a related STEPS Forward module to increase physician awareness and understanding of SDH. Also, national initiatives exist to incentivize providers for screening for SDH. Based on these factors, the Board of Trustees believes existing policy and actions regarding access of screening tool are sufficient. However, AMA Policy D-478.995, “National Health Information Technology,” could be amended by addition to urge EHR vendors to adopt SDH templates without adding further cost for physicians.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolutions 711-A-17 and 816-I-17 and the remainder of the report be filed.

1. That the following policies be reaffirmed:
   - H-160.909, “Poverty Screening as a Clinical Tool for Improving Health Outcomes”
   - H-160.919, “Principles of the Patient-Centered Medical Home”
   - H-295.874, “Educating Medical Students in the Social Determinants of Health and Cultural Competence”

2. That Policy D-478.995, “National Health Information Technology,” be amended by addition to read as follows:
   1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
   2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health
systems work toward standardized login procedures and parameters to reduce user login
fatigue; and (C) advocates for continued research and physician education on EHR and CPOE
user interface design specifically concerning key design principles and features that can
improve the quality, safety, and efficiency of health care.; and (D) advocates for more research
on EHR, CPOE and clinical decision support systems and vendor accountability for the
efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an
external, independent evaluation of the effect of Electronic Medical Record (EMR)
implementation on patient safety and on the productivity and financial solvency of hospitals
and physicians' practices; and (B) develop minimum standards to be applied to outcome-based
initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize
standard and interoperable software technology components to enable cost efficient use of
electronic health records across all health care delivery systems including institutional and
community based settings of care delivery; and (B) work with CMS to incentivize hospitals
and health systems to achieve interconnectivity and interoperability of electronic health records
systems with independent physician practices to enable the efficient and cost effective use and
sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record
(EHR) data portability as part of the Office of the National Coordinator for Health Information
Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance
transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in
EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation
requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt SDH templates without adding further cost for
physicians.

Fiscal Note: Less than $250
REFERENCES
At the 2017 Annual Meeting, the House of Delegates referred Resolution 705, “Regulating Health Plans Medical Advice,” which was introduced by the Washington Delegation. The Board of Trustees assigned this resolution to the Council on Medical Service for a report back to the House of Delegates. Resolution 705-A-17 asked:

That our American Medical Association (AMA) define when medical advice is the practice of medicine, and study options for regulating medical advice given by health plans.

This report provides background on medical advice services provided by health plans, discusses California’s regulation of telephone medical advice services, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Health plans have been offering medical advice services (eg, “nurse lines,” “ask a nurse,” or “telephone triage”) since at least the 1980s, when managed care organizations began using health professionals (predominantly nurses) to manage demand and also prevent unnecessary physician office and emergency department visits. Although Resolution 705-A-17 pertains to medical advice services provided by health plans, some hospitals and large physician practices also operate telephone and/or online medical advice services. The “advice” is usually provided by nurses using detailed screening protocols to answer questions, provide basic health information, or determine when enrollees should be urged to go to a hospital emergency department or make an appointment with a physician. Although these services may be provided directly by a health plan or care provider, most large health plans contract with vendors to operate their medical advice services.

Many health plans advertise medical advice services as a no-cost benefit for enrollees who can call nurse lines, or fill out online “e-visit” questionnaires, to ask basic health questions at any hour of the day or night. Assessments of users’ health care needs are obviously limited, however, because enrollees are not physically observed. Many health plans also offer condition-specific programs—such as those for pregnant women or chronic disease patients—that provide text messages to enrollees in addition to online or telephone access. Patient navigator and nurse advocate programs are also offered by health plans to enrollees with complex medical conditions.

Health plans include an assortment of legal disclaimers when advertising medical information and advice services. Most clarify that call center or online staff (typically nurses) cannot diagnose conditions or prescribe or recommend treatment, and further state that the information provided is
not a substitute for care by physicians. Some services specify that staff cannot give medical advice, while others advertise themselves as medical advice lines. Although these services are likely to produce some cost savings by reducing unnecessary physician and emergency department visits, there have been questions and concerns over the years regarding how they are managed, whether staff are qualified to evaluate enrollees’ medical needs and make appropriate referrals, and how care is coordinated with enrollees’ medical homes or treating physicians. Additionally, there have been allegations that medical call centers, in particular, have engaged in the unauthorized practice of medicine. Call centers operated by health plans and hospitals can voluntarily seek accreditation by meeting a set of “health call center” standards developed by the Utilization Review Accreditation Committee, a nonprofit accrediting organization.

Resolution 705-A-17 posits that medical advice given by health plans may be considered the practice of medicine when it is specific to a person’s illness or injury. It is the policy of the AMA that the diagnosis of disease and diagnostic interpretation of studies for specific patients constitutes the practice of medicine. Because states are responsible for providing medical licenses, each state regulates the practice of medicine and defines conduct that constitutes the practice of medicine within its jurisdiction. States may define the practice of medicine slightly differently. Each state could similarly define “medical advice” in statute or regulation. However, a Lexis search for state regulations defining “medical advice” or “telephone medical advice” turned up just a single result—California’s regulation of telephone medical advice services, which was cited in Resolution 705-A-17.

California regulation of telephone medical advice services

California enacted legislation in 2003 to protect consumers receiving telephone medical advice services. California Health and Safety Code §1348 requires that telephone medical advice must be provided by appropriately licensed health professionals, and prohibits other staff from misrepresenting themselves as licensed, certified or registered professionals. “Telephone medical advice” is defined in the Code as a “telephonic communication between a patient and health care professional in which the health care professional’s primary function is to provide the patient a telephonic response to the patient’s questions regarding his or her or a family member’s medical care or treatment.” It includes assessment, evaluation, or advice provided to patients and their families. Health care service plans providing telephone medical advice are required to make physicians and surgeons available on an on-call basis, and must maintain records—including transcripts of conversations and complaints—for five years. Until 2017, when the Telephone Medical Advice Services Bureau was repealed, businesses engaged in telephone medical advice were required to register with the state.

Neither “medical advice” nor “telephone medical advice” is defined in AMA policy, in part because these terms do not have universally accepted legal definitions and could vary by state. However, it is important to ensure that medical advice services—which do not allow users to be physically examined—are not engaged in the practice of medicine, which generally involves the diagnosis and treatment of disease or injury. Health plans’ medical advice services are not usually used for these purposes. If they were, the services could be considered telemedicine in those states that do not exclude telephone calls from their definition of telemedicine.

Apart from medical advice services, many health plans offer their own telemedicine services whereby enrollees can access physicians virtually via computer or mobile device, usually for a fee. Some health plans also contract with vendors offering home visits and other care management services that constitute the practice of medicine and are provided outside of established patient-physician relationships. While the Council has concerns regarding the expansion of care
management services—including telemedicine—that are increasingly provided by health plans, and
the coordination of these services with patients’ treating physicians, the scope of this report is
limited to health plan medical advice services.

AMA POLICY

Policy H-140.919 affirms that the physician-patient relationship should be reinforced and not
disrupted by direct communications from health plans to patients regarding clinical matters. This
policy further states that health plan communications to patients promoting improved outcomes
through evidence-based approaches (eg, promotion of preventive measures or disease management
programs) should reinforce the primacy of the patient-physician relationship, and also be sensitive
to confidentiality as well as patients’ concerns about their health status. If a health plan directly
communicates with a patient, Policy H-140.919 asserts that a copy of that communication should
be sent to the patient’s primary physician.

Disease management and demand management, through the use of telephone triage by health plans,
is addressed by Policy H-285.944. Principles outlined in this policy specify that referral algorithms
or protocols used in telephone triage should be developed by knowledgeable physicians, and
should be updated regularly; telephone triage centers should routinely inform primary or principal
care physicians of the disposition of all calls received from their patients; telephone counseling and
triage should be performed by health professionals with a level of knowledge and training no less
than that of a registered nurse; and qualified physicians should be readily accessible for
consultation and second-level triage to the nurses or other health professionals providing telephone
counseling or triage. Additional policy on “phone counseling” (Policy H-160.935) maintains that
medical phone counseling services must appoint a physician director, and that the director is
ultimately responsible for telephone triaging patients, updating the protocols and algorithms used
by non-physicians, and maintaining accountability for patients until referrals have been effected by
accepting physicians.

Guidelines for patient navigator and patient advocacy programs, including those offered by health
plans, are outlined in Policy H-373.994. This policy states that these programs should establish
procedures to ensure direct communication between patient navigators and the patient’s medical
team, and that navigators should refrain from activity that could be construed as clinical in nature.

Policy H-35.971 affirms that the diagnosis of disease and diagnostic interpretation of studies for
who make judgments or recommendations regarding the necessity or appropriateness of services or
site of services should be licensed to practice medicine and actively practicing in the same
jurisdiction as the practitioner who is proposing or providing the reviewed service and should be
professionally and individually accountable for his or her decisions. Policy H-285.995[7] reaffirms
that the portion of AMA model state legislation that calls for certain elements of utilization review
to be defined as the practice of medicine.

The practice of medicine by non-physicians is the focus of Policy H-160.949. This policy actively
opposes legislation allowing non-physicians to engage in the practice of medicine without
physician training or physician supervision. The AMA also opposes regulations and legislation that
would interfere with and/or redefine the practice of medicine (Policy H-390.994). Policy
H-285.954 states that certain professional decisions critical to high quality patient care should
always be the ultimate responsibility of the physician regardless of the practice setting (eg, health
plan, physician practice, hospital or integrated delivery system).
The AMA has substantial policy on telemedicine, including Policy H-480.946, which outlines principles guiding appropriate coverage of and payment for telemedicine services, and also how to establish a valid patient-physician relationship via telemedicine. This policy also maintains that physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services, and be licensed in the state where the patient receives services, or be providing services as authorized by that state’s medical board. Additional principles affirm that telemedicine services must be consistent with state scope of practice laws, and that the provision of telemedicine services must include care coordination with the patient’s medical home and treating physicians, who should be provided with a copy of the medical record. Principles for the supervision of non-physician providers when telemedicine is used are outlined in Policy H-160.937, which asserts that in all settings and circumstances, physician supervision is required when non-physician providers deliver services via telemedicine. A compilation of AMA policy on telemedicine can be found at https://www.ama-assn.org/sites/default/files/media-browser/public/arc-public/telemed-policy.pdf.

DISCUSSION

The Council’s deliberations distinguished between health plans’ medical advice services, which are the subject of referred Resolution 705-A-17, and medical management and telemedicine services offered by plans that explicitly constitute the practice of medicine. Policies H-35.971, H-285.998 and H-285.995, which delineate the practice of medicine, are recommended for reaffirmation.

Medical advice services are typically provided by health plans via telephone or online questionnaire, and are offered to enrollees free of charge. Nurses usually provide the service, with industry disclaimers clarifying that medical advice service staff cannot diagnose conditions or recommend specific treatments, and that the information provided is not a substitute for physician care. AMA policy on health plan disease management programs and demand management through telephone triage (Policy H-285.944), as well as phone counseling (H-160.935), remain relevant to the Council’s discussion and are recommended for reaffirmation. The Council further recommends reaffirmation of Policy H-140.919, which maintains that the physician-patient relationship should be reinforced and not disrupted by direct communications from health plans to patients regarding clinical matters, and that in cases where a health plan directly communicates with a patient, a copy of that communication should be sent to the patient’s primary physician.

The Council recognizes that health plans’ medical advice services offer enrollees convenient, 24/7 access to nurses or other health professionals for general information and advice. The Council further recognizes that these services may be used to manage overall costs to the plan and that safeguards may be needed to ensure that patients receive timely and appropriate care. Because state medical practice laws vary, it would be difficult for the Council to precisely define all of the circumstances in which medical advice crosses over into the practice of medicine. Instead, the Council recommends a more general policy statement: That real-time interactions between health plans and enrollees that are utilized for patient assessments and result in the creation of treatment plans constitute the practice of medicine.

The Council also utilized existing AMA policy and the California regulation to develop guidelines that health plans’ medical advice services should adhere to. Accordingly, the Council recommends that AMA policy affirm that medical advice services provided by health plans should adhere to a series of guidelines related to their primary goals, relevant requirements under state law, staff knowledge and training, physician availability, policies and procedures regarding efficiency and responsiveness to treating physicians, assurance that non-clinical staff are not providing medical advice, and disclosure of training and credentials. Finally, the Council recommends that the AMA
work with interested state medical associations to advocate for appropriate policy on health plans’
medical advice services.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution
705-A-17, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-35.971, which states that
   the diagnosis of disease and diagnostic interpretation of studies for specific patients constitutes
   the practice of medicine; Policy H-285.998, which states that physicians who make judgements
   or recommendations regarding the necessity or appropriateness of services or site of service
   should be licensed to practice medicine; and Policy H-285.995, which reaffirms that certain
   elements of utilization review be defined as the practice of medicine. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-285.944, which outlines principles that should guide health
   plans’ disease management programs and demand management through telephone triage, and
   Policy H-160.935 on phone counseling. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-140.919, which maintains that the physician-patient
   relationship should be reinforced and not disrupted by direct communications from health plans
   to patients regarding clinical matters, and that in cases where a health plan directly
   communicates with a patient, a copy of that communication should be sent to the patient’s
   primary physician. (Reaffirm HOD Policy)

4. That it be the policy of our AMA that real-time interactions between health plans and enrollees
   that are utilized for patient assessments and result in the creation of treatment plans constitute
   the practice of medicine. (New HOD Policy)

5. That our AMA policy affirm that medical advice services provided by health plans should
   adhere to the following guidelines:

   a) The primary goals of health plans’ medical advice services should be to inform, educate and
      empower patients to make good health care choices and receive timely and appropriate care.
      These services should not be used to assess patients in order to inform diagnosis or
      treatment.

   b) Health plans’ medical advice services should comply with state licensure laws, state
      medical, nursing, or other relevant practice acts, state scope of practice laws, and other
      relevant requirements within the state in which enrollees receive services.

   c) Staff providing health plans’ medical advice services should have a level of knowledge
      and training no less than a registered nurse (eg, nurse with a bachelor of science in nursing,
      advanced practice registered nurse, or physician assistant) and be appropriately licensed in
      the state in which enrollees receive services.

   d) Qualified physicians should be available for consultation at all times that the medical advice
      service is advertised as available.

   e) Health plans should have policies and procedures in place that allow medical advice
      services to quickly and effectively respond to enrollees’ health concerns.
f) Health plans should have policies and procedures in place to ensure that medical advice service providers routinely provide feedback to enrollees’ treating physicians regarding the nature of the enrollees’ contacts.

g) Health plans should ensure that non-clinical staff who may be screening enrollee calls or emails for the medical advice service are neither providing medical advice nor making medical decisions.

h) Health plans’ medical advice services staff should fully disclose relevant training and credentials, and not misrepresent themselves to users. (New HOD Policy)

6. That our AMA work with interested state medical associations to advocate for appropriate policy on health plans’ medical advice services. (New HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

2 URAC health call center accreditation. Available online at: https://www.urac.org/programs/health-call-center-accreditation
4 Id.
5 Id.
6 State of California Telephone Medical Advice Services Website. Available online at: http://www.dca.ca.gov/tmas/
EXECUTIVE SUMMARY

The Council on Medical Service initiated this report to provide an overview of the current financing mechanisms for long-term services and supports (LTSS) and to raise awareness about the importance of identifying sustainable methods of financing LTSS in light of a growing aging population. This report builds off of the American Medical Association’s long-standing policy on LTSS and presents policy recommendations to modify the current financing structure of LTSS with options that weave together financing reforms through publicly funded programs and private insurance.

LTSS refers to the range of clinical health and social services that assist individuals in their activities of daily living. In 2015, national spending for LTSS was about $331 billion, up from $310 billion in 2013. Medicaid accounts for over half of national spending on LTSS and is the primary payer across the nation for long-term care services. Demand for long-term services and supports (LTSS) is expected to double in the next 30 years and is fiscally unsustainable. For example, one funding source, long-term care insurance (LTCI), is too expensive and complex for most consumers, and its traditional policy design has not been sustainable. With few affordable options in the private insurance market and limited coverage under Medicare, individuals with insufficient resources rely on Medicaid to fund their LTSS needs, which puts a strain on Medicaid financing that will worsen as baby boomers age. More effective methods of financing LTSS and expanding the availability and affordability of LTCI would help not only alleviate the financial strain on public payers but also avert the need for individuals to deplete their retirement funds and savings to pay for LTSS or to be eligible for Medicaid.

The Council recognizes that there may be no single, comprehensive solution to address the growing demand for LTSS and that the challenges to affordable and politically viable LTSS financing mechanisms are varied and complex. Though its recommendations are not intended to solve the LTSS financing crisis in its entirety, there is an opportunity to formulate a series of pragmatic recommendations to modify the current financing structure. The Council notes that a growing consensus has emerged around a set of incremental steps that have the ability to improve the availability and affordability of LTSS. To that end, the Council proposes a multi-pronged approach to alter the financing and viability of LTSS through a mix of public and private reforms. The Council’s recommendations are intended to provide feasible steps to alleviate the financial strain of providing LTSS on Medicaid and families. The Council offers these recommendations as a pragmatic step forward to address the needs of an aging population and help shift away from an LTSS system dependent on insolvency and last-resort public financing to a sustainable system of meaningful insurance.
REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-18

Subject: Financing of Long-Term Services and Supports

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

This report, initiated by the Council, addresses the growing need for long-term care services and supports (LTSS) in the US. The report provides an overview of LTSS; details the cost and need for LTSS; discusses the lack of public education on LTSS; provides a summary of the current financing structure for LTSS; outlines possible LTSS financing mechanisms; summarizes relevant policy; and presents policy recommendations to modify the current financing structure of LTSS with options that weave together financing reforms through publicly funded programs and private insurance.

BACKGROUND

Long-term services and supports (LTSS) refers to the range of clinical health and social services that assist individuals in their activities of daily living (ADL) when these individuals are limited or unable to care for themselves. ADLs include eating, bathing, dressing, and instrumental tasks like medication management, house cleaning, and meal preparation. Unlike medical care, LTSS are function-based and holistic in nature. In 2013, national spending for LTSS was $310 billion and by 2015, that figure grew to $331 billion. Medicaid spending accounts for over half of national spending for LTSS and is the primary payer for LTSS across the nation.

NEED FOR REFORM

The need for LTSS is expected to increase sharply in the coming decades; however, a possible funding source, long-term care insurance (LTCI), is too expensive and complex for most consumers, and its traditional policy design has not been sustainable. With few affordable options in the private insurance market and limited coverage under Medicare, individuals with insufficient resources rely on Medicaid to fund their LTSS needs, which puts a strain on Medicaid financing that will worsen as baby boomers age. More effective methods of financing LTSS and expanding the availability and affordability of LTCI through a mix of public and private reforms would help not only alleviate the financial strain on public payers but also avert the need for individuals to deplete their retirement funds and savings to pay for LTSS or to be eligible for Medicaid.

COST AND NEED FOR LTSS

The number of Americans needing LTSS in 2010 was 12 million, and it is expected that by 2050, 27 million Americans will need LTSS. This increased demand for LTSS is driven by a life expectancy that remains relatively high, the aging of the large baby boomer generation, and advances in technology that allow people with chronic illness and disabling conditions to live longer.
The number of elderly people is expected to more than double in the next 40 years. Baby boomers began turning 65 in 2011, and, within the next 20 years, the 65+ population will double and the 80+ population will more than double. Additionally, it is estimated that at least 70 percent of baby boomers will need some form of LTSS at some point in their lives, and 40 percent are expected to require nursing home care. 

Not only is the size of the baby boomer generation a strain on the LTSS system, but baby boomers are also more likely than previous generations to be divorced, have fewer children, and have more children in the workforce, making informal family caregiving less likely. Further, many baby boomers have not saved enough for retirement and appear to be unprepared for unplanned expenses such as LTSS. The average retirement savings for baby boomers is about $75,000 while the cost of providing LTSS is significant. For example, in 2017 the average annual cost for a community-based adult day-care center was $16,900; a home health aide was approximately $49,000; and the average annual cost to live in a nursing facility was $97,455. The need for LTSS is one of the primary risks to retirement security, and some aging individuals will have to deplete their retirement savings and overwhelm funding sources such as Medicaid to meet their LTSS needs.

There is great variation in LTSS spending among individuals. Although some individuals will not have any LTSS needs, others will have significantly high spending. About 27 percent of individuals turning 65 will have LTSS costs of at least $100,000 over their lifetimes, and 15 percent will have costs that exceed $250,000.

PAYING FOR LTSS

The responsibility of paying for LTSS is shared among the elderly, people with disabilities, family, friends, volunteer caregivers, communities, states, and the federal government. However, this shared-responsibility system is severely stressed and increasingly will become unable to withstand the swelling demand for LTSS.

LTSS are expensive, with institutional care costs far exceeding costs for home and community-based services (HCBS). Aside from unpaid care provided by friends or relatives, LTSS costs often exceed what individuals and families can afford out-of-pocket. Therefore, many with LTSS needs rely on publicly funded programs to help pay for or supplement the cost of their care needs.

Many people expect Medicare to be their primary source of health coverage in retirement, but long-term care (LTC) is only covered in limited circumstances and for a short period of time. Medicare only pays for LTC for individuals requiring skilled services or rehabilitation care, generally following a hospitalization. Importantly, there is an expectation that the beneficiary will recover from the condition. In a nursing home, Medicare pays for a maximum of 100 days; however, the average covered stay is about 22 days. If a beneficiary is receiving skilled home health or other skilled in-home services, commonly these are provided only for a short period of time. Notably, Medicare does not pay for non-skilled ADL, which make up the majority of needed LTC services.

Already, about 40 percent of state Medicaid budgets go toward LTSS. Medicaid pays for most of LTSS while Medicare post-acute care pays for 23 percent of LTSS. The remaining sources of funding include out-of-pocket spending, LTCI, other private sources, and other public sources.

Because many middle-class people fail to anticipate and plan for their LTC needs, Medicaid has effectively become the default payer instead of a safety net for the poorest individuals. This creates an enormous strain in funding and threatens services for the poorest and most vulnerable.
Individuals are only eligible for public LTC coverage through Medicaid after they spend down most, if not all, of their personal liquid financial resources. In order to qualify for Medicaid services, one’s income must be below a certain level and must meet minimum state eligibility requirements based on the amount of assistance needed with ADL. Generally, in order to qualify for Medicaid, one cannot have assets exceeding $2,000, which excludes a car or home if the applicant intends to move back into the home or a spouse or dependent lives in the home.

Medicaid is the default payer for about 65 percent of nursing home residents.

Individuals and families must pay for LTSS that are not covered or partially covered by a public or private insurance program. Individuals pay for about 53 percent of their total LTSS expenditures out-of-pocket, typically through savings, retirement funds, or borrowed funds such as a reverse mortgage. For those who lack sufficient personal resources to pay for LTSS out-of-pocket, Medicaid is the primary payer. As baby boomers begin to need these services and supports, states will face a great challenge balancing their budgets with an increasing amount used in financing LTSS under Medicaid.

LACK OF PUBLIC EDUCATION

Exacerbating the lack of funding for LTSS is the public’s misunderstanding of how much such care costs and how it is currently financed. Many Americans mistakenly believe that Medicare will pay for their LTSS needs. A recent survey conducted by the SCAN Foundation found that 57 percent of respondents said that they expect to rely on Medicare for LTSS. Only 25 percent of respondents think that they will get help from Medicaid, and many respondents are counting on Social Security to finance LTSS needs, even though average Social Security benefits would pay for less than 15 percent of the cost of a typical nursing home and perhaps one-third of the cost of assisted living.

Some others know parents or friends who have received LTSS through Medicaid and fail to understand the limits of Medicaid coverage and strict eligibility criteria. In order to qualify for Medicaid, individuals have to have spent practically all of their assets or have appropriately given away or transferred them at least five years before the date that they are applying for Medicaid benefits. Some generally have a belief that the government will ultimately pay for any future LTSS needs, further encouraging them to avoid the expense and discomfort of purchasing LTCI.

HURDLES TO LONG-TERM CARE INSURANCE ENROLLMENT

LTCI provides an opportunity to shift some of the cost of providing LTSS from Medicaid but has remained a relatively niche product. Not only is LTCI often cost-prohibitive, but also, often potential purchasers do not believe that they will need the benefit later in life, are in denial about the probability of future care needs, or erroneously believe that Medicare will pay for their LTSS needs. Less than 10 percent of individuals in their early 60s have LTCI, which puts pressure on the Medicaid program to bear most of this burden.

Because of the declining LTCI market, many insurance carriers are reluctant to offer LTCI due to the difficulty of predicting costs far in the future and the risk that many beneficiaries will live for a long time. This reluctance to participate in the LTCI market and inability to predict future costs drives up premiums, especially for those in their 60s when they are likely to have preexisting conditions that may disqualify them from coverage and fewer working years to pay premiums that usually increase with age.
In addition, LTCI marketing materials are often confusing, and, at this stage in life, consumers are also balancing other competing financial demands such as saving for their own retirement and paying for children’s college tuition.

PUBLIC CATASTROPHIC INSURANCE

Seventy percent of older Americans will need LTSS at some point in their lives. Fifteen percent of the population will have significant LTSS expenses representing lifetime costs of over $250,000. For this high-cost population in particular, personal assets and informal family caregiving will not meet their care needs. The vast majority of those facing catastrophic costs must deplete their personal savings and sell assets to qualify for Medicaid.

In 2015, Milliman, Inc. and the Urban Institute conducted a microsimulation analysis of financing options for LTSS. The analysis found that a universal approach would not only be less expensive for individuals than a voluntary approach but also save the Medicaid program and states significant funds and avert out-of-pocket spending. For example, they projected that a mandatory public catastrophic insurance plan would reduce Medicaid LTSS spending by 35 percent in 2070, while a voluntary subsidized public catastrophic plan would reduce Medicaid LTSS by 7 percent.

Additionally, the analysis found that public catastrophic plans that cover LTSS later by providing back-end benefits would offset more Medicaid spending than alternatives that cover only front-end costs. Without the ability to accurately predict future costs, many insurers have instituted significant rate increases further driving potential buyers out of the private insurance market. However, a public catastrophic insurance option could ease the reluctance of insurance carriers to offer LTCI and the reluctance of consumers to purchase LTCI thereby reducing the cost of private LTCI. Importantly, a back-end catastrophic program would have the effect of stabilizing the private insurance market. For example, a back-end catastrophic program with a five year waiting period and a $100 per day lifetime benefit would cost a median-income worker about $300 per year.

Insurers will only participate in the private market on any meaningful scale if they have enough information to accurately price their products, and a public back-end catastrophic program allows for accurate prediction. The path to affordable private LTCI depends on a competitive and growing private insurance market, which relies on predictability. Offering public back-end insurance could encourage new private insurers to enter the market in the context of well-defined public and private responsibilities.

LTCI BENEFIT UNDER MEDIGAP AND MEDICARE ADVANTAGE

Most seniors are enrolled in either Medicare with a supplemental insurance policy (Medigap) or a Medicare Advantage (MA) plan, but they do not have LTCI. Medigap insurance is offered on a guaranteed basis without medical underwriting at the time a beneficiary enrolls in Medicare. Many MA plans also provide supplemental benefits for services that are not covered under Medicare Part A or Part B. MA plans can provide either mandatory supplemental benefits that generally must be provided to all beneficiaries or optional supplemental benefits in which the MA plan provides the beneficiary with the option of enrolling in coverage of additional services not covered by Medicare in exchange for additional premiums that are paid by the beneficiary.

In February 2018, Congress passed the Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care (CHRONIC) Act that will, for the first time, allow MA plans to pay for some LTSS. While the law does not change the rules for traditional FFS Medicare, it allows MA...
plans to include in their benefit packages nonmedical services such as home-delivered meals or transportation to and from medical appointments.

Milliman, Inc. and the Bipartisan Policy Center analyzed a potential limited LTSS benefit for Medigap and MA plans wherein the Centers for Medicare & Medicaid Services (CMS) would amend Medigap and MA requirements to permit plans to offer existing benefits as well as a new limited and voluntary LTSS benefit. In the model analysis, beneficiaries could choose to enroll in and pay corresponding premiums to cover the cost of the new benefit. When estimating the added cost of the benefit to Medigap or MA premiums, one analysis assumed a $75 daily benefit with a 180-day elimination period that would need to be satisfied prior to commencement of the benefit. Consistent with existing Medigap policies, beneficiaries would have a one-time option to purchase this coverage when enrolling in Medicare. The analysis suggests that this policy could result in premiums of $35-$40 per member per month.

RESpite CARE

A significant amount of LTSS is provided by unpaid caregivers who are typically family members or friends. Though potentially rewarding, caregiving can be strenuous physically, mentally, and financially. Many caregivers often miss work time or leave the labor market altogether thereby eroding their ability to accumulate resources for retirement and their own LTC needs. Though valuing unpaid care is difficult, it is estimated that, in 2013, 40 million family caregivers in the US provided 37 billion hours of care to adults with ADL limitations representing a total economic value of unpaid caregiving of $470 billion. Family caregivers on average spend 13 days per month on tasks such as shopping and housekeeping and six days per month on personal tasks such as feeding, dressing, and grooming. Taken together, the average individual with LTSS needs who relies exclusively on family for help receives about 173 hours of care over the course of a month, which is equivalent to a full-time job. Without this family-provided support, the economic cost of providing LTSS would rise sharply and worsen the current financing crisis.

Respite care helps individuals needing assistance to stay in their homes while giving their caregivers a reprieve from caregiving, which can prevent the caregiver from declining physically or emotionally. Currently, respite care benefits are only available for Medicare beneficiaries who are enrolled in Medicare’s hospice benefit, a benefit that is only available for beneficiaries expected to die within six months.

The Urban Institute and the Bipartisan Policy Center analyzed the cost of a potential respite care benefit in Medicare and MA that would be triggered when certain Medicare providers determined that respite care was needed. Among several analyses, one found that the 10-year federal budgetary cost of a 96-hour respite benefit would cost $29 billion if beneficiaries with spousal caregivers were eligible for the benefit.

HOME AND COMMUNITY-BASED SETTINGS (HCBS)

Historically, states and the federal government have limited the use of Medicaid-funded LTSS by restricting eligibility for services and providing care primarily in institutional settings such as nursing homes and residential facilities. However, there has been significant agreement that the current bias toward LTSS being delivered in an institution should be eliminated. Not only are HCBS significantly cheaper than institutional care, but also, there has been a growth in beneficiary and societal preferences for them. Over the years, states have used waivers and state plan options
to enable Medicaid-funded LTSS to be delivered in other less expensive settings. Progress has been made at the community level in finding ways to keep seniors and people with disabilities out of institutions and in the community. HCBS keep people happier, less isolated, and can be provided more effectively and cheaper than nursing home facilities. Expanding HCBS could provide individuals with more flexibility in how they receive LTSS and a higher quality of life.

There has also been a call to better integrate medical care and social care, predominantly for the dually eligible population. The Program of All-Inclusive Care for the Elderly (PACE) both supports HCBS and improves the delivery of LTSS through better care integration for this particular population. PACE is a program under Medicare wherein states can elect to provide services to Medicaid beneficiaries as an optional Medicaid benefit. The PACE program becomes the sole source of Medicaid and Medicare benefits for participants. It provides comprehensive medical and social services to certain frail, elderly individuals enabling them to remain in the community rather than receive care in a nursing home. The PACE program is an interdisciplinary team of health professionals providing participants with coordinated care. Notably, financing for the program is bundled, allowing the providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans.

RELEVANT AMA POLICY

Policy H-280.991 addresses financing of LTC and outlines relevant principles and policy proposals for LTC. It states that programs to finance LTC should cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual and coordinate benefits across different LTC financing programs. Policy H-210.994 echoes providing LTC services in the least restrictive setting by affirming support of home health care as an alternative to nursing home or institutional care. Further, Policy H-280.991 suggests providing coverage for the medical components of LTC through Medicaid for all individuals with income below 100 percent of the poverty level and providing sliding scale subsidies for the purchase of LTCI coverage for individuals with income between 100-200 percent of the poverty level.

Policy H-280.991 also considers tax incentives and employer-based LTC coverage to help fund LTC including creating tax incentives to allow individuals to prospectively finance the cost of LTC coverage and encouraging employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTCI premiums and expenses. Additionally, the policy supports use of a tax deduction or credit to encourage family caregiving.

Furthermore, Policy H-280.991 states that consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to provide an environment within their states that permits innovative LTC financing and delivery arrangements, and assures that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. Additionally, consistent with other AMA policy on state-based innovation, Policy H-280.991 supports health system reform legislative initiatives that could increase state flexibility to design and implement long-term care delivery and financing programs.
Policy H-165.852 supports legislation promoting the establishment and use of Health Savings Accounts (HSAs) and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care.

Policy H-290.982 supports allowing states to use LTC eligibility criteria that distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related LTC needs; and supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new LTC infrastructures and to encourage expansion of LTC financing to middle-income families who need assistance.

DISCUSSION

The Council’s recommendations are intended to provide feasible steps forward to alleviating the financial strain of providing LTSS on Medicaid and families. The Council’s recommendations are not intended to solve the LTSS financing crisis in its entirety. The Council recognizes that a growing consensus has emerged around a set of incremental steps that have the ability to improve the availability and affordability of LTSS. To that end, the Council proposes a multi-pronged approach to alter the financing and viability of LTSS through a mix of public and private reforms. Though the following recommendations are consistent with Policy H-280.991, the Council considers these recommendations to be distinct and with a broader view of LTSS financing.

The Council believes it is important to help consumers prepare thoughtfully for their LTSS needs and to provide individuals with a reasonable assessment of the likelihood of future need. Accordingly, the Council recommends reaffirming Policy H-280.991, which states that consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional Medigap policies.

Regarding private reform, the Council firmly believes in the importance of strengthening and improving the private insurance market. There are a number of steps that may be taken to revitalize the market for private LTCI. First, the Council recommends a policy statement to standardize and simplify private LTCI to achieve increased coverage and improved affordability. Additionally, Policy H-280.991 encourages employers to offer LTCI policies as a part of employee benefit packages, and the Council recommends expanding this principle to support adding LTCI coverage as part of workplace automatic enrollment with an opt-out provision. In this case, enrollment in the LTCI coverage would be paid through annual premiums that are almost half the cost of typical current-market LTCI policies. Additionally, the Council stipulates that these employer-offered plans should be available to both current employees and retirees.

To further improve the market for private insurance, the Council recommends allowing retirement savings to be used for LTCI premiums. Such a strategy includes supporting penalty-free withdrawals from employer-based retirement savings accounts for purchase of private LTCI. The Council notes that Policy H-280.991 already supports the creation of tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs for payment of LTC insurance premiums and expenses. Similarly, the Council recommends reaffirming Policy H-165.852 promoting the establishment and use of HSAs and allowing the
tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care. The Council is confident that such private reforms would reduce premium costs while reaching segments of the population that are not yet served by private LTIC.

As another step toward developing the private insurance market, the Council recommends exploring innovations in LTCI product design. Such innovations may include LTCI covering home and community-based LTC needs as well as marketing products with health insurance, life insurance, or annuities. Not only is home and community-based care less expensive than traditional facility-based care, but also, most people are able to stay at home and avoid nursing home care altogether.40

The Council believes increasing the availability of LTCI is vital to a sustainable financing structure moving forward. As such, the Council recommends supporting the ability of Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed through additional premiums paid by the beneficiaries who choose to enroll. Similarly, the Council recommends supporting the implementation of the CHRONIC Act allowing MA plans to offer social supports in benefit packages. Correspondingly, the Council recommends permitting a respite care benefit as part of Medigap and MA policies.

There is widespread agreement among advocacy organizations and think tanks of the need for a public catastrophic program for individuals with extraordinary LTSS costs to protect against poverty and bankruptcy.41 There is also public support for such a program. A recent survey found that about two-thirds of people favor a public catastrophic insurance program.42 Many agree that a public catastrophic option should help cover the back-end risk of LTSS costs that discourages private insurers from offering comprehensive protection. Back-end catastrophic coverage could be compared to the concept of reinsurance in that it may protect against premium increases in the private LTCI market by serving as a safety-net to those high-cost individuals who may require LTSS for a long period of time. It would be used in the event of catastrophic LTSS expenses after a period of using private LTCI or self-funding. Therefore, such a program could stabilize the private insurance market and allow insurers to focus on shorter-term, defined, and predictable coverage. The Council believes that a back-end public catastrophic insurance program could help shift away from the current welfare-based model and toward a system of insurance.

Consistent with Policy H-280.991 advocating for states to be permitted to pilot innovative LTSS financing and delivery arrangements, the Council suggests incentivizing states to expand the availability of and access to HCBS. Such services could help individuals remain in home and community settings for a longer period of time and relieve some of the burden of more costly LTSS care such as that provided in nursing homes. Increasing the availability of HCBS not only helps in eliminating the current bias in financing toward more expensive institutional care but also relieves family caregivers and allows them some time off. Furthermore, and consistent with Policy H-280.991 supporting the coverage of services in a coordinated manner in the least restrictive setting, the Council supports better integration of health and social services and supports, including the PACE.

Demand for LTSS will more than double over the next 30 years, and the challenges to affordable and politically viable LTSS financing mechanisms are varied and complex. While it is unlikely that there is one straightforward solution to the growing demand for LTSS, the Council offers these recommendations as a pragmatic step forward to address the needs of an aging population and help shift away from an LTSS system dependent on insolvency and last-resort public financing to a sustainable system of meaningful insurance.
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-280.991 supporting consumer education regarding the likelihood of future need for long-term services and supports (LTSS) and the limits of public funding sources and supporting tax-free withdrawals from retirement savings accounts for payment of long-term care insurance (LTCI) premiums and expenses. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-165.852 supporting legislation promoting the establishment and use of Health Savings Accounts and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care. (Reaffirm HOD Policy)

3. That our AMA support policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability. (New HOD Policy)

4. That our AMA support adding LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees. (New HOD Policy)

5. That our AMA support allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI. (New HOD Policy)

6. That our AMA support innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities. (New HOD Policy)

7. That our AMA support permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy. (New HOD Policy)

8. That our AMA support Medicare Advantage plans offering LTSS in their benefit packages. (New HOD Policy)

9. That our AMA support permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit. (New HOD Policy)

10. That our AMA support a back-end public catastrophic long-term care insurance program. (New HOD Policy)

11. That our AMA support incentivizing states to expand the availability of and access to home and community-based services. (New HOD Policy)

12. That our AMA support better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly. (New HOD Policy)

Fiscal Note: Less than $500.
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EXECUTIVE SUMMARY

Genetic/genomic discoveries and precision medicine innovations are occurring simultaneously with payment and delivery reforms that require health care services to demonstrate value as a prerequisite for payment and coverage. The sustained push to contain health care costs has led to increased interest in alternative payment models (APMs) that incentivize high-quality, cost-effective care. Examples of well-known APMs include accountable care organizations, bundled payments, and patient-centered medical homes.

Precision medicine is a tailored approach to health care that accounts for individual variability in the genes, environment, and lifestyle of each person. It has the potential to revolutionize the diagnosis and treatment of disease and may ultimately help address rising health care costs by streamlining clinical decision-making, reducing unnecessary treatments and hospitalizations, tailoring treatments, reducing late-stage diagnoses, and improving outcomes over time.

APMs have the capacity to incentivize use of care protocols, clinical pathways and other decision support tools. However, the structure of APMs often requires cost savings within a specific window of time that may not account for improved outcomes downstream. The Council initiated this report to explore how APMs can support and integrate precision medicine services to provide high-quality, high-value health care. The Council’s recommendations encourage APMs to consider the value of precision medicine and to integrate precision medicine approaches into patient care where appropriate and when recommended by national medical specialty societies.
This report, initiated by the Council, explores how alternative payment models (APMs) can support and integrate genetic/genomic precision medicine services with the end goal of providing high-quality, high-value health care. Previous Council reports have discussed physician-focused APMs (Report 9-A-16) and barriers that interfere with the shift to these value-based payment models (Report 10-A-17). Policy developed via the I-17 Joint Report of the Councils on Science and Public Health and Medical Service is intended to facilitate more consistent payment and coverage for evidence-based genetic/genomic precision medicine services.

This report discusses APMs and precision medicine; describes clinical pathways and decision support tools; provides examples of APMs that incorporate precision medicine approaches; discusses AMA activity; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

Precision medicine, which is a tailored approach to health care that accounts for individual variability in the genes, environment and lifestyle of each person, has the potential to revolutionize diagnosis and treatment of disease and, in doing so, improve health outcomes downstream. It has the potential to more accurately diagnose disease, predict individual susceptibility to disease, detect the onset of disease at earlier stages, and reduce invasive procedures and no longer necessary screenings and treatments. Physicians already practice precision medicine by diagnosing and treating each patient according to his or her unique symptoms, history, and preferences. However, significant advances in technology—including the development of large-scale biological databases, powerful methods for characterizing patients (eg, proteomics, metabolomics, genomics, cellular assays, and mobile health technologies), and computational tools for analyzing large sets of data—have vastly expanded the ability to apply precision medicine principles to patient care.

Accelerated rates of genetic/genomic discoveries and clinical innovations are occurring simultaneously with payment and delivery reforms including the proliferation of APMs driven by the push for cost-containment strategies and value-based purchasing. Driven by the Affordable Care Act (ACA) and Medicare Access and CHIP Reauthorization Act (MACRA), the Centers for Medicare & Medicaid Services (CMS) has developed and implemented a number of initiatives to test APMs.

New health care payment and delivery models focus on value and require that health care services demonstrate their value to patients and the health care system as a prerequisite for payment and coverage. The sustained push to contain health care costs has led to increased interest in APMs that incentivize high-quality, cost-effective care. Examples of well-known APMs include accountable
care organizations (ACOs), bundled payments, and patient-centered medical homes (PCMHs).

APMs have the capacity to create incentives for the use of care protocols, clinical pathways, and shared decision-making. However, such tools should reflect advances in precision medicine and support continued scientific innovation so that “one-size-fits-all protocols” are not universally imposed when evidence-based targeted treatments may be more cost-effective in the long term.

Precision medicine holds the potential to improve patient care and may ultimately help address rising health care costs overall by streamlining clinical decision-making, reducing unnecessary treatments and hospitalizations, tailoring treatments, reducing late-stage diagnoses, and improving outcomes over time. For example, genotype testing of patients initiating warfarin treatment has been found to reduce hospitalizations for bleeding or thromboembolism. Another study estimated that there would be substantial cost savings ($604 million) if patients with metastatic colorectal cancer were screened for the KRAS gene prior to beginning treatment. A retrospective analysis of precision medicine outcomes in patients with advanced cancer found improved progression-free survival and lower charges per week for patients who received genomic testing and targeted therapy. Over time, it is anticipated that genetic/genomic services will become more affordable and thus potentially produce greater cost savings. Payment and coverage for genetic/genomic services, which was addressed in the I-17 Joint Report, continues to be a barrier to patient access to precision medicine. While some genetic/genomic tests and therapeutics are covered by insurers, many others are not, and there is substantial variability among public and private insurers with regard to payment and coverage and prior authorization requirements. Coverage may also vary based on the intended use of genetic/genomic testing.

The market shift from a fee-for-service (FFS) to a value-based model should support and encourage the adoption of evidence-based genetic/genomic precision medicine services. However, it is a challenge to design new payment models that aim to improve care for whole populations while implementing precision medicine that is aimed at identifying the correct diagnosis and treatment plan for an individual patient. Stakeholders must engage in ongoing discussions to identify areas where APMs and precision medicine may work together and support one another. If properly designed and incentivized, together APMs and precision medicine have the capacity to yield better care, better health, and lower costs over the long term.

POTENTIAL IMPACT OF APMS ON PRECISION MEDICINE

Precision medicine represents life-altering opportunities and potential. However, policymakers must be diligent to appropriately weigh the balance between quality and cost-savings and, in particular, short term cost-savings. The drive to make genetic/genomic medicine available may be stifled when providers are assessed or penalized for spending, as they are in APMs. Such assessment of providers based on spending may be particularly problematic when that spending yields improvements that cannot be considered in a specific or small window of time.

A recent MedPAC report denotes a potential issue with the structure of many APMs being that the paradigm of cost savings in a specific period of time may be appropriate for some services and procedures that have remained unchanged over the course of many years; however, such a structure may not be appropriate for new tests and technologies, especially those that might improve patient quality of life over the course of many years. For example, it may be challenging to align a payment system, such as a bundled payment APM, with the appropriate quality measures. While the use of precision medicine could improve a patient’s quality of life or prevent downstream disease recurrence, it is difficult to identify and promote quality measures that capture the value of such interventions within a specified window. Policymakers must acknowledge such challenges of
implementing precision medicine within the context of APMs so as to realize the potential of
innovative technologies to improve care quality, value, and patient satisfaction.

As medical knowledge of the genome continues to evolve and grow, the number of options and
tools to assist providers in diagnosis and treatment is rapidly expanding. While tens of thousands of
genetic tests are currently available, there is widespread variability in the costs and insurer
coverage of these tests and clinicians may have a difficult time determining the right test for a
given patient. For example, oncology clinical practice guidelines currently recommend more than
30 tumor biomarkers across all cancers to support appropriate treatment and decision-making with
the list of potential biomarkers growing and changing in response to the rapid pace of clinical
research. Genetic tests range from testing for a specific alteration and a specific gene to testing
large genetic panels on many hundreds of genes at the same time. Though guidelines from the
National Comprehensive Cancer Network and other professional groups help direct physicians to
the best genetic tests for a given patient, physicians need the decision support to help determine
which mutations to consider for a specific tumor type and what genetic tests are most appropriate
for a given patient. Studies have suggested that many physicians report being inadequately
prepared to use genetic/genomic information for patient care, while others remain unsure that
genomic information is clinically useful. Education and awareness are needed for successful
implementation of genetic/genomic precision medicine, and tools used by APMs may be able to
help address some of the knowledge gaps.

CLINICAL PATHWAYS AND DECISION SUPPORT TOOLS

Many APMs already create incentives to use care protocols, clinical pathways, and other decision
support tools in treatment decision-making. Pathways act as a decision support tool for physicians
to know the right genetic test to use for each patient based on the nature of the patient’s disease.
The pathways then recommend treatments based on the test results. At times these pathways
receive prior authorization from payers, having the effect of expediting the process of getting the
test and treatment to the patient. Yet many providers can have difficulty using the decision support
resources necessary to assess the value of precision medicine when confronted with high upfront
costs of new technologies.

Often clinical pathways produce a single instance of savings after use. However, because pathways
are generally developed based on the broader population, requirements to adhere to clinical
pathways may have the effect of constraining the ability of providers and patient to identify and
choose the patient’s best available treatment options. Therefore, one-size-fits-all pathways and
adherence requirements may result in missed opportunities to tailor treatment based on individual
patient genetics, environment, and lifestyle choices.

Stakeholders are attempting to combat the issue of one-size-fits-all pathways by using data
registries that expand the evidence base of available therapies. The use of data registries and rapid
learning systems can extract clinically relevant data and apply the data to practice guidelines in
real-time. One example of an adjustable pathway model is the Department of Veterans Affairs
(VA) Point-of-Care Precision Oncology Program (POCOP). The POCOP uses electronic health
records (EHRs) and real-time data sharing to integrate knowledge from external sources about
molecular medicine in cancer with experience and information of other veterans in the program
including genomic information from a patient’s tumor and history with prior therapies.
Ultimately, the POCOP could guard against simply using short-term lower cost pathways and serve
as a model of rapid data-sharing, creating an evidence base that is continuously updated and can
inform treatment decisions at the point of care.
Similarly, the American Society of Clinical Oncology (ASCO) is developing a rapid learning system by building a cloud-based, big data, health IT platform called CancerLinQ. CancerLinQ extracts data from EHRs and other data sources and employs data analytics to generate knowledge that is available at the point of care to oncologists and patients. The primary objective of the learning system is to provide real-time feedback to physicians to enable them to deliver personalized insights at the point of care and accelerate new clinical hypotheses and pathways by uncovering patterns in patient and tumor characteristics, therapies, and outcomes. As precision medicine evolves and we gain insight on the role of genetic and other variation in patient response to treatment, clinical pathways and other decision support tools will need to keep pace.

INCORPORATING PRECISION MEDICINE INTO APMS TO IMPROVE DIAGNOSIS

A current barrier in the health care delivery and payment system is a lack of payment for some key aspects of the work associated with obtaining an accurate diagnosis. Current payment structures often do not pay for consultation with other physicians, and patients often face delays in access to care, particularly specialists, which can lead to exacerbations in symptoms and disease progression before a diagnosis is established and a treatment plan is developed. Furthermore, often significant amounts of time are dedicated to ruling out diagnoses rather than establishing an accurate diagnosis. This issue of the diagnostic odyssey is driven in part by the structure of FFS in which payments are made for conducting tests rather than paying for the process of determining what tests to order.

To overcome this barrier, APMs should be encouraged to leverage technology to support the goals of the APM and help physicians improve patient engagement, collaboration, diagnosis, treatment planning, and quality. APMs have the capacity to support more accurate diagnoses and tailored treatment plans, and precision medicine can play an important role in realizing this potential. Not only can APMs support collaborative efforts between various health professionals such as pathologists, radiologists, and others, but also, APMs, with the help of clinical pathways and guidelines, can pay for targeted genetic and genomic tests that support faster and more accurate diagnoses and the development of an individualized treatment plan. It is important to note that genetic/genomic testing provides clinical information beyond diagnostics, including prognosis and therapeutic tailoring. APMs should support new approaches to care delivery, and precision medicine is an important component of achieving more accurate diagnoses.

EXAMPLES OF APMS IMPLEMENTING PRECISION MEDICINE

The Radiation Oncology Alternative Payment Model (RO-APM)

Though the role of precision medicine across health care settings and payment models is still evolving, oncology care illustrates how an APM can help support precision medicine. Specifically, the American Society for Radiation Oncology is developing the RO-APM, which would incentivize the appropriate use of cancer treatments that result in the highest quality of care and best patient outcomes. The RO-APM holds physicians accountable for the spending related to the condition and applies to major disease sites treated with radiation therapy, creating an episode-based payment that begins with clinical treatment planning and concludes 90 days after the last radiation treatment. Throughout the episode, clinicians must adhere to nationally accepted clinical treatment guidelines and other quality improvement requirements.

With the use of genetic/genomic precision medicine, providers can optimize radiation therapy based on a patient’s tumor profile. Its use can shape dosage to minimize side effects and spare healthy tissue. A recent study conducted at the University of North Carolina found that
approximately 20 percent of radiation therapy patients experienced an unplanned hospital admission within 90 days of their treatment. Precision medicine can yield better, more targeted treatment planning to lower the risk of post-radiation therapy toxicities and avoid the need for toxicity-related inpatient visits. An APM can support enhanced patient monitoring and better management of patient care and result in fewer inpatient visits, ultimately decreasing the average cost of care per radiation therapy patient.

**Patient-Centered Oncology Payment**

The ASCO developed the Patient-Centered Oncology Payment (PCOP) model to improve the quality and affordability of cancer care. The model pays practices for services that are not currently billable, including non-face-to-face visits and consultation with other specialists, and imparts practices with the flexibility to tailor services to unique patient needs, which results in the delivery of high-quality, individualized services. The PCOP system is designed to provide supplemental, non-visit-based payments to practices to support accurate diagnosis, treatment planning, and care management. Using PCOP, practices would bill for new patient treatment planning, care management, active monitoring, and participation in clinical trials. In return for PCOP paying adequately for patient services at the outset, practices agree to adhere to appropriate use criteria and other accepted standards of care. Furthermore, practices and payers agree to a robust performance measurement system, so payers are assured that oncology practices are accepting accountability for spending and agreeing to standards of care while focusing on care approaches that have the demonstrated ability to lower costs without harming quality.

**Private Insurer Incorporating Precision Medicine into Value-Based Care**

Harvard Pilgrim Health Care is an example of a private insurer that has taken steps to incorporate precision medicine into a value-based care model. In February 2018, Harvard Pilgrim entered into a contract with the test developer Illumina to broaden eligibility of noninvasive, prenatal genetic testing to pregnant women under age 35 (average risk pregnancies). While the insurer anticipates that savings on other prenatal screenings will offset the costs of the next generation sequencing tests, Illumina has agreed to pay for cost overages. A two-year study will help determine whether expanded availability of noninvasive prenatal genetic testing will affect spending and demonstrate clinical value to patients.

**AMA ACTIVITY**

The AMA continues to work to aid physicians in the implementation of APMs and other components of MACRA. The AMA has conducted educational activities including webinars and regional conferences for physicians and staff and continues these activities. Recent AMA advocacy activity has called for improvements in the methodologies behind APMs to reduce barriers and enable more physicians to participate. The AMA has made extensive comments on all MACRA proposed and final rules and has successfully advocated for a number of changes, including the modification of the definition of financial risk.

AMA advocacy efforts are also focused on the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and Physician-Focused Payment Models (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 has convened APM workshops to bring together many of the leading physicians who are working on PFPM proposals to discuss potential solutions to these issues.
The AMA is also engaged in ongoing advocacy related to genetic/genomic precision medicine, including oversight of laboratory-developed tests, and implementation of the Protecting Access to Medicare Act which significantly revised the Medicare payment system for laboratory tests, including genetic tests.

**Health IT and Digital Health**

Significant improvements in EHRs and other health IT capabilities are critically needed for precision medicine to reach its potential under the new payment models. Robust and interoperable health IT systems must be able to access and display longitudinal health data from each patient regardless of where the data are stored. EHRs hold biological, behavioral and environmental data; however, impediments to accessing and securely exchanging data across health care systems must be overcome. The AMA actively promotes EHRs that can provide clinical decision support and use genetic/genomic data to provide clinically meaningful information to physicians. The AMA’s Integrated Health Model Initiative supports a continuous learning environment to enable interoperable technology solutions and care models that evolve based on real-world use and feedback.

Beyond EHRs, the AMA is committed to influencing the evolution of health IT and digital health, both of which are integral to the implementation of precision medicine. The AMA provides leadership on digital solutions involving telemedicine and telehealth, mobile health, wearables, and remote monitoring. Using the expertise of physicians and input from partners on the leading edge of health technology, the AMA has developed resources, toolkits and training to help physicians evaluate and optimally use newly available technology for improved care.

Additionally, the AMA continues to educate physicians about the clinical uses of genetic/genomic services. To assist physicians encountering new precision medicine technologies, the AMA has partnered with Scripps Translational Science Institute and The Jackson Laboratory to develop “Precision Medicine for Your Practice,” a series of online continuing medical education modules covering topics such as expanded carrier screening in prenatal care, prenatal cell-free DNA screening, somatic cancer panel testing, large scale sequencing as a diagnostic tool, and pharmacogenomics.\(^{19}\) The AMA has partnered with the NIH All of Us Research Program, a soon-to-be launched precision medicine initiative to study one million or more Americans.\(^{20,21}\) Furthermore, the AMA has conducted surveys to better understand physician awareness and confidence with precision medicine practices. The AMA is also maintaining dialogue with other key stakeholders through activities such as the National Academies of Science, Engineering and Medicine Genomics Roundtable.\(^{22}\)

**RELEVANT AMA POLICY**

Policy H-385.913 created foundational policy 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 provision of assistance to physician practices implementing APMs. The policy has been influential in related AMA advocacy thus far, which has included submission of extensive comments on the MACRA proposed and final rules and responses to draft documents from the PTAC and proposed models from Center for Medicare & Medicaid Innovation. The AMA has a key role in helping physicians develop and participate in APMs.

Building on Policy H-385.913, Policy H-385.908 offers a set of guidelines to address the barriers that interfere with the shift to value-based payment. Such barriers to the development and
implementation of APMs include limitations of existing health IT capabilities, resource use
measures, and resource use challenges including risk adjustment, attribution, and performance
target-setting.

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 high value to
patients. In transitioning from the sustainable growth rate (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 reformed payment rates that are
sufficient to maintain a sustainable medical practice and that payment reform implementation
should be undertaken within a reasonable timeframe and with adequate assistance.

Policy D-185.980 established foundational policy on payment and coverage for genetic/genomic
precision medicine. The policy encourages payers to adopt processes and methodologies for
determining coverage and payment for genetic/genomic precision medicine that: promote
transparency and clarity; involve multidisciplinary stakeholders; describe the evidence being
considered; provide opportunities for comment and review as well as meaningful reconsiderations;
and incorporate value assessments that consider the value of genetic/genomic tests and therapeutics
to patients, families and society as a whole, including the impact on quality of life and survival.
Policy D-185.980 also encourages the development of a comprehensive payment strategy that
facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical
impact, and also encourages national medical specialty societies to develop clinical practice
guidelines incorporating precision medicine approaches.

Policy H-410.948 provides guidance on the development of clinical pathways and supports the
development of transparent, collaboratively constructed clinical pathways that are implemented in
ways that promote administrative efficiencies for both providers and payers; promote access to
evidence-based care for patients; recognize medical variability among patients and individual
patient autonomy; promote access to clinical trials; and are continuously updated to reflect the
rapid development of new scientific knowledge. Additionally, the AMA has significant and
comprehensive policy on health IT. 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.

DISCUSSION

With MACRA taking effect and precision medicine gaining traction in clinical practice, the
Council believes that physicians need to lead the development and integration of these two
promising innovations. It is important that the payment and delivery reform movement recognizes
the incremental value of precision medicine, especially as more evidence of its effectiveness
becomes available. With the emergence of APMs and the drive to value, the AMA is poised to be a
leader in addressing unnecessary care costs and realizing the benefits of APMs, and one of the most
valuable ways to maximize value may be through precision medicine, particularly for certain
specialties.

The Council believes that clinical pathways provide an opportunity to confront the tension between
achieving cost-savings targets and providing better patient care and improving outcomes and
recognizes the utility of data registries. To that end, AMA policy on clinical pathways (Policy
H-410.948) and data registries (Policy H-450.933) is recommended for reaffirmation. To further
ensure that clinical pathways are successful, the Council recommends affirming that they should be
developed by clinical experts, including national medical specialty societies, and be leveraged by
or integrated into EHRs for decision support, unified documentation, and automation of
communication with payers for authorization.

Because expert-driven, evidence-based clinical pathways can help physicians identify
genetic/genomic tests and services for patients, the Council recommends encouraging APMs to
incorporate them as appropriate and as recommended by national medical specialty societies. The
Council further believes that appeal mechanisms should be available to patients and physicians
when national medical specialty society-recommended pathways are rejected. The Council also
recognizes the potential impact of rapid learning systems on precision medicine and APMs, and
recommends supporting transparent and accessible rapid learning systems with the ability to extract
clinically meaningful information and use it to modify clinical practice guidelines and pathways in
real-time.

For many providers, especially those participating in APMs, it is challenging to use the resources
necessary to assess the full clinical and economic value of precision medicine when confronted
with high up front cost of new technologies, particularly when the use of new tests or therapeutics
may negatively affect a provider’s cost-savings targets. Accordingly, the Council recommends that
the AMA support assessment within new payment and delivery models of the value of evidence-
based precision medicine tests and therapeutics to patients, families and the health care system,
including the impact on patient experience, disease progression, quality of life and survival.

The Council firmly believes that the APM focus on lowering costs must not have the unintended
effect of discouraging adoption and use of innovative tests and therapeutics that, though more
expensive in the short-term, have the potential to deliver better long-term outcomes for patients.
Accordingly, the Council recommends that the AMA encourage APMs to integrate precision
medicine approaches, where appropriate, to improve the diagnostic process and personalize patient
care.

Finally, the Council recognizes that a key challenge to integrating precision medicine into new
payment models is that APMs are generally structured around cost savings within a specified
window of time and may not account for improved outcomes downstream. Therefore, the Council
recommends that the AMA encourage APMs to consider measuring patient outcomes and quality
improvements over time to allow for the use of precision medicine tests and therapeutics that have
clinical value.
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-410.948 supporting the development of transparent, collaboratively constructed clinical pathways that promote administrative efficiencies and access to evidence-based care, recognize variability among patients and individual patient autonomy, promote access to clinical trials, and are continuously updated to reflect new scientific knowledge. (Reaffirm HOD Policy)

2. 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)

3. That our AMA affirm that clinical pathways should be developed by clinical experts, including national medical specialty societies, and should be leveraged by or integrated into electronic health records for decision support, seamless documentation, and automation of communication with payers for authorization. (New HOD Policy)

4. That our AMA encourage alternative payment models (APMs) to incorporate evidence-based clinical pathways as appropriate and as recommended by national medical specialty societies. (New HOD Policy)

5. That our AMA support transparent and accessible rapid learning systems with the ability to extract clinically meaningful information and use it to modify clinical practice guidelines and pathways in real-time. (New HOD Policy)

6. That our AMA support assessment within new payment and delivery models of the value of evidence-based precision medicine tests and therapeutics to patients, families and the health care system, including the impact on patient experience, disease progression, quality of life and survival. (New HOD Policy)

7. That our AMA encourage APMs to integrate precision medicine approaches, where appropriate, to improve the diagnostic process and personalize patient care. (New HOD Policy)

8. That our AMA encourage APMs to consider measuring patient outcomes and quality improvements over time to allow for the use of precision medicine tests and therapeutics that have clinical value. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

7 Supra note 4.
8 Topalian, S, Schilsky, R. ASCO Panel: Precision Medicine in Practice can be Challenging. Available online at: https://www.healio.com/hematology-oncology/practice-management/news/online/%7B29c7e4a2-1d9b-41e1-84e1-804341997d73%7D/ascopanel-precision-medicine-in-practice-can-be-challenging
10 Id.
12 Supra note 8.
13 Supra note 4.
14 Id.
21 National Institutes of Health. All of Us Research Program. Available at: https://allofus.nih.gov/
Whereas, The continuing consolidation of healthcare by hospital mergers and practice acquisitions has resulted in the majority of physicians now being employed by corporations and healthcare systems, which leads to physician practice uncertainty and disputes that are likely to grow as career options become more limited; and

Whereas, The past several years have witnessed a shift of the practice of medicine by transforming physicians from clinical decision makers to salaried technicians with a job description that includes data entry, coding/billing, transcribing, medical guideline implementation, and patient care coordination so as to enhance revenue reimbursement for their employer; and

Whereas, Employed physicians have increasingly become merely revenue generators, resulting in individual contract negotiations becoming one-sided under the direction of corporate executives and managers with no leverage for the physicians; and

Whereas, This relationship is modeled after the hotel/hospitality industry standards of short-term occupancy, centralized decision making, customer relations and structured pricing that is then taught in hospital administration programs; and

Whereas, During the period from 1970 to 2016, there has been a doubling of the number of physicians to match the same increase of the population of the United States but a 3000% rise in hospital executives, and a corresponding 2300% increase in healthcare spending per capita; and

Whereas, The increasing need for revenue generation from employed physicians by medical corporate interests has led to the systematic devaluation of medical inquiry, experience, independence and professional growth leading to despondency within the profession of medicine; therefore be it

RESOLVED, That our American Medical Association adopt an “Employed Physician’s Bill of Rights” (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities (New HOD Policy); and be it further
RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that physician activities performed outside of defined employed-time boundaries are the sole prerogative of the individual physician and not the employer organization unless it directly conflicts with or increases risk to the organization (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that conflict-of-interest disclosures should be limited to physician activities that directly affect the organization and should only be disclosed to entities that directly reimburse the physician during their employed time period (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act) (New HOD Policy); and be it further

RESOLVED, That this bill of rights include the principle that all physicians be empowered to first be the patient’s advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient’s health care and dignity. (New HOD Policy)

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

Received: 12/04/17
Whereas, A shortage of physicians is present in the U.S.; and

Whereas, Physicians have the longest standard duration of education, representing both significant societal and personal investment; and

Whereas, Physicians have, at different points in their careers, different factors they must consider to maintain a work-life balance; and

Whereas, Currently, about 80 percent of Indiana physicians are employed by non-physician owned hospitals/businesses; and

Whereas, This resolution should also be considered by the Organized Medical Staff Section, which has an interest in the relationship between medical staff and hospital administration; therefore be it

RESOLVED, That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.

2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.

3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.

4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of locum tenens coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other "greater societal good" organizations.

5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region. (New HOD Policy)

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

Received: 02/12/18
WHEREAS, More hospitals are moving toward a volume-based surgery metric for privileging and smaller practices may not maintain volume purported to foster patient safety when there is little basis for volume alone as metric for maintaining privileges to function; and

WHEREAS, Volume-based surgery metric can be another name for economic credentialing which is opposed by our AMA; therefore be it

RESOLVED, That our American Medical Association vigorously oppose clinical credentialing based solely on surgical and non-surgical case volume when there is no other basis for questioning the physician’s ability to function with skill and safety. (New HOD Policy)

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

Received: 04/24/18
Whereas, The Centers for Medicare and Medicaid Services now disallows any claim made if there is any discrepancy in the charted note; and

Whereas, In a review they will use this as evidence of false claims and demand a percentage of the yearly payment made back from the physician; and

Whereas, The patients often give us different answers to questions during different parts of the history which may then seem discordant; and

Whereas, Physicians do use a template format to make the charting less time consuming and to be able to spend more time with the patients face to face; a small error can be made; and

Whereas, We are humans, and humans make mistakes; and

Whereas, A mistake of this nature in no way proves that the physician has not spent time and effort doing the work of a physician for the patient; and

Whereas, This type of measure, although easy for a low level examiner to do, in no way reflects the quality, importance, and appropriateness of the medical care delivered; and

Whereas, This is clearly a ploy to not pay physicians for their work; or at best, delay payment which causes a substantial increase of the cost of doing billing; therefore be it

RESOLVED, That our American Medical Association seek through legislation and/or regulation policies opposing claim nonpayment due to minor wording or clinically insignificant documentation inconsistencies (Directive to Take Action); and be it further

RESOLVED, That our AMA seek through legislation and/or regulation policies opposing extrapolation of overpayments based on minor inconsistencies (Directive to Take Action); and be it further

RESOLVED, That our AMA seek through legislation and/or regulation policies opposing bundled payment denial based on minor wording or clinically insignificant documentation inconsistencies. (Directive to Take Action)

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

Received: 04/25/18
Whereas, Federal regulation requires all physicians who do specimen testing to purchase a federal CLIA\(^1\) permit that must be renewed every 2 years; and

Whereas, The same CLIA tests performed in a physician’s office are deemed CLIA-waived tests, the same tests that any consumer may purchase and use without a CLIA permit; and

Whereas, The use of a microscope by a physician is likewise subject to additional payment and regulation as per the CLIA Amendment; therefore be it

RESOLVED, That our American Medical Association adopt the position that it is proper to remove the CLIA certification mandate requirement for physicians who only use CLIA-waived tests and physician-performed microscopy. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-18)

Introduced by: New York

Subject: Ensuring Medicare Coverage for Long Term Care

Referred to: Reference Committee G
(Theodore A. Calianos, II, MD, Chair)

Whereas, Long term care services are received by over 12 million Americans today, with projections pushing the number to over 27 million in the next 40 years; and

Whereas, Long term care services can quickly exhaust private resources and, as a result, two-thirds of long term care is paid out of state Medicaid programs; and

Whereas, Medicare currently covers 100% of the 20-days of a skilled nursing facility; but on day 21 leaves a daily coinsurance (currently at $167) as the responsibility of the patient’s family, which for many is unaffordable; and

Whereas, Past and current discussions of our healthcare system are silent on long term care; therefore be it

RESOLVED, That our American Medical Association support the concept of increasing the existing 20-day limit of full Medicare coverage for a patient’s skilled nursing facility stay (New HOD Policy); and be it further

RESOLVED, That our AMA work to identify mechanisms by which the additional costs for this care can be fairly covered. (Directive to Take Action)

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

Received: 04/25/18
RELEVANT AMA POLICY

Policy Directions for the Financing of Long-Term Care H-280.991
The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.

Whereas, Health insurance is a contract between a health insurance company and a patient; and

Whereas, Health insurers and employers have created insurance products with copayments, coinsurance, and increased deductibles to lower premium costs, reduce utilization of unnecessary services, and to transfer costs to patients and physicians; and

Whereas, Insurers establish cost sharing via contracts with employers and their insured; and

Whereas, According to the Kaiser Family Foundation, between 2004-2014, patient cost sharing rose substantially faster than payment for care by health plans; and

Whereas, High deductible health plans have increased dramatically. According to a Commonwealth Fund study, the share of privately insured adults who had a health plan without a deductible fell from 40% in 2003 to 25% in 2014. By 2014, 11% of adults had a deductible of $3,000 or more, up from just 1% in 2003. Plans experienced a 22% increase of enrollment in high deductible plans in 2015 from 2014; and

Whereas, EMTALA providers are obligated to provide care without any guarantee that the patient will be able to meet any cost sharing obligations, particularly because there is not an established relationship with the patient. According to CroweHorwath.com hospitals collect significantly less from patients with higher cost-sharing amounts; and

Whereas, The shift to more patient cost-sharing means physicians must collect more costs directly from patients and physicians are collecting less. According to an MGMA study, 23% of total patient services revenue is attributed to patient cost-sharing. For patient obligations of $200 or more, a physician collects payment within one year only 66% of the time. An average of 3.33 billing statements were sent before a patient’s outstanding balance was paid in full; and

Whereas, Payment for services may be more convenient for patients if the health plan bills the enrollee directly for the total cost-sharing balance; therefore be it

RESOLVED, That our American Medical Association urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance and deductibles. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/01/18
RELEVANT AMA POLICY

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849

1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.

2. Our AMA will engage in a dialogue with health plan representatives (e.g., Americas Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.

WHEREAS, Regulations for Medicare admissions to acute care hospitals and inpatient rehabilitation units include arbitrary paperwork and signature deadlines; and

WHEREAS, An entire rehab stay has been denied by reviewers because a document was signed an hour too late; and

WHEREAS, An entire acute hospital admission has been denied because a verbal admission order was not signed before discharge; and

WHEREAS, These arbitrary deadlines are not related to the medical necessity of the admission; and

WHEREAS, Denials based on time frame of signature are unfair to the patient, physician and hospital as the denial is based on a technical issue, not on true medical necessity of the procedure or admission; therefore be it

RESOLVED, That our American Medical Association work to change admission order signature timeframe regulations at the Centers for Medicare and Medicaid Services to be consistent with timeframe regulations for other verbal and telephone orders. (Directive to Take Action)

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

Received: 05/02/18
Whereas, The prior authorization process for durable medical equipment for power wheelchairs and other equipment has turned into a process based on time frames and arbitrary deadlines rather than medical necessity; and

Whereas, Denials occur when all the appropriate paperwork does not arrive within a specific limit timeframe regardless of whether the paperwork is complete and comprehensive; and

Whereas, Denials based on arbitrary time frames are unfair to patients who desperately need the equipment and physicians who are doing their best to justify the equipment; therefore be it

RESOLVED, That our American Medical Association advocate that denials of prior authorization for durable medical equipment must be based on true medical necessity not arbitrary time limits or other paperwork issues (New HOD Policy); and be it further

RESOLVED, That our AMA continue to work to improve the prior authorization process for Medicare Managed Care Plans. (Directive to Take Action)

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

Received: 05/02/18
Whereas, Health care statistics have shown that the majority of health care dollars are spent for patients in the last six months of their lives; and

Whereas, Implementation of Advance Directives with clear goals of care, including code status, has been shown to reduce these costs, preserve the dignity of the patient, improve patient and family satisfaction, and reduce patient and family anxiety as the end of life nears; and

Whereas, Conversations about Advance Directives and goals of care are reimbursable visits and a quality metric for primary care physicians who often have a longitudinal relationship with the patient and, thus, may be the ideal health care provider to have these difficult conversations with patients; and

Whereas, Repetitive conversations about end-of-life decisions may be emotionally taxing for patients and their families, particularly when the patient may be encountering ill health and may be receiving health care in different settings; and

Whereas, Current Centers for Medicare and Medicaid Services rules require that code status orders be discussed and reordered upon transfer to a skilled nursing facility (subacute rehabilitation facility or long-term care facility) rather than transferring code status orders from the acute care setting or the ambulatory setting; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to revise or rescind the rules that prevent transfer of code status across the continuum of care in order to better meet the needs of our patients and our health care system in a comprehensive, cohesive, and more cost-effective manner. (Directive to Take Action)

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

Received: 05/02/18
RELEVANT AMA POLICY

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient’s advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17;
Whereas, Commercial health insurance companies are increasingly exacting and costly in requiring pre-authorization requests which consume extra-ordinary time of physicians and their office employees; and

Whereas, Medical offices can no longer absorb the costs of these increasingly time-consuming pre-authorization processes; and

Whereas, Many insurers are refusing to approve needed medical care and refusing to provide appeals processes; and

Whereas, A former commercial health insurance company medical director recently admitted under oath that he never looked at patients' records when deciding whether to approve or deny medical care; therefore be it

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services that CPT code 99080 be reimbursed by Medicare. (Directive to Take Action)

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

Received: 05/02/18
Whereas, In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA had many goals, but its key driver was to “fix” the Sustainable Growth Rate (SGR). The SGR formula was legislation established in the Balance Budget Act of 1997 and utilized by Centers for Medicare and Medicaid Services (CMS) to control Medicare spending for physician and other health care providers’ services. The SGR formula was developed to limit Medicare Physician spending based on the GDP growth; and

Whereas, MACRA places providers in one of two tracks: the advanced Alternative Payment Model (APM) or the Merit-Based Incentive Payment System (MIPS). The providers participating in the MIPS program will be evaluated based on the Quality Payment Program (QPP). The goals of the QPP are to promote quality, cost-effective and value-based care, encompassing provider accountability and patient care coordination. Providers will receive payment bonuses or penalties based on performances. On the other hand all Alternative Payment Models do not qualify to be an advanced APM. Advanced APM criteria are listed below:

Table 1

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<tr>
<th>CMS requirements for Advance APM Qualification</th>
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<tbody>
<tr>
<td>1. Clinicians must use certified electronic health record technology</td>
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<tr>
<td>2. The APM pays for covered services “based on quality measures comparable to those used in the quality performance category of the MIPS”</td>
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<tr>
<td>3. “Either be a Medical Home Model expanded under CMMI Center authority; or (2) require participating APM Entities to bear more than a nominal amount of financial risk for monetary losses”</td>
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Whereas, APMs have a framework to improve quality, increase provider accountability and potentially improve coordination of high value care, the advance APM incorporates not only upside risk but also downside risk which is reflected in financial risk for monetary losses; and

Whereas, Providers are rewarded with shared savings if their patients’ average Medicare Spending per Beneficiaries (MSPB) falls below a benchmark MSPB, in contrast providers whose patients’ cost exceeds the MSPB benchmark this results in a shared loss; and
Whereas, Risk adjustment for financial cost should include the factors that lead to higher cost of comprehensive comparable care and needs to include comorbid conditions, poverty and other social economic status factors; and

Whereas, Vulnerable populations, such as those living in poverty, and people with disabilities disproportionately encounter high health care cost and in addition have poor outcomes; and

Whereas, Disproportionate share hospital systems have an increased proportion of impoverished, dual eligible and minority patients and they are subjected to greater penalties associated with readmission rates, hospital acquired conditions reduction Program and the Physician Value-Based Payment Modifier; and

Whereas, Under advanced APMs the vulnerable population may present the greatest opportunity for cost saving and improved coordination of care. The impact of the current risk adjustment tool (with advanced APMs) on providers who care for vulnerable population needs to be further studied; therefore be it

RESOLVED That our American Medical Association study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations (Directive to Take Action); and be it further

RESOLVED That our AMA advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population). (Directive to Take Action)

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

Received: 05/08/18
Whereas, Private practices in several specialties -- including dermatology, anesthesiology, radiology, ophthalmology, pediatric, emergency medicine -- are consolidating due to the burden of current administrative requirements; and

Whereas, Private equity (PE) groups and venture capital firms have an increasing interest in acquiring a majority and/or controlling stake in specialty practices; and

Whereas, There are some pros and cons that physicians should be aware of when considering selling their private practice to larger practices or companies backed by PE firms or considering joining a private equity-owned business or controlled business; and

Whereas, It is necessary to ensure there is no conflict between corporate profit seeking and physician’s fiduciary responsibility to their patient; and

Whereas, Since this is an emerging trend, minimal data is available to determine the impact of PE groups and venture capital firms on physician practices; and

Whereas, A study on this topic is necessary to guide future AMA activities; therefore be it RESOLVED, That our American Medical Association study, with report back at the 2018 Interim Meeting, the effects on the healthcare marketplace of venture capital/PE firms acquiring a majority and/or controlling stake in physician private independent, small group and large group practices, including, but not limited to, such topics as:

- the degree of venture capital/PE penetration and investment in the healthcare marketplace;
- the impact on physician practice and independence;
- patient access;
- resultant trends in the use of unsupervised, independently practicing non-physician extenders;
- long term financial viability of purchased practices;
- effects of ownership turnovers and bankruptcies on patients and practice patterns;
- effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces;
- and the relative impact venture capital/PE purchases have on the paths and durations of junior, mid-career and senior physicians (Directive to Take Action); and be it further
RESOLVED, That, in order to address the particular concerns of physicians entering into management service organization contracts, our AMA amend the AMA Annotated Model Physician-Group Practice Employment Agreement (H-215.981) to read:

“(2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.” (Modify Current HOD Policy)

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

Received: 05/10/18

RELEVANT AMA POLICY

Corporate Practice of Medicine H-215.981
(1) Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. (2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs. (3) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Whereas, Health insurance payers’ use of laboratory benefit management has the potential to impinge upon the practice of medicine if not properly administered and structured; and

Whereas, Laboratory benefit management programs used by health insurance payers should be based upon transparent, verifiable and published medical and scientific evidence, and should not be influenced by improper financial conflicts of interests in the administration of such programs arising from the health insurance payer or administrator of the program; and

Whereas, More than nine in 10 physicians (92 percent) say that prior authorizations programs have a negative impact on patient clinical outcomes, according to a physician survey released in March 2018 by the American Medical Association; and

Whereas, AMA currently has general policy on benefit management and prior authorization, as well as specific policies on radiology benefit management (H-320.946) and pharmaceutical benefits management companies (H-125.986), however no policy specifically address laboratory benefit management; and

Whereas, The use of laboratory benefit management programs by health insurance payers should not adversely curtail physician medical judgment nor adversely impact patient diagnosis and treatment, especially for life-threatening medical conditions; and

Whereas, Ordering physician referrals to in-network laboratories, made in a manner consistent with the ethics policies of the American Medical Association, should not be dictated nor constrained by laboratory benefit management, when such referral remains in-network; and

Whereas, No adverse claims impact should accrue to any laboratory or physician who performs a pathology or laboratory service pursuant to a lawful order for such services by a health care provider; therefore be it
RESOLVED, That our American Medical Association adopt policy that supports the adoption of laws, regulations and public or private sector policies regarding laboratory benefit management arrangements to preclude:

1) Any potential financial conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory;

2) Health insurance payer constraints on ordering physician discretion for referrals made to any in-network laboratory or pathology providers when such referrals are medically and ethically appropriate;

3) Any adverse claims impact on the laboratory or pathology provider who receives a lawful order from a health care provider for medically necessary services, based upon a compliance failure in the laboratory benefit management ordering process;

4) The implementation by a health insurance payer of prior authorization or prior notification imposed on ordering physicians for any pathology or laboratory test ordered on a patient specimen obtained in a hospital or ambulatory surgical center. (New HOD Policy)

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

Received: 05/10/18