Reference Committee J

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- 821* Direct Primary Care and Concierge Medicine Based Practices

* contained in the Handbook Addendum
At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 716-A-18, “Hospital Closures and Physician Credentialing.” Resolution 716 was sponsored by the Organized Medical Staff Section and asked the AMA to:

work with appropriate stakeholders—such as the AMA Organized Medical Staff Section and National Association Medical Staff Services (NAMSS)—to produce an AMA credentialing repository that would allow hospitals and other organizations that credential physicians to access verified credentialing information for physicians who were on staff at a hospital (or one of its departments) at the time of closure, and report back at the 2018 Interim Meeting.

Testimony largely supported the intent of Resolution 716. However, some members noted that not only would the cost of implementing Resolution 716 be significant, but there are also many unanswered questions about the demand for such a service and how it would work. Other members were concerned as to whether the AMA is the organization best positioned to take up this issue.

DISCUSSION

Resolution 716 suggests that a lack of institutional policies for preserving medical staff credentialing files when a hospital closes can lead to undue delays in future credentialing efforts due to inaccessibility of historical credentialing information. To minimize the potentially devastating impact this shortcoming may have on physicians and other displaced medical staff members, Resolution 716 asks that the AMA create a centralized repository to facilitate the verification of credentialing information as it relates to a physician’s hospital affiliation history.

Existing AMA policy supports the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities. Policy H-230.956, “Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records” states that, where in accordance with state law and regulations, “...[t]he governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility...” and “...make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.” Policy H-230.956 also states that the closing facility “...shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information.”
Notwithstanding this comprehensive policy, a thorough review of existing law reveals few requirements for the retention of physician credentialing records when a hospital closes. While some states require hospitals to implement policies for the preservation of medical staff credentialing files (e.g., Illinois and New York), most states have no specific law or regulations providing for the timely transfer of medical staff credentialing files and proper notification to physicians of the location of those files. As a starting point, the AMA should encourage emulation of appropriate existing laws and regulations by developing model state legislation that supports timely physician access to credentialing files following the closure of a hospital.

Even if closing hospitals were required by law to preserve credentialing files, it remains to be seen where and how this information would be most appropriately stored. Resolution 716 suggests the development of a comprehensive and centralized repository of credentialing files from closed hospitals. States, payors, and other stakeholders are already in the process of developing credentialing repositories for verification of physicians’ current and past hospital affiliations. For example, Oregon passed legislation to establish a centralized credentialing database from which medical staff professionals, hospitals, health plans, and other organizations can get up-to-date information on every licensed physician in the state. Additionally, the National Association Medical Staff Services (NAMSS) has launched an online repository to provide medical staff offices a place to quickly find and upload physician affiliation history. Either of these efforts could be expanded to address the problems raised by closed facilities. Recognizing the value that the AMA could provide alongside expert leaders in the credentialing industry, the AMA should continue to monitor these efforts and explore the feasibility of developing a universal clearinghouse that centralizes the verification of physician practice and affiliation history.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 716-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-230.956, which states that the governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility should be responsible for making arrangements for the disposition of physician credentialing records upon the closing of a facility and should make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, and medical staff status. (Reaffirm HOD Policy)

2. That our AMA develop model state legislation and regulations that would require hospitals to:
   (a) implement a procedure for preserving medical staff credentialing files in the event of the closure of the hospital; and (b) provide written notification to its state health agency and medical staff before permanently closing its facility indicating whether arrangements have been made for the timely transfer of credentialing files and the exact location of those files. (Directive to Take Action)

3. That our AMA: (a) continue to monitor the development and implementation of physician credentialing repository databases that track hospital affiliations; and (b) explore the feasibility of developing a universal clearinghouse that centralizes the verification of credentialing information as it relates to physician practice and affiliation history, and report back to the House of Delegates at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest – Between $1,000 and $5,000
Relevant AMA Policy

H-230.956, “Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records”

1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:

   A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.

   B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

   C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

   D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.

   E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

2. Our AMA advocates for the implementation of this policy with the American Hospital Association.
At the 2017 Interim Meeting, the House of Delegates referred Resolution 226-I-17, “Prescription Drug Importation for Personal Use,” which was sponsored by the Minnesota delegation. Resolution 226-I-17 asked that our American Medical Association (AMA) support legislation that would allow for the personal purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy, provided such drugs are for personal use and of a limited quantity. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Interim Meeting.

This report addresses the in-person purchase and importation of prescription drugs obtained directly from a licensed, “brick-and-mortar” Canadian pharmacy, not the importation of drugs via online or mail-order pharmacies. The Council notes that Policy D-100.983 guides AMA advocacy on these aspects of the prescription drug importation issue, and states that our AMA will:

1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if:
   a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations;
   b) the drug distribution chain is “closed,” and all drug products are subject to reliable, “electronic” track and trace technology; and
   c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported;

2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured;

3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation; and

4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts.

This report provides background on prescription drug pricing and spending in the United States and Canada; summarizes US federal law and regulatory authority addressing prescription drug
importation; highlights activities to ensure US pharmaceutical chain integrity; reviews how
prescription drugs and pharmacies are regulated in Canada; outlines relevant legislative and
administrative activity; and presents policy recommendations.

BACKGROUND

In 2016, the US had the highest pharmaceutical spending per capita in the world at $1,443, versus
$613 in Canada. Retail spending on prescription drugs per capita was also highest in the US at
$1,026, with Canada’s retail per capita spending amounting to roughly half that of the US. Public
spending on prescription drugs accounted for 36 percent of total pharmaceutical spending in
Canada, and 34 percent in the US. Private insurance accounted for 36 percent of total
pharmaceutical spending in the US and 30 percent in Canada, with private out-of-pocket spending
accounting for 34 percent in Canada, and 30 percent in the US.¹

Differential pricing for pharmaceuticals between the US and Canada reflects differences in how
pharmaceutical prices are determined in each country. Contributing factors to pharmaceutical
pricing include the level of government negotiation authority, price controls mandated by law, and
market exclusivity and manipulations. In Canada, the Patented Medicine Prices Review Board, a
federal, independent, quasi-judicial body, regulates the prices of patented medications to ensure
that they are not excessive. Price increases of existing patented drugs cannot exceed the Consumer
Price Index. Of note, the Board only regulates the price at which patented drugs are sold to
wholesalers, hospitals, pharmacies and other entities by their respective patent holders, and does
not have jurisdiction over wholesale or pharmacy prices. In addition, the Board only has the
authority to regulate the prices of patented drugs, not generic drugs. Provinces have the authority
over the pricing of generic drugs, as well as the pricing of prescription drugs under public drug
plans.²³ In addition, the pan-Canadian Pharmaceutical Alliance, with the participation of provinces,
territories and federal drug plans, conducts joint negotiations for the pricing of publicly covered
drugs.⁴

When faced with high out-of-pocket costs for prescription drugs, some patients in the US pursue
the importation of their medications from other countries, including Canada. In fact, eight percent
of respondents in a recent Kaiser Health Tracking Poll indicated that they or someone in their
household had imported prescription drugs from Canada or other countries outside of the US.⁵

FEDERAL LAW ADDRESSING PRESCRIPTION DRUG IMPORTATION

Under current US law, based on provisions of the Medicare Modernization Act of 2003 as well as
the Medicine Equity and Drug Safety Act of 2000, HHS has the authority to permit importation of
prescription drugs from Canada if the HHS Secretary certifies to Congress that they would pose no
additional risk to the public’s health and safety, and would result in a significant reduction in the
cost of the drugs to Americans. However, no HHS Secretary has been willing to provide the
enabling certification for prescription drug importation, thus preventing its implementation.⁶
Because prescription drugs from other countries often have not been approved by the FDA for use
and sale in the US, it generally remains illegal for individuals to import prescription drugs into the
US for personal use. Without FDA approval and enforcement authority, the safety and
effectiveness of imported drugs cannot be assured.

Current law, however, also gives the FDA discretion in enforcement of the importation of
prescription drugs by individuals, which allows the FDA’s “personal-use” or “compassionate-use”
policy. Under the policy, the FDA allows the personal importation of prescription drugs under very
limited circumstances, described by the agency as:
• The drug is for use for a serious condition for which effective treatment is not available in
  the US;
• There is no commercialization or promotion of the drug to US residents;
• The drug does not represent an unreasonable risk;
• The individual importing the drug verifies in writing that it is for personal use, and
  provides contact information for the doctor providing treatment or shows the product is for
  the continuation of treatment begun in a foreign country; and
• Generally, not more than a 3-month supply of the drug is imported.7

The FDA also has utilized its enforcement discretion to allow importation in the case of a shortage
of a prescription drug. In the case of such shortages, when manufacturers of an FDA-approved
prescription drug cannot resolve a shortage immediately, the FDA sometimes has had to turn to
foreign versions of the drug with the same active ingredient manufactured by firms the FDA deems
as reputable and reliable. As a result, the limited importation of the foreign version of the drug has
been allowed until the shortage is resolved.8 Of note, such enforcement discretion has been used
sparingly, including for propofol in 2010 and 2012, ethiodol in 2011 and 2015, methotrexate
injection and liposomal doxorubicin in 2012 and tretinoin capsules in 2016.9

US PHARMACEUTICAL SUPPLY CHAIN INTEGRITY

In the US, the FDA has the authority to ensure the integrity of the US pharmaceutical supply chain,
from raw materials to manufacturing facilities to use by patients. The FDA is undergoing several
initiatives to protect the global prescription drug supply chain, responding to the fact that
approximately 40 percent of finished prescription drugs are imported in the US, and 80 percent of
active pharmaceutical ingredients come from overseas sources. Such initiatives are targeted at
preventing substandard, adulterated and counterfeit drugs from entering the US, and appropriately
communicating risks to patients and providers. The FDA completed 4,936 Good Manufacturing
Practice inspections of registered drug and device establishments in 2017, and issues annual reports
outlining such inspections as well as the percentage of the FDA budget used to fund such
inspections. The FDA also has administrative detention authority to prevent the distribution or
subsequent use of drugs suspected to be adulterated or misbranded at the time of inspection until
the agency determines what action it should take concerning the drugs, including the initiation of
legal action.10,11 In addition, the FDA is working towards fully implementing the Drug Supply
Chain Security Act by 2023. The Act, which was Title II of the Drug Quality and Security Act, was
enacted into law in 2013 and outlines steps to build an electronic, interoperable system to identify
and trace certain prescription drugs as they are distributed in the US.12

CANADIAN REGULATION OF PRESCRIPTION DRUGS AND PHARMACIES

Health Canada reviews prescription drugs to assess their safety, effectiveness and quality before
they are authorized for sale in Canada, and performs continuous evaluations after such drugs are on
the market, including monitoring adverse reactions. Once approved for sale, prescription drugs in
Canada are issued an eight-digit Drug Identification number, which indicates that Health Canada
considers the drug safe and effective, and provides a mechanism to track adverse reactions. Also,
Health Canada licenses and conducts inspections of pharmaceutical manufacturers, importers and
distributors. In order to prevent unauthorized drug products from entering Canada, including
counterfeit and adulterated drugs, Health Canada works in cooperation and coordination with the
Canada Border Services Agency.13,14 The FDA has voiced its confidence in Health Canada in
providing effective oversight of drugs approved for use by Canadian patients.15
There are 10,947 licensed pharmacies in Canada, including 10,463 community pharmacies.\textsuperscript{16} Provincial and territorial pharmacy regulatory authorities regulate the practice of pharmacy and the operation of pharmacies in their respective jurisdictions in Canada. This includes the licensing of pharmacies in Canada, including traditional “brick-and-mortar” pharmacies and storefront pharmacies that conduct business online.\textsuperscript{17}

**RELEVANT ADMINISTRATIVE AND LEGISLATIVE ACTIVITY**

In response to the request of HHS Secretary Alex Azar in July 2018, a work group will assess how to safely import prescription drugs from other countries under certain narrow circumstances not involving a shortage, namely in the event of a significant price increase for a prescription drug that is only produced by one manufacturer and not protected by patents or exclusivities. The FDA Commissioner has stressed that if drugs that fall under this categorization can be imported in a manner that ensures safety and effectiveness, such importation would be temporary until there is sufficient competition.\textsuperscript{18,19}

In addition, legislation has been introduced to permit prescription drug importation. Legislative approaches to prescription drug importation vary in many respects. For example, while some bills focus on the importation of prescription drugs from Canada, therefore requiring the Secretary of HHS to promulgate the necessary regulations on this issue, other bills could potentially allow prescription drug importation from additional countries that meet standards for ensuring the safety and effectiveness of drugs that are at least as protective as such standards in the US. Bills also vary in defining the foreign pharmacies and entities from which individuals can import prescription drugs.

Senator John McCain (R-AZ) and Congresswoman Chellie Pingree (D-ME) have introduced S 64/HR 1480, the Safe and Affordable Drugs from Canada Act of 2017. S 64/HR 1480, if enacted into law, would compel the HHS Secretary to promulgate regulations within 180 days permitting individuals to import a prescription drug purchased from an approved Canadian pharmacy that: is dispensed by a pharmacist licensed in Canada; is purchased for personal use in quantities not greater than a 90-day supply; is filled using a valid prescription issued by a physician licensed to practice in the US; and has the same active ingredients, route of administration, dosage form, and strength as a prescription drug approved under the Federal Food, Drug, and Cosmetic Act. The legislation does not authorize importation of certain medications, including controlled substances and biological products. The bill establishes a certification process for approving Canadian pharmacies and HHS would have to publish a list of approved Canadian pharmacies.\textsuperscript{20,21} Senator McCain also introduced S 92, legislation with the same title and most of the same text as S 64, but differing in that it would give HHS 185 days to promulgate regulations permitting individuals to import a prescription drug purchased from an approved Canadian pharmacy instead of 180 days.\textsuperscript{22}

Congressman Keith Ellison (D-MN) has introduced HR 934, the Personal Drug Importation Fairness Act of 2017. If enacted into law, the legislation would allow a drug to be imported by a person other than the drug’s manufacturer if the drug has the same active ingredients, route of administration, and strength as an approved drug. The bill also states that drugs could be imported or reimported from the following countries if the FDA determines that they have standards for ensuring drug safety and effectiveness that are at least as protective as US standards: Australia, Canada, Israel, Japan, New Zealand, Switzerland, South Africa, a member-state of the European Union, or a country in the European Economic Area. Prescription drugs to be imported would be required to be dispensed by a licensed pharmacist; be shipped directly to, or imported by, the ultimate consumer; and shipped or imported in quantities that do not exceed a 90-day supply. The bill would prohibit the importation of controlled substances.\textsuperscript{23}
Senator Bernie Sanders (I-VT) and Congressman Elijah Cummings (D-MD) have introduced S 469/HR 1245, the Affordable and Safe Prescription Drug Importation Act. If enacted into law, the legislation would require HHS to issue regulations within 180 days allowing wholesalers, licensed US pharmacies, and individuals to import qualifying prescription drugs manufactured at FDA-inspected facilities from licensed Canadian sellers. After two years, the Secretary would have the authority to permit importation from countries in the Organisation for Economic Co-operation and Development that meet specified statutory or regulatory standards that are comparable to US standards. The bill would prohibit the importation of controlled substances, anesthetic drugs inhaled during surgery, and compounded drugs. The bill stipulates that an individual may import a qualifying prescription drug for personal use in quantities not greater than a 90-day supply from an online pharmacy or by a certified foreign seller that is a licensed foreign pharmacy. The bill also would require that individuals importing qualifying prescription drugs must provide to the licensed foreign pharmacy a valid prescription issued by a health care practitioner licensed to practice in the US.

There also has been state activity in the arena of prescription drug importation. Nine states have introduced drug importation legislation this year, with Vermont enacting a law that would allow drug importation from Canada through authorized wholesalers. The state is required to submit a drug importation proposal for federal approval. Without federal approval, Vermont’s law will face the same fate as Maine’s, which was enacted in 2013 to allow its citizens to import prescription drugs from Canada, New Zealand, Australia, and the United Kingdom. However, in 2015, a federal district court ruled that Maine’s law was unconstitutional, as federal law preempts state law on this issue.

DISCUSSION

Supporting the ability of US patients to purchase and import prescription drugs in-person from a licensed Canadian pharmacy has the potential to improve patient cost-sharing levels if significant cost savings could be achieved, which would positively address one barrier to medication adherence. The Council notes that under such a policy, some patient medications, including controlled substances and biologicals, may not be allowed to be imported. Nevertheless, the Council believes that a risk to patients who pursue the importation of prescription drugs from Canada remains, especially those who import such drugs via the Internet which increases the risk of receiving substandard, adulterated and counterfeit drugs.

Policy D-100.983 provides a strong, balanced approach to guide the support of our AMA for the legalized importation of prescription drug products by wholesalers and pharmacies, as well as the personal importation of prescription drugs via the Internet. Critically, the policy predicates AMA support for prescription drug importation on ensuring that safety concerns with imported prescription drugs are addressed, to ensure that they are of the same quality and chemical makeup as those currently distributed in the US. While in-person importation from licensed pharmacies in Canada may face fewer safety concerns than importing prescription drugs via the Internet which would then be shipped to patients, ensuring the safety of such imported drugs must remain a priority. Therefore, the Council recommends that our AMA support the in-person purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity.

The Council also believes that the FDA needs new and additional resources to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the safety of in-person importation can be assured.
Also addressing the critical issue of safety of imported prescription drugs, the Council recommends the reaffirmation of Policy D-100.985, which states that our AMA will continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting. In addition, the policy calls for our AMA to work with the Congress, the FDA, the Drug Enforcement Administration, and other federal agencies, the pharmaceutical industry, and other stakeholders to ensure that these illegal activities are minimized.

Allowing for the in-person importation of prescription drugs from licensed Canadian pharmacies is not a comprehensive, long-term solution to addressing the problem of unaffordability of prescription drugs in the US. The Council believes that sustainable solutions to addressing high and unaffordable prescription drug prices can be found by addressing the flaws and inefficiencies in the US pharmaceutical marketplace. However, patients that face high and unaffordable costs for their prescription drugs need relief in the meantime. Your Council believes that supporting the in-person purchase and importation of prescription drugs from Canada, if the safety of importation can be assured, represents a measured and conservative option to lower patient costs for prescription drugs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the in-person purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity. (New HOD Policy)

2. That our AMA advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured. (New HOD Policy)

3. That our AMA reaffirm Policy D-100.983, which outlines criteria for supporting the legalized importation of prescription drug products by wholesalers and pharmacies, and opposes the personal importation of prescription drugs via the Internet until patient safety can be assured. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-100.985, which opposes the illegal importation of prescription drugs and drug counterfeiting, and supports working with Congress, federal agencies and other stakeholders to ensure that these illegal activities are minimized. (Reaffirm HOD Policy)

Fiscal Note: Less than $500
REFERENCES

8 US Food and Drug Administration. FDA Works to Lessen Drug Shortage Impact. Available at: https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm258152.htm.
19 US Food & Drug Administration. Statement by FDA Commissioner Scott Gottlieb, M.D., on the formation of a new work group to develop focused drug importation policy options to address access challenges related to certain sole-source medicines with limited patient availability, but no blocking patents or exclusivities. July 19, 2018. Available at: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm613931.htm.
20 S 64, the Safe and Affordable Drugs from Canada Act of 2017. Available at: https://www.congress.gov/115/bills/s64/BILLS-115s64is.pdf.
21 HR 1480, the Safe and Affordable Drugs from Canada Act of 2017. Available at: https://www.congress.gov/115/bills/hr1480/BILLS-115hr1480ih.pdf.
22 S 92, the Safe and Affordable Drugs from Canada Act of 2017. Available at: https://www.congress.gov/115/bills/s92/BILLS-115s92is.pdf.
23 HR 934, the Personal Drug Importation Fairness Act of 2017. Available at: https://www.congress.gov/115/bills/hr934/BILLS-115hr934ih.pdf.
24 S 469, the Affordable and Safe Prescription Drug Importation Act. Available at: https://www.congress.gov/115/bills/s469/BILLS-115s469is.pdf.
25 HR 1245, the Affordable and Safe Prescription Drug Importation Act. Available at: https://www.congress.gov/115/bills/hr1245/BILLS-115hr1245ih.pdf.
At the American Medical Association’s (AMA) 2017 Interim Meeting, the House of Delegates adopted policy D-130.964, “Air Ambulance Regulations and Reimbursements,” which directs the AMA and appropriate stakeholders to study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement.

This report provides background on air ambulances including an outline of the various air ambulance business models in the market, discusses the costs and insurance coverage of air ambulance services, summarizes relevant AMA policy, provides an overview of legislative activity on air ambulances, and suggests policy recommendations.

BACKGROUND

Helicopters provide emergency scene responses and interfacility transfers while fixed-wing aircraft provide longer distance airport-to-airport transports. For the purposes of this report, the Council focuses on helicopter air ambulances, which account for about 74 percent of all air ambulances and most of the research on air ambulances. Furthermore, Policy D-130.964 directs the report’s scope to focus on the role, clinical efficacy, and cost for air ambulance services.

Air ambulances are used to expeditiously transport critically ill patients during life-threatening emergencies. Air ambulances are equipped with medical equipment and staffed by medical professionals similar to traditional ground ambulances. Air ambulances are widely considered to have a beneficial impact on improving the chances of survival and recovery for both trauma victims and other patients in critical condition. In some rural areas that lack advanced-care facilities like trauma centers, air ambulances fill a critical gap and provide patients timely access to the treatment they need.

Air ambulances allow for optimization of patient care and outcomes. In emergency medicine, the “golden hour” refers to a time period lasting for about one hour following traumatic injury or medical emergency during which there is the highest probability that rapid medical treatment will prevent further deterioration or death. Air ambulances increase the likelihood of patients receiving needed care within the “golden hour” because of their ability to land at accident sites and quickly fly to nearby hospitals therefore reducing transport times. Unlike other aviation and medical services, air ambulance transfers take place in response to time-sensitive medical emergencies and generally are not scheduled ahead of time. Patients often have little to no ability to make cost-saving decisions before the transport, such as ensuring that the air ambulance provider participates in the patient’s insurance plan.
It is estimated that more than 550,000 patients in the US use air ambulance services every year. Further, air ambulance services have increased significantly in recent years. In 2002, there were about 400 air ambulances in use across the US, and that number more than doubled to over 800 air ambulances by 2008. This increase in the number of air ambulances has sparked criticism from consumer groups of oversupply and contributing to the overuse of air ambulance services that may not be medically necessary. It is estimated that nearly a third of patients transported via air ambulance helicopter were minimally injured. In addition to possible unnecessary use of air ambulances, other reasons for the growth in the industry include an aging population, a decrease in the number of emergency departments in hospitals, and changes in health care delivery in rural settings.

Air ambulances have emerged as one solution to the problem of rural health care facility closures. A quarter of Americans, or 85 million people, are estimated to be unable to access health care in less than an hour of travel time without an air ambulance, and such ambulances may be the only viable means of transporting patients to the care center they need. However, over the past decade, many states have reported issues with air ambulance providers who are not affiliated with any hospital or insurance carrier.

AIR AMBULANCE BUSINESS MODEL

Air ambulance providers generally function in one of three business models based on the entity that owns the air ambulance and the individuals providing medical services aboard the aircraft. The first model is a hospital-based model wherein the hospital provides medical services and staff and typically contracts with third parties for the pilots, aircraft, and maintenance. The second model is the independent model wherein operations are not controlled by a specific medical facility. Independent models may consist of for-profit or non-profit providers who directly employ the medical and flight crews to provide services. The third model is the government model where a state, municipal government, or military unit owns and operates the air ambulances.

Until 2002, air ambulances were primarily owned and operated by hospitals. However, in 2002, Medicare created a national fee schedule for air ambulances based on a thorough investigation into the “reasonable cost” for emergency medical services (EMS). The national fee schedule had the effect of increasing the Medicare reimbursement rate for helicopter air ambulance transport and in particular raising the rate of payment for rural air transports.

Due in part to the establishment of the fee schedule, for-profit companies established and expanded their air ambulance businesses. Currently, it is estimated that more than half of the air ambulance industry is controlled by four for-profit air ambulance operators. The doubling of the number of air ambulances since 2002 potentially may be attributed to the closure of clinics and hospitals in rural areas.

COST AND COVERAGE OF SERVICES

Patients typically have little to no choice over the service or provider of an air ambulance due to the urgent nature of the transports. Furthermore, air ambulance providers generally do not turn away patients based on their ability to pay and garner payments from patients’ insurance companies. Air ambulance providers typically charge standard rates based on an established lift-off fee and per mile fee for all transports and receive payments from various sources at differing rates depending on a patient’s insurance coverage. Further, the amount paid by private health insurance hinges on whether the air ambulance provider participates in a contract with the private insurer.
Depending on insurance coverage, patients can be billed for air ambulance charges that have potentially significant financial consequences. Costs for the average air ambulance trip run in the tens of thousands of dollars. According to the Centers for Medicare & Medicaid Services (CMS) and private health insurance data, between 2010 and 2014, the median prices providers charged for air ambulance service doubled from about $15,000 to about $30,000 per transport. According to numerous air ambulance providers, privately insured patients account for the largest percentage of their revenue. The median payment that three large national private insurers paid per air ambulance transport increased from about $15,600 to $26,600 from 2010 to 2014, an increase of 70 percent. With insurers under pressure to cut costs, they have been reducing payments for air ambulances.

Although air ambulances account for less than one percent of total ambulance claims, they represent about eight percent of Medicare spending on ambulance services due to their significant cost. Air ambulance providers are not permitted to balance bill Medicare and Medicaid patients beyond deductibles and coinsurance requirements. Patients with private insurance may be balance billed only if the air ambulance provider is out-of-network. Patients without insurance may be billed for the total price of the air ambulance bill. Due to a lack of information, it is unclear to what extent air ambulance providers balance bill.

Numerous factors likely contribute to the high costs of air ambulance services, including the price and maintenance of the necessary equipment and employment of specialized medical personnel around-the-clock. In order to stay in operation, air ambulance providers must earn revenue sufficient to cover their costs. The median cost per base for independent air programs is almost $3 million, with 77 percent of the costs incurred being fixed costs associated with operating a base. To increase revenue, air ambulance providers need to increase the number of transports or the cost charged per transport. According to eight air ambulance providers, the average cost they incurred per transport is between $6,000 to $13,000.

A more thorough look into the factors affecting air ambulance pricing is not possible due to lack of data. For example, the cost incurred by air ambulance providers to provide service is not readily available, and there is no national database with this information. Moreover, there are no data available that address cost differences of air ambulance service capabilities and how cost is affected not only by transport but also service level. In addition, available data are insufficient to discern the prices charged by air ambulances, charges across various air ambulance business models, and charges to individuals with varying coverage statuses. The lack of systematic data collection makes it impossible to determine the market share of particular air ambulance providers and corresponding price information.

**LEGISLATIVE ACTIVITY**

Though some states have attempted to create consumer protections from costly air ambulance bills, federal preemption has largely prevented state regulation. The Airline Deregulation Act (ADA) of 1978 prohibits states from regulating the price, route, or service of an air carrier for the purposes of keeping national commercial air travel competitive. The ADA applies to air carriers that provide air ambulance services and are, therefore, protected from state attempts to regulate their price, route, and service. Accordingly, air ambulance providers generally are not subject to the price competition that usually occurs in competitive markets wherein high prices will lead consumers to find lower-cost alternatives.
In contrast to air ambulances, ground ambulances are regulated under the Affordable Care Act (ACA) and applicable state laws. However, for air ambulances, such protections are applied only with the model in which the ambulance service is affiliated with the hospital and, therefore, considered an extension of the emergency department service.

Numerous states have attempted to pass legislation to protect consumers from out-of-network air ambulance bills; however, these laws have been preempted by the ADA. Federal legislation is necessary in order to give states the authority to address the issue. Generally, state insurance regulators support legislation allowing states the flexibility to protect consumers from excessive out-of-network charges. Regulators have shown a willingness to regulate how air ambulance carriers are paid, participate in networks, balance bill, and make information transparent to consumers.

RELEVANT AMA POLICY

Policy H-285.904 includes principles related to unanticipated out-of-network care and states that patients must not be financially penalized for receiving unanticipated care from an out-of-network provider, insurers must meet appropriate network adequacy standards, and patients seeking emergency care should be protected under the “prudent layperson” legal standard. Similarly, Policy D-130.975 advocates that insurers pay for EMTALA services regardless of in-network and out-of-network status.

Policy D-130.989 states that legislation and regulation should be used to require all health payers to cover emergency services. Policy H-130.970 promulgates principles on access to emergency services and states that all physician and health care facilities have an ethical and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. Importantly, the policy notes that health plans should educate enrollees regarding the appropriate use of emergency facilities. Similarly, Policy H-130.954 supports the education of physicians and the public about the costs of inappropriate use of emergency patient transportation systems and encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care. Moreover, Policy H-130.970 states that all health plans should be required to cover emergency services provided by physicians and hospitals to plan enrollees without regard to prior authorization or the emergency care physician’s contractual relationship with the payer. The policy also encourages states to enact legislation holding health plans and third-party payers liable for patient harm resulting from any restrictions on the provision of emergency services. Policy D-130.975 similarly states that all insurers should be required to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of network status.

Policy H-240.978 supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term “appropriate facility” to allow full payment for transport to the most appropriate facility based on the patient’s needs and the determination made by physician medical direction. The policy goes on to state that the AMA will work with CMS to pay emergency medical service providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

To promote the safety of emergency medical service helicopters, Policy D-130.967 highlights the importance of the Federal Aviation Administration’s Helicopter Medical Service Operations and Safety Alert for Operators and its role as a critical component of Helicopter Emergency Medical Services in assuring the safety of patients and medical providers. The policy goes on to advocate that its members contract with or implement a Helicopter Emergency Medical Service that is
compliant with risk reduction systems/programs established in standards set forth in the Federal Aviation Administration’s Helicopter Medical Service Operations and Safety Alert for Operators.

DISCUSSION

Air ambulances serve to reduce the transit time for critically ill patients in emergent circumstances. Due to the nature of air ambulance services, patients typically have little or no choice over their mode of transportation and the provider of such transportation and can face significant air ambulance bills.

To address the appropriate provision of emergency care and consistent with ethical delivery of care, the Council recommends amending Policy H-130.954 not only to support the education of physicians and the public, but also first responders, about the costs associated with inappropriate use of emergency patient transportation systems and encouraging the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Many aspects of the air ambulance market and the extent patients are balance-billed are unclear due to lack of available data. There is a void in data on ownership, revenue, and service capabilities. Similarly, data on the costs to provide service, the number of transports, and provider information are not readily available. For example, it is unclear whether price increases are tied to market concentration or whether providers adjust prices to receive sufficient revenue from private insurance to account for lower-paid transports, such as those paid for by Medicare. Moreover, there is evidence that in markets with predominantly hospital-owned air ambulance providers, patients are balance-billed at lower rates and face lower costs. However, because these data cannot be verified at this time, the Council believes it is most appropriate to support increased data collection and data transparency of air ambulance providers and services, particularly increased price transparency. Subsequently, the Council recommends supporting consumer disclosures that include price variation among air ambulance providers and the potential limits of insurance coverage.

As previously discussed, the ADA preempts state-level regulation of air ambulance prices, routes, and services. Due to a profound void in air ambulance data, the Council believes that calling for an amendment to the ADA is premature. Before such a recommendation could even be considered, the Council believes that requisite information is needed on air ambulance command and control practices as well as additional data to determine the root cause of the issue at hand, and whether it is a result of market failure or other causes. Therefore, the Council strongly calls for additional data collection and transparency on air ambulances and sees merit in working with relevant stakeholders to evaluate the ADA as it applies to air ambulances.

The AMA believes that access to affordable emergent health care services must be preserved and strengthened. In that spirit, the Council recommends supporting the sharing of industry best practices among stakeholders across various regions. The Council’s recommendations build upon the AMA’s work to improve safe and affordable air ambulance access and protect patients in life-threatening emergencies.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:
1. That our American Medical Association (AMA) amend Policy H-130.954, "Non-Emergency Patient Transportation Systems," by addition as follows:
   The AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients. (Modify Current HOD Policy)

2. That our AMA support increased data collection and data transparency of air ambulance providers and services to the appropriate state and federal agencies, particularly increased price transparency. (New HOD Policy)

3. That our AMA work with relevant stakeholders to evaluate the Airline Deregulation Act as it applies to air ambulances. (New HOD Policy)

4. That our AMA support stakeholders sharing air ambulance best practices across regions. (New HOD Policy)

5. That our AMA rescind Policy D-130.964, which directed the AMA to conduct the study herein. (Rescind AMA Policy)

Fiscal Note: Less than $500.
REFERENCES

3 Supra note 1.
7 Supra note 1.
9 Supra note 1.
10 Id.
12 Supra note 1.
14 Id.
15 Id.
EXECUTIVE SUMMARY

At the American Medical Association (AMA) 2017 Interim Meeting, the House of Delegates referred Resolution 813, “Sustain Patient-Centered Medical Home Practices,” which was introduced by the Michigan delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2018 Interim Meeting. Resolution 813-I-17 asked (1) that our AMA amend Policy H-160.918 to urge the Centers for Medicare & Medicaid Services (CMS) to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources; and (2) encourage CMS to subsidize the cost of sustaining Patient-Centered Medical Home (PCMH) designated practices.

The Council believes that primary care and the PCMH are bedrocks of high-quality, patient-centered health care. However, in order to make the transition to a PCMH, practices of all sizes and settings must have the support to confront the challenges of practice transformation. The Council notes that cultural and financial obstacles of becoming a PCMH are substantial and demand significant investment and buy-in. To that end, the Council recommends a set of recommendations recognizing that it is critical to not only have financial support during the initial stages of practice transformation, but also to maintain ongoing funding and continuous cultural and monetary support for PCMH activities.
At the American Medical Association (AMA) 2017 Interim Meeting, the House of Delegates referred Resolution 813, “Sustain Patient-Centered Medical Home Practices,” which was introduced by the Michigan delegation. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2018 Interim Meeting. Resolution 813-I-17 asked:

(1) That our American Medical Association (AMA) amend Policy H-160.918, “The Patient-Centered Medical Home,” by addition as follows:

Our AMA:

a. Will urge the Centers for Medicare & Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;

b. Will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;

c. Will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule; and

d. Will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home; and

(2) That our AMA work with and encourage CMS to subsidize the cost of sustaining Patient-Centered Medical Home designated practices for practicing physicians.

This report provides background on Patient-Centered Medical Homes (PCMHs), outlines the costs of sustaining a PCMH, discusses the various payment methodologies employed with the model, provides an example of a PCMH, outlines relevant AMA policy and AMA advocacy efforts, and proposes policy recommendations.
BACKGROUND

The PCMH is a team-based practice that is led by a personal physician who provides continuous and coordinated care throughout a patient’s lifetime to maximize health outcomes. The PCMH model emphasizes population management, team-based care, and care management, particularly for at-risk patients with the objective of having a centralized setting that facilitates partnerships between individual patients, their physicians, and, when appropriate, the patient’s family. The PCMH encompasses five functions and attributes: comprehensiveness, patient-centered, coordinated, accessibility, and quality and safety. Evidence suggests that PCMHs improve quality, the patient experience and staff satisfaction, while reducing health care costs.

While recognizing the utility of specialty care medical homes, the Council chose to limit the scope of this report to PCMHs. Improving and investing in primary care has become a major health policy objective, and, for many patients, primary care services are their entry point into the health care system. As such, primary care is well positioned to help address the fragmentation in the health care system and optimize the delivery of health care. Moreover, the Council believes that primary care physicians are the touchstone of the physician-led health care team and are the gateway to health care.

Building a PCMH requires hard work from all stakeholders including physicians, practice teams, patients, and institutional partners. It requires time, money, dedication, sustained effort, and a cultural shift.

COST OF SUSTAINING A PCMH

Identifying the costs of maintaining PCMH functions can contribute to effective payment reform and sustainability of transformation. The costs for a practice to implement these PCMH services vary depending on factors such as practice size, existing capabilities, characteristics of the patient population, and availability of low-cost or funded resources.

Generally, the most significant cost to sustaining a PCMH is the ongoing cost of maintaining personnel. A recent study assessed the direct personnel costs to 20 primary care practices that differed in PCMH recognition status, ownership, payer mix, and patient populations. The study looked into the practice costs associated with the staffing necessary to deliver PCMH functions per the National Committee for Quality Assurance (NCQA) Standards. The NCQA is the most widely adopted PCMH recognition program. The study looked at 20 differing primary care practices in Utah and Colorado and found that the incremental costs per full-time equivalent primary care clinician associated with PCMH functions varied across practices with an average of $7,691 per month in Utah practices and $9,658 in Colorado practices. Also, the study found that PCMH incremental costs per encounter were $32.71 in Utah and $36.68 in Colorado. The average estimated cost per member per month for an assumed panel of 2,000 patients was $3.85 in Utah and $4.83 in Colorado. In addition to finding that the staffing and care coordination requirements of a PCMH could have an average incremental cost of $8600 per month, the study found that smaller practices may be particularly susceptible to increased costs.

Additional insight on practice transformation costs may be gleaned from the traditional cost of electronic health record implementation. According to an extensive study of EHR implementation in Texas-based primary care practices that were not PCMHs, it is estimated that the first-year cost of implementation is about $162,000 with about $86,000 in maintenance expenses for a five-physician practice. This figure is likely a significant underestimate of the costs and challenges of
implementing a medical home. Similar implementation and maintenance costs have been reported across the country including in Massachusetts and New York City.

Moreover, a recent RAND study found that overall PCMH transformation costs are likely anywhere between $83,829 and $346,603 per year and that practice transformation could take several years. Further, the report found that the costs per clinician ranged from $18,585 to $93,856, with ongoing median costs at $147,573 per practice and nearly $65,000 per clinician.

PCMH PAYMENT

PCMHs are a care delivery concept rather than a defined payment model and do not have a defined payment structure. However, many PCMH payment models have similarities. For example, PCMHs often receive payment based on an established fee schedule and supplemental payments for care coordination. The structure of PCMH payment is intended to support and promote practice activities that traditionally do not qualify for payment such as e-mail and phone communications, care coordination, and workflow changes. Therefore, the supplemental payments may be adjustment payments for traditionally non-reimbursed care management services. Other models’ supplemental payments are simply additional lump sum payments to incentivize care management. Other models use a capitation-based payment that may include enhanced payment to support medical home activities. Additionally, many models participate in shared savings.

EXAMPLES OF A PCMH

Comprehensive Primary Care Initiative

The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer CMS PCMH initiative intended to strengthen primary care. In initiating CPC, CMS recognized concerns that primary care has been traditionally underfunded and that sufficient payment is critical for the practice-wide changes needed to transform primary care. CPC launched in 2012, and in the ensuing years of the program CMS has partnered with commercial and state health insurance plans to offer population-based care management and shared savings opportunities to participating primary care practices to support the delivery of CPC functions.

A recent study that looked at the cumulative results of CPC over four years found that CPC practices reported improved primary care delivery, such as care management for high-risk patients, enhanced access, and improved coordination after care transitions. Moreover, CPC slowed growth in emergency department visits by two percent and hospitalizations by two percent relative to the comparison group. Importantly, CPC fostered substantial local collaboration wherein payers and practices came together to collectively work on solutions. This has signaled a paradigm shift wherein payers are now working together in communities to build primary care capacity, and some payers are funding community resources such as data aggregation to drive success. All CPC regions are sharing the lessons learned and best practices to drive further innovation.

In 2015, the CPC initiative generated $57.7 million in gross savings for Medicare Parts A and B. Moreover, over half of the participating CPC practices shared in savings of over $13 million. In addition to generating overall savings, practices in the CPC program exhibited improvement in quality measures including a lowering of hospital admissions and readmission rates. Stakeholders believe that CPC demonstrates the potential for primary care clinicians to redesign their practices to deliver better care to patients and improved outcomes to patients.
However, despite decreased utilization and improved outcomes, CPC did not reduce Medicare spending enough to cover care management fees or appreciably improve physician or beneficiary experience or practice performance on a limited set of Medicare claims-based quality measures. Comprehensive Primary Care Plus (CPC+), which qualifies as an advanced alternative payment model (APM), was built on the CPC structure and is a five-year PCMH model that launched in 2017 in 14 regions across the country. While CPC practices had to achieve savings in total cost of care for their state, CPC+ practices have to achieve good performance on metrics such as reducing ambulatory care sensitive admissions. CPC+ has two tracks. One track is for practices building medical home capabilities, and the second track is for those practices that are already delivering advanced primary care. Moreover, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended to the Secretary of Health & Human Services a proposal developed by the American Academy of Family Physicians (AAFP) for Advanced Primary Care, and the AMA supported this proposal. There is now a second round of CPC+ which expanded the program to more regions.

CPC+ provides primary care practices with up-front and improved payment in addition to technical assistance. Its payment components de-emphasize fee-for-service (FFS) and increase payment to support practice improvement and delivery transformation. Both CPC+ tracks offer three payment components. The first component is a care management fee (CMF) paid per-beneficiary-per-month. The CMF is paid prospectively on a quarterly basis and is based on the complexity of the patient population. The second component is a performance-based incentive payment (PBIP) that is received as a prospective payment at the beginning of each program year in order to meet patient needs and build practice capacity. At the end of the year, if practices do not meet the quality and cost benchmarks, they will repay some or all of the PBIP. The third component is a payment under the Medicare fee schedule. Track 1 practices continue to receive FFS payments while Track 2 practices receive a hybrid payment with a prospective portion paid quarterly called the Comprehensive Primary Care Payment (CPCP) coupled with a reduced FFS payment. The CPCP and FFS payments taken together are larger than the practice’s historical FFS payment.

CareFirst

In 2011, a PCMH program operated by CareFirst BlueCross BlueShield launched, which is the largest coordinated care program of its kind. The program is structured around groups of primary care providers organized into panels of between five to fifteen physicians. These physicians are grouped together to coordinate the care of CareFirst members with the most pressing health care needs, and how the panels operate is largely up to them. As teams, panels are eligible to earn Outcome Incentive Awards that are paid as increases to their fee schedules based on the level of quality and the savings achieved against projected costs.

Recognizing that coordinated care often involves services that are not typically compensated under traditional insurance arrangements, CareFirst’s PCMH provides for an across-the-board 12 percentage point increase in compensation for primary care services. Additionally, the insurer also pays physicians $200 per patient to develop care plans for high-risk patients and $100 for every time a care plan needs to be updated.

Importantly, the program is designed to appeal to solo and small group practices. CareFirst understands that the needed investments, particularly IT investments, to create and maintain a PCMH are often cost-prohibitive to physicians in solo or small practice arrangements. Therefore, the program provides physicians with access to all necessary IT to participate in the PCMH. Additionally, CareFirst has dedicated more than 100 nurses across the region to help coordinate care and ensure that the program runs smoothly.
Over the course of the program, it has lowered the expected cost of care for CareFirst members by nearly $1.2 billion. In 2017 alone, the CareFirst PCMH helped save $223 million against the expected cost of care. The savings was largely driven by reductions in hospital admissions and the length of hospital stays. Since the program’s inception, all CareFirst members experienced 21.3 percent fewer hospital admissions; 22.5 percent fewer emergency department visits; and 7.8 percent fewer days in the hospital.

AMA POLICY

Relevant to the subject of this report, Policy H-160.918 addresses the financial aspects of the PCMH model. It urges CMS to work with the AMA and national medical specialty societies to enhance care coordination among providers who provide medical care for patients outside the medical home and urges CMS to assist physician practices seeking to qualify for medical home status with financial and other resources. Specifically, Policy H-160.918 calls for Medicare incentive payments associated with the medical home model to be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule. Moreover, it calls for all health plans and CMS to use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.

Policy H-160.919 articulates principles of the PCMH and adopts the Joint Principles of Patient-Centered Medical Homes developed and endorsed by primary care societies including the American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, and AAFP, among others. The organizations initially developed these principles to emphasize the patient-physician relationship, physician leadership of a care team and physician responsibility for care coordination, supported by other qualified providers. The policy states that payment should appropriately recognize the added value provided to patients who have a PCMH. The policy calls for the AMA to recognize the value of physician work associated with remote monitoring of patients and clinical data and states that PCMH payment models should allow for separate payments for face-to-face visits. Consequently, Policy H-160.919 supports physician payments that reflect the value of care management work outside of the face-to-face visit and calls for additional payments for achieving measurable and continuous quality improvements and supports a structure for shared savings. The policy promotes a voluntary recognition process for medical homes and supports integrated care across all elements of the health care system. It advocates for quality and safety, patient-centered outcomes, evidence-based decision making, physician engagement in achieving medical outcomes and utilization of information technology (IT). Further, the policy also advocates for access to care through systems such as open scheduling, expanded hours and new options for communicating with patients.

Policy H-450.931 supports the move to APMs and calls for the AMA to provide physician practices with support and guidance in the transition. Policy H-385.908 calls for the AMA to work with organizations to improve the availability and use of health IT, including continuing to expand technical assistance and developing IT systems that support and streamline clinical participation. Policy H-385.908 also urges CMS to limit financial risk to costs that physicians participating in APMs have the ability to influence or control.

AMA ACTIVITY

The AMA continues to work to assist physicians with the requirements and incentives contained in the Medicare Access & CHIP Reauthorization Act (MACRA), which includes the development and
successful implementation of PCMHs. The AMA has been active in educational activities including webinars and regional conferences for physicians and staff and will be continuing these activities. Recent AMA advocacy activity has called for improvements in the methodologies behind APMs to reduce practice barriers and enable more physicians to participate. The AMA has urged CMS to enhance proposals that provide credit for and promote medical homes and APMs. Therefore, the AMA has repeatedly advocated for CMS to extend the CPC+ model nationwide for all of Medicare. Further, the AMA has called for an increase in medical home flexibility and to expand medical home eligibility to specialty medical homes. Additionally, the AMA has called for the lower financial risk requirements available for patient-centered primary care medical homes to be extended to specialty medical homes. Moreover, the AMA continues to advocate for proper risk adjustment in APMs and has urged CMS to prevent stringent two-sided risk requirements from being extended to primary care medical homes serving vulnerable populations, such as children with Medicaid coverage.

Additionally, the AMA is advocating for PCMHs to earn more credit in the Merit-Based Incentive Payment System (MIPS). PCMHs can be recognized by a variety of organizations and have this recognition count as their Improvement Activity under MIPS. However, because the Improvement Activity score is only weighted at 15 percent of the total score so it does not count for a significant percentage of overall score. However, the AMA has advocated that practices that go to the effort of transforming to PCMHs should be able to utilize their PCMH status for more credit in MIPS.

AMA advocacy efforts are also focused on the 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 APM proposals to help address challenges they face in APM design. Additionally, the AMA convenes workshops and a workgroup to bring together many of the leading physicians who are working on PFPM proposals to discuss potential solutions to these issues.

In its advocacy efforts, the AMA has highlighted that some practices are effectively doing the work of the PCMH but are not being compensated for its activities or recognized because the certification process is arduous and expensive. To that end, the AMA has advocated for CMS to recognize programs that accredit medical homes based on the advanced primary care functions, including state-based, payer-sponsored, and regional medical home recognition programs. Moreover, the AMA has stated that physicians should not be required to pay a third party accrediting body to receive recognition as a PCMH. Recognition or certification by an accrediting body may not necessarily capture the actual advanced primary care functions.

**DISCUSSION**

The value of primary care is often underemphasized relative to other parts of the health care system. However, payers and other stakeholders are increasingly recognizing the need to strengthen primary care and to help reduce overall health care costs and improve care quality. Accordingly, the Council recommends reaffirming Policy H-160.919 that contains principles of the PCMH including that payment should appropriately recognize the added value provided to patients who have a PCMH and the additional physician and team work associated with participating in a PCMH. The Council also recommends reaffirming Policy H-385.908 stating that physicians should only be held responsible for costs that they can reasonably control.

Additionally, recognizing that flexibility is integral to ensuring that PCMHs are designed in ways that improve care for patients and are feasible for physicians to implement, the Council recommends rescinding Part 4 of Policy H-160.918, which states that the AMA will advocate that
all health plans and CMS use a single standard to determine whether a physician practice qualifies
to be a PCMH because the AMA has continued to support increased medical home flexibility.
Rescinding this section of the policy would support flexibility in practices to implement medical
home functions with methods best suited for their practice designs and patient populations.

As Resolution 813-I-17 recognizes, adequate compensation for ongoing and incremental costs is
critical for practices to sustain PCMH functions. Not only are the costs of implementation and
maintenance significant, but also, care innovations such as telemedicine that increase access and
improve care quality also may be expensive. Therefore, the Council recommends advocating that
all payers support medical home transformation and maintenance efforts recognizing that payer
support is crucial to the long-term sustainability of delivery reform. Similarly, the Council believes
many stakeholders have a role to play in assisting PCMHs and thus recommends encouraging
health agencies, health systems, and other stakeholders to support and assist medical home
transformation and maintenance efforts. The Council believes that these stakeholders have a critical
role to play in supporting PCMHs financially, with technical assistance, and culturally by
increasing awareness of the PCMH and improving patient education.

Primary care and the PCMH are acknowledged as bedrocks of high-quality, patient-centered health
care. However, in order to make the transition to a PCMH, practices of all sizes and settings must
have the support to confront the challenges of practice transformation. The cultural and financial
obstacles of becoming a PCMH are substantial and demand significant investment and buy-in. It is
critical to not only have financial support during the initial stages of practice transformation but
also to maintain ongoing funding and continuous cultural and financial support for PCMH
activities.

The Council recognizes that both PCMHs and specialty care medical homes play an increasingly
important role in an evolving payment and delivery system. As such, the Council will continue to
monitor primary care and specialty medical homes.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-160.919 that contains
   principles of the Patient-Centered Medical Home (PCMH) including that payment should
   appropriately recognize the added value provided to patients who have a PCMH and the
   additional physician and team work associated with participating in a PCMH. (Reaffirm HOD
   Policy)

2. That our AMA reaffirm Policy H-385.908 urging that financial risk should be limited to costs
   that physicians have the ability to influence or control. (Reaffirm HOD Policy)

3. That our AMA amend Policy, H-160.918, “The Patient-Centered Medical Home,” by addition
   and deletion as follows:

   Our AMA:
   a. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA
      and national medical specialty societies to design incentives to enhance care coordination
      among providers who provide medical care for patients outside the medical home;
b. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources; and

c. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule; and

d. will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home. (Modify Current HOD Policy)

4. That our AMA advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform. (New HOD Policy)

5. That our AMA encourage health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care. (New HOD Policy)

Fiscal Note: Less than $500

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22 Schilling, Brian. As CareFirst Tweaks the Medical Home, Doctors Flock and Costs Dip. The Commonwealth Fund. Available at: https://www.commonwealthfund.org/publications/newsletter/carefirst-tweaks-medical-home-doctors-flock-and-costs-dip
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25 Id.
26 Supra note 18.
REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-18)
The Site-of-Service Differential
(Resolution 817-I-17)
(Reference Committee J)

EXECUTIVE SUMMARY

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program’s use of separate payment systems in its rate-setting calculations. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care settings, including the offices of physicians and other health professionals, hospital outpatient departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be provided across multiple clinical settings, and although the choice of outpatient site for many services has no discernible effect on patient care, it significantly impacts Medicare’s payment for such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates for outpatient services performed in hospital facilities than to physician offices or ASCs for furnishing the same service to similar patients. The scope of the payment differential varies, depending on the procedure.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, explains how Medicare determines payments for outpatient services in each setting, compares Medicare physician payment updates to inflation, and summarizes relevant American Medical Association (AMA) policy and activity. The Council recommends reaffirmation of existing AMA policy as well as new policy addressing the site-of-service differential. The Council recommends that the AMA support Medicare payment policies for outpatient procedures that are site-neutral without lowering total Medicare payments. The Council further recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

While the focus of this report is the site-of-service differential, the Council recognizes that broader physician payment issues must also be addressed. To help build the case for future Medicare payment reforms that support site-neutrality without lowering total Medicare payments, the Council recommends that the AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.
At the 2017 Interim Meeting, the House of Delegates referred Resolution 817-I-17, “Addressing the Site of Service Differential,” introduced by the New Mexico Delegation, for report back at the 2018 Annual Meeting. The Board of Trustees assigned this item to the Council on Medical Service. Resolution 817-I-17 asked the American Medical Association (AMA) to:

1) Study the site-of-service differential with a report back no later than the 2018 Interim Meeting, including: a) the rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) the increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) the expense of maintaining hospital-based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) the methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges; and

2) Advocate for a combined health care payment system for patients who receive care that is paid for by the Centers for Medicare & Medicaid Services (CMS), that: a) follows the recommendation of MedPAC to pay “site-neutral” reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (OPPS) or the Physician Fee Schedule (PFS); b) pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

This report describes ongoing disparities in Medicare payment for outpatient procedures across care settings, summarizes relevant AMA policy and activity, and presents policy recommendations addressing the outpatient site-of-service differential.

BACKGROUND

The site-of-service differential is a longstanding payment policy issue stemming from the Medicare program’s use of more than a dozen separate payment systems—some of which are based on the location where services are provided—in its rate-setting calculations. Several of these payment systems base payments on the location where services are provided. This report addresses disparities in Medicare Part B payment for covered items and services across outpatient care.
settings, including the offices of physicians and other health professionals, hospital outpatient
departments (HOPDs), and ambulatory surgical centers (ASCs). Most outpatient procedures can be
provided across multiple clinical settings, and although the choice of outpatient site for many
services has no discernible effect on patient care, it significantly impacts Medicare’s payment for
such services and patient cost-sharing expenses. Generally speaking, Medicare pays higher rates
for outpatient services performed in hospital facilities than to physician offices or ASCs for
furnishing the same service to similar patients. The scope of the payment differential varies,
depending on the procedure, and in some cases may be difficult to ascertain because units of
payment differ across payment systems. Furthermore, the payment differential may extend beyond
primary services to entire episodes of care. One analysis found that payments for cardiovascular
imaging, colonoscopy, and evaluation and management services are higher when furnished in
HOPDs, and that the higher payments extend to related services provided to patients as part of
episodes of care associated with these procedures. The variations in payment persisted after
controlling for patient demographic and severity differences, thereby attributing a substantial
portion of the pay disparities to the payment systems themselves.

The Council previously studied aspects of the site-of-service differential—and confirmed that
Medicare payments for many procedures are higher when furnished in HOPDs—during the
Council Report 3-A-13 compared Medicare payments for five common procedures performed
across outpatient settings, and built upon the AMA’s substantial policy supporting site neutrality by
encouraging private payers to incentivize outpatient care delivery in lower-cost settings. Council
Report 3-A-14 found that existing Medicare payment formulas have contributed to growth in the
volume of outpatient services provided in hospitals and hospital-owned facilities, even when these
services can be safely performed in lower-cost settings. Council Report 3-A-14 focused primarily
on equalizing payments between HOPDs and ASCs because payments to these settings are based
on the same Medicare payment system (OPPS), with ASCs paid at lower rates. Developing policy
addressing payment disparities between hospital-owned facilities and independent physician
practices is more complex because, under current statute, the rate-setting for items and services in
these outpatient sites is based on separate Medicare payment systems that calculate payments for
different units of service.

Medicare Payment Rates for Off-Campus Provider-Based Hospital Departments

For many years, higher payments to HOPDs likely incentivized the sale of physician practices and
ASCs to hospitals because acquired facilities meeting certain criteria (eg, located within 35 miles
of the hospital) were routinely converted to HOPDs and allowed to charge higher OPPS rates for
services performed at these off-campus facilities. However, a provision in the Bipartisan Budget
Act of 2015 (BBA) disallowed provider-based billing by hospitals for newly acquired physician
practices and ASCs. The Congressional Budget Office estimated in 2015 that this provision would
save $9.3 billion over 10 years. Beginning in 2017, off-campus entities acquired after enactment
of the BBA—in November 2015—were no longer permitted to bill for services under the OPPS,
and instead required to bill under the applicable payment system (PFS). Since 2017, CMS has paid
for services at non-excepted off-campus provider-based hospital departments using a PFS relativity
adjuster that is based on a percentage of the OPPS payment rate. Currently, CMS regulations
stipulate that these services be paid 40 percent of OPPS payment rates, although provider-based
departments acquired prior to November 2015 continue to bill under the OPPS. In July 2018, CMS
proposed extending site-neutral payments to include clinic visits provided at off-campus provider-
based hospital departments acquired prior to November 2015, that were excepted from the BBA
provision. CMS proposed to reduce payment rates for clinic visits at hospital-owned physician
practices located off the hospital campus from $116 with $23 cost-sharing to $46 with $9 cost-sharing. At the time this report was written, the CMS proposal had not been finalized.

Hospital Employment of Physicians

It is possible that Medicare payment reductions for services provided at off-campus provider-based hospital departments acquired after November 2015 have contributed to a leveling off of hospital acquisitions of physician practices. Data from the AMA’s 2012, 2014, and 2016 Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week, demonstrate recent stability in the ownership structure of physician practices. Analyses of the surveys found that the share of physicians who worked directly for a hospital or in practices that were at least partially owned by a hospital remained unchanged between 2014 and 2016—at 33 percent. This percentage represented an increase from 29 percent in 2012. Although detailed information on practice ownership structure is not available for years prior to 2012, research suggests that in 2007-2008, only 16 percent of physicians worked directly for a hospital or in practices that were at least partially owned by a hospital.

Medicare Payment Systems for Outpatient Services

The separate methodologies used for rate-setting under the OPPS and the PFS are at the root of the outpatient site-of-service differential (see Table 1). Under current law, Medicare’s payment systems do not account for the fact that many outpatient services can be provided safely and at lower cost to Medicare and patients outside of the hospital setting. Because there is no linkage between OPPS and PFS payment systems, Medicare may pay dramatically different rates for the same services based on whether they are provided in hospital facilities or physician offices.

<table>
<thead>
<tr>
<th>Site</th>
<th>Physician Office</th>
<th>Hospital Outpatient Department</th>
<th>Ambulatory Surgical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment System</td>
<td>Physician fee schedule (non-facility rate)</td>
<td>Physician fee schedule (facility rate) plus OPPS rate</td>
<td>Physician fee schedule (facility rate) plus ASC payment system (based on relative weight under the OPPS)</td>
</tr>
<tr>
<td>Basis for Updates</td>
<td>Medicare Access and CHIP Reauthorization Act (MACRA)</td>
<td>Hospital market basket</td>
<td>Consumer price index for all urban consumers</td>
</tr>
<tr>
<td>Unit of Payment</td>
<td>Individual service</td>
<td>Ambulatory payment classification</td>
<td>Ambulatory payment classification</td>
</tr>
</tbody>
</table>

For services furnished in physician and other practitioner offices, Medicare pays for units of service billed under the PFS. There is a single payment for each service which amounts to 80 percent of the PFS rate, with the patient responsible for cost-sharing that covers the remaining 20 percent. For procedures provided in hospital outpatient departments, Medicare pays a reduced physician fee under the PFS plus a facility fee established under the OPPS. Patients are responsible for cost-sharing associated with both the physician fee and the facility fee. Whereas providers generally receive separate payments for each service under the PFS, services paid under the OPPS
are grouped together into ambulatory payment classifications based on clinical and cost similarities.

Formulas unique to each payment system are then used to annually adjust payment rates for inflation, which may actually widen existing payment disparities. HOPD updates are based on the hospital market basket, and annual updates to the PFS were established by MACRA. The Medicare program currently uses the consumer price index for all urban consumers (CPI-U) to annually update ASC payment rates, although—consistent with AMA policy—CMS recently proposed updating ASC rates using the hospital market basket instead of the CPI-U for a five-year period. If this proposal is finalized, CMS will examine whether the change incentivizes a migration of services to lower-cost ASC settings over the five-year period.

**Medicare Physician Payment Updates Compared to Inflation**

Medicare payments for physician services have for many years failed to keep pace with the actual costs of running a practice. From 2001 to 2017, Medicare physician pay rose just six percent (0.4 percent per year on average), although Medicare’s index of inflation in the cost of running a practice increased 30 percent (1.7 percent per year on average). Economy-wide inflation, as measured by the Consumer Price Index, has increased 39 percent over this time period. If adjusted for inflation in practice costs, Medicare physician pay has declined 19 percent from 2001 to 2017, or by 1.3 percent per year on average.

During the same time period, Medicare hospital pay has increased roughly 50 percent, with average annual increases of 2.6 percent per year for inpatient services, and 2.5 percent per year for outpatient services. Medicare skilled nursing facility pay has increased 51 percent between 2001 and 2017, or 2.6 percent per year. There are some significant differences between hospitals and physician practices that may lead to higher costs of providing care in HOPDs. For example, hospitals maintain operations 24/7, and also standby capacity for handling emergencies, although payment for standby costs is included in Medicare’s payment for emergency department services.

**Uncompensated/Inadequately Compensated Physician Practice Expenses**

The need for sustainable physician payments under the Medicare program is compounded by numerous uncompensated administrative tasks that are extremely costly to practices and reduce time spent with patients, yet increase the work necessary to provide medical services. CMS alone publishes thousands of pages of regulations affecting physician practices every year, including rules governing the reporting of quality measures, the Recovery Audit Contractor (RAC) Program, MACRA implementation, and Medicare’s numerous payment systems. Utilization management has become so burdensome that in 2017 the average physician reported completing 29 prior authorizations per week, a process that required 14.6 hours of work or the equivalent of two business days. In addition to navigating a plethora of payer protocols and utilization management requirements, physician practices have to purchase, manage and update electronic health records (EHRs) to document the care they are providing. Incorporating EHR technology into practice workflows is costly and consumes a significant amount of physician time that could otherwise be spent with patients. Notably, a 2016 *Annals of Internal Medicine* study found that, for every hour of clinic time spent with patients, physicians spend approximately two hours per day during office hours, and another one to two hours outside of office hours, on EHR and desk work. According to a 2016 *Health Affairs* study, physician practices across four common specialties spend over $15.4 billion annually to report quality measures, with physicians on average spending 2.6 hours per week on these measures. Many physician practices also provide high-technology outpatient
services (ie, infusions and/or imaging) that were once the domain of hospitals and for which practices are not adequately compensated under the PFS.

Hospitals that treat a disproportionate share of low-income patients receive additional payments to offset the financial effects of treating these patients. Traditionally, disproportionate share hospital (DSH) payments were based on hospitals’ share of Medicaid patients and Medicare patients with Social Security Disability Insurance. Beginning in 2014, DSH payments were calculated as 25 percent of that payment amount, and hospitals also began receiving uncompensated care payments from a pool of funds equal to 75 percent of the DSH payment received under the traditional formula, minus an amount that increases in proportion to decreases in the uninsured population. Part of this pool is distributed to hospitals based on the share of uncompensated care they provide. Physician practices are not eligible for either DSH or uncompensated care payments, despite the fact that most physicians (89 percent) treat Medicare patients and, in 2016, most also had Medicaid (82.6 percent) and uninsured (75.6 percent) patients. There have been questions as to whether Medicare DSH and uncompensated care payments are appropriate proxies for the amount of uncompensated care provided by hospitals, and Medicare Payment Advisory Commission (MedPAC) has recommended that uncompensated care payments to hospitals be based on actual uncompensated care data.

**Expert Policy Recommendations for Reducing Payment Variations**

To address shifts in outpatient care to higher cost sites-of-service (eg, hospital-owned facilities), which increase costs to the Medicare program and its patients, several policy options have been proposed to equalize payments across settings for certain services. After the MedPAC found that payments to HOPDs for 15-minute evaluation and management visits were 80 percent higher than payments to physician offices for the same service, it recommended in 2012 that HOPD payments for these services be reduced to physician office rates. In 2014, MedPAC recommended that differences in payment rates between HOPDs and physician offices be eliminated by reducing HOPD rates for 66 ambulatory payment classifications. These groups of services were selected by MedPAC based on patient severity being similar in HOPDs and physician offices, and because they are frequently furnished in physician offices.

A 2011 RAND Health analysis examined several policy options for addressing Medicare payment differentials across outpatient sites, such as increasing uniformity in the units of service across payment systems, and basing payment rates on the least costly setting. This analysis concluded that basing payment differentials on justifiable cost differences would promote payment equity across outpatient sites-of-care and value-based care, but would also be administratively burdensome. Determining justifiable cost differences would also be impractical.

The Office of the Inspector General (OIG) has also recommended reductions in HOPD payment rates to those of less costly settings, and has even recommended pursuing legislative changes to OPPS budget neutrality provisions so that payment rates to HOPDs could be reduced without offsetting those reductions with payment increases. Several administrations have also proposed equalizing payment variations via budget proposals, and President Trump’s budget published in February 2018 proposed applying physician office rates to all hospital-owned physician offices located off the hospital campus. As stated previously, CMS has proposed extending site-neutral payments to include clinic visits provided at off-campus hospital-owned facilities.

It is clear that most of the policy options identified to date have recommended leveling the site-of-service playing field by reducing payment rates to the amounts payable in the least costly outpatient setting. Although CMS has not implemented the MedPAC or OIG recommendations, in
2014 the agency identified approximately 200 services for which physician office payments were higher than HOPD or ASC rates and proposed lowering physician fees for these services. Most experts, including MedPAC, believe that Medicare payments to physician offices, HOPDs and ASCs will continue to be based on the program’s current payment systems for the foreseeable future. The combined payment system called for in the second resolve of Resolution 817-I-17 would require legislative changes that would face significant obstacles in a Congress that is hamstrung by partisanship and budgetary concerns. Opponents, including hospitals and other stakeholders whose payment rates would be affected, are likely to counter that physicians’ facility costs are already covered through the practice expense component of the PFS.

Moreover, convincing Congress to redesign Medicare’s payment systems would be extremely difficult. Given existing pressures to reduce health care costs, there is also a risk that advocating for a combined payment system could encourage Congress or CMS to design a system that lowers payments to all providers and/or does not provide relief for independent physician practices. CMS could also choose to impose the OPPS payment system, on which HOPD and ASC payments are based, on physician practices. Doing so would mean that units of service currently paid separately under the PFS would be grouped together into an ambulatory payment classification, which is the unit of payment under the OPPS.

### Updating Physician Practice Expenses Paid under the PFS

Alternatively, the Council considered requesting that CMS update the inputs used to calculate the indirect practice expense component of the PFS, which is analogous to OPPS facility fees and which is based in part on 10-year-old survey data that no longer reflect current practice arrangements or the relative costs of running a practice. Updated data are urgently needed to ensure that practice expenses under the PFS more accurately reflect the costs to physician practices of furnishing office-based services. However, it is important to recognize that any practice expense changes under the current system will need to be budget neutral.

Payments under the PFS are required by statute to be based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service. In brief, RVUs are established for work, practice expense, and malpractice expense categories, which are adjusted for geographic cost variations. These values are multiplied by a conversion factor to convert the RVUs into payment rates. Statutory budget neutrality provisions require that annual adjustments to the RVUs that increase by more than $20 million must be offset by cuts in other RVUs or through a cut in the conversion factor.

CMS establishes separate facility-and nonfacility-based practice expense RVUs for services furnished in facility settings (eg, HOPD or ASC) and in nonfacility settings (eg, physician offices). Facility-based RVUs are generally lower than nonfacility-based RVUs, so that HOPDs and ASCs receive facility payments under the OPPS whereas physician offices receive a facility fee under the PFS. Nonfacility practice expense RVUs are intended to reflect all of the direct and indirect practice expenses associated with furnishing a service in a physician office.

Direct expenses include cost inputs related to clinical labor, medical equipment and supplies. Indirect expenses include administrative labor, rent, billing services, and other office-related expenses that cannot be directly attributed to a service. In its proposed rule for CY 2019, CMS proposed updated pricing recommendations for 2,017 supply and equipment items currently used as direct practice expense inputs. The proposal is based on a report from a CMS contractor that used market research resources and methodologies to determine the updated prices. As described in the following section, survey data are used by CMS to determine the indirect practice expenses
incurred per hour worked.\textsuperscript{25} Each procedure is then assigned practice expense RVUs that are supposed to reflect the practice expenses required to provide the service relative to those required to provide other procedures.

The need for accurate data on practice costs is significant, considering many of the points raised in Resolution 817-I-17. Physician practices have experienced significant increases in practice expenses due to cumbersome regulations, quality measure requirements, EHRs (purchases, software upgrades, ongoing support and maintenance), complex payment and utilization management protocols, costly equipment used to provide, for example, imaging or infusions, and other costs that have changed dramatically since practice expense survey data was collected a decade ago. It may also be challenging for many independent and small group practices to accurately determine their total practice expenses when completing surveys about the costs of running a practice.

\textit{The Physician Practice Information Survey (PPI Survey)}

In 2010, CMS began basing indirect practice expenses on the PPI Survey, a multispecialty, nationally representative survey of both physicians and non-physician practitioners paid under the PFS that was administered by the AMA over a period of time in 2007 and 2008. The PPI Survey collected data from 3,656 respondents across 51 medical specialties and health care professional groups.\textsuperscript{26} Participating practices were asked to fill out expense worksheets that itemized expenses such as payroll, supplies and equipment. They were also asked about the costs of managing a practice, charity care, time spent on quality improvement activities, and the acquisition, operating and maintenance costs associated to EHRs. PPI Survey data were used by CMS to confirm the accuracy of PFS practice expense data. As required by statute, CMS uses medical oncology supplemental survey data from 2003 for practice expenses per hour for oncology drug administration services. For specialties that did not participate in the PPI Survey, CMS develops proxy practice expense values by crosswalking practice expense data from specialties providing similar services.\textsuperscript{27}

Section 220 of the Protecting Access to Medicare Act of 2014, allocates funds for CMS “…to collect and use information on physicians’ services in the determination of relative values in the formulae for setting physician’s fees.”\textsuperscript{28} The AMA/Specialty Society RVS Update Committee and other entities have encouraged CMS to use these funds to conduct an updated survey on practice expense data. Even CMS has expressed concerns regarding the accuracy of the outdated data used to determine practice expense RVUs but, lacking other sources, the agency continues using PPI Survey data to inform physician payments under the PFS. The collection of physician practice expense data is a necessary first step which will enable comparisons to hospital cost and payment metrics and provide insight into the costs of care provided in hospital-owned and independently-owned practices.

AMA POLICY

The AMA has substantial and long-standing policy supporting equitable payments across outpatient sites of service. Policy H-240.993 calls for equity of payment between services provided by hospitals on an outpatient basis and similar services in physicians’ offices. AMA policy also supports defining Medicare services consistently across settings and encouraging the CMS to adopt payment methodologies that assist in leveling the playing field across all sites of service (Policy D-330.997).
Policy H-330.925 encourages CMS to fairly pay physicians for office-based procedures and adopt a site-neutral payment policy for hospital outpatient departments and ambulatory surgical centers; advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; advocates that in place of the CPI-U, CMS use the hospital market basket index to annually update ASC payment rates; and encourages the use of Current Procedural Terminology (CPT) codes across all sites of service as the only acceptable approach to payment methodology.

Policy H-400.957 encourages CMS to expand the extent and amount of reimbursement for procedures performed in the physician office, to shift more procedures from the hospital to the office setting, which is more cost effective, and to seek to have practice expense RVUs reflect the true cost of performing office procedures. Policy H-400.966 directs the AMA to aggressively promote the compilation of accurate data on all components of physician practice costs, and the changes in such costs over time, as the basis for informed and effective advocacy concerning physician payment under Medicare.

Policy D-240.994 directs the AMA to work with states to advocate that third-party payers be required to assess equal or lower facility coinsurance for lower-cost sites of service; publish and routinely update pertinent information related to patient cost-sharing; and allow their plan’s participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. Furthermore, AMA policy urges private third-party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently owned outpatient facilities with respect to payment of facility costs (Policy H-240.979). 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, do not require budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to cover the full cost of sustainable medical practices.

AMA ACTIVITY

Enhancing Practice Efficiency and Promoting Physician Satisfaction

A strategic focus area within the AMA is working diligently to help physicians succeed in a rapidly changing health care environment. From advancing health care delivery and payment reforms that promote affordable care to restoring and preserving physician professional satisfaction, the AMA is driving practice transformation by translating regulatory requirements into actionable information; developing and disseminating practice improvement strategies and tools; establishing national benchmarks for physician burnout, leading to organizational level changes; and producing evidence-based research. To accelerate advancements in—and support for—physician and care team well-being, the AMA sponsors conferences that bring top investigators and thought leaders together to debate and advance health policies.

Encouraging Value-Based Payment

The AMA has been working for several years to encourage the development and implementation of Medicare payment models that will improve the financial viability of physician practices in all specialties, and help independent practices of all sizes remain independent; give physicians more resources and greater flexibility to deliver appropriate care to their patients; minimize administrative burdens that do not improve the quality of patient care; enable physicians to help control aspects of health care spending that they can influence, rather than having Medicare use inappropriate mechanisms to control costs such as payment cuts, prior authorization or non-
coverage of services. Since the passage of MACRA, the AMA has been accelerating its efforts to
help national medical specialty societies and other physician organizations to develop, refine and
implement alternative payment models (APMs) that will achieve these goals. Ideally, payment
under these models should extend across sites of care.29 AMA policy (Policy H-385.913)
recognizes that APMs should provide adequate resources to support the services physician
practices need to deliver to patients. The AMA has urged the US Department of Health and Human
Services to reconsider testing a number of APMs as recommended by the Physician-Focused
Payment Model Technical Advisory Committee.30

Improving Price Transparency

As the health care market evolves, patients are increasingly becoming active consumers of health
care services rather than passive recipients of care in a market where price is often unknown until
after the service is rendered. Achieving meaningful price transparency can help lower costs and
empower patients to make informed care decisions, including decisions about where to receive
certain outpatient services. Many patients may not be able to readily distinguish between hospital-
owned and independent practices, and may not understand how choice of outpatient setting impacts
their cost-sharing expenses. The AMA supports measures to expand the availability of health care
pricing information that allows patients and their physicians to make value-based decisions when
patients have a choice of provider or facility.

DISCUSSION

The AMA has long supported and advocated for fair, equitable and adequate Medicare payments
across outpatient sites of service, as well as payment policies that support value-based care and
encourage use of the most cost-effective care setting. The policy priority established by the Council
in previous reports addressing the site-of-service differential has been to ensure patient access to
services in the most clinically appropriate setting, depending on their needs and the severity of their
conditions. While an HOPD may be the appropriate setting for certain medically complex patients,
the migration of many services from physician offices to hospital-owned facilities is of significant
concern not only because of increased costs to the Medicare program, but also because it has
become increasingly difficult for practices in certain specialties to remain competitive or even
sustain operations because of declining payment rates and the increased costs to practices of
dealing with regulatory and administrative burdens. The Council continues to be concerned for
independent physician practices, and for Medicare patients who incur higher cost-sharing expenses
for outpatient services provided in hospital facilities whose care could have been safely provided in
lower-cost settings. The Council believes that policy proposals addressing the site-of-service
differential must be patient-centric and ensure adequate payment that supports the costs of
providing high-quality, high-value physician services.

Accordingly, the Council recommends reaffirming four existing policies that guide AMA advocacy
regarding the site-of-service differential: Policy H-240.993, which calls for equity of payment
between services provided by hospitals and similar services provided in physician offices; Policy
D-330.997, which supports defining Medicare services consistently across settings and
encouraging CMS to adopt payment policies that assist in leveling the playing field across all sites
of service; Policy H-400.957, which encourages CMS to expand the extent and amount of payment
for procedures performed in physician offices, to shift more procedures from the hospital to the
office setting, and to seek to have practice expense RVUs reflect the true cost of performing office
procedures; and Policy H-400.966, which promotes the compilation of accurate physician practice
cost data as the basis for informed and effective advocacy concerning Medicare physician payment.
Building on these policies, the Council recommends that the AMA support Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. This policy recommendation enables ongoing AMA advocacy in support of site-neutral payments while at the same time seeking solutions that do not simply lower payments for services to amounts paid to the least costly setting. The Council is mindful that there is the potential for physicians to be adversely affected as Congress and the Administration promote site-neutrality based solely on cost as a means of reining in health care spending.

The site-of-service differential impedes the provision of high-value care because it incentivizes payment based on the location where a service is provided. Payment should be based on the service itself, and not the location where it is provided. Accordingly, the Council recommends that the AMA support Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the real costs of providing the service in each setting.

After extensive exploration of the “combined health care payment system” described in the second resolve of Resolution 817-I-17, the Council concludes that the practice expense component of the PFS is analogous to the facility fee paid under the OPPS, and that the valuation of the practice expense component needs to be updated to accurately reflect the costs of running a practice. The Council further believes that if physicians are paid a facility fee as called for in the second resolve, that fee is likely to be smaller than the current one and might not make up for the probable elimination of the practice expense differential in the current system. Rather than seeking the statutory changes to implement a combined payment system that pays facility fees for both hospital-owned and independent physician practices—which would be extremely challenging to accomplish in a Congress hamstrung by partisanship and a trillion-dollar deficit—the Council recommends urging CMS to update the data used to calculate the practice expense component of the PFS. The Council believes that CMS should conduct a survey similar to the PPI Survey to confirm the accuracy of practice expense data, given the many changes that have occurred since the survey was administered in 2007 and 2008, and that this survey should be administered every five years to ensure that timely data are used to inform PFS calculations. The Council believes that CMS should collect data to ensure that all physician practice costs are captured. Examples of data that must be collected by CMS include administrative and other costs that cannot be directly attributed to a service, costs of managing the practice, costs of providing uncompensated care, costs of navigating payer protocols and utilization management requirements, costs of purchasing, managing and updating EHRs, and costs related to quality measures and improvements.

Advocating for regular ongoing collection of physician practice expense data that more accurately reflect the costs of sustaining a practice is a viable option that could be impactful in the nearer term although, under Medicare’s current system, PFS payments would be redistributed rather than increased overall. The updated data could be used to help measure differences in the costs of providing services in physician offices and hospital settings, and would inform future AMA advocacy on broader payment reforms.

To address concerns regarding the methodology used for DSH and uncompensated care payments to hospitals and the care provided by many physicians for which they are not fully compensated, the Council recommends that the AMA encourage CMS to both: a) base DSH and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.

While the focus of this report is the site-of-service differential, the Council recognizes the need to address broader physician payment issues. The Council further recognizes that achieving site-
neutral payments for outpatient procedures will require increases in Medicare payment for
physician services so that physician practices can be sustained and patient choice of care setting is
safeguarded. To help build the case for future Medicare payment reforms, the Council recommends
that the AMA collect data and conduct research both: a) to document the role that physicians have
played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the
Medicare budget allocated to physician services that more accurately reflects practice costs and
changes in health care delivery.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-240.993, which urges more
   aggressive implementation by the US Department of Health and Human Services of existing
   provisions in federal legislation calling for equity in payment between services provided by
   hospitals on an outpatient basis and similar services in physician offices. (Reaffirm HOD
   Policy)

2. That our AMA reaffirm Policy D-330.997, which encourages the Centers for Medicare &
   Medicaid Services (CMS) to define Medicare services consistently across settings and adopt
   payment methodology for hospital outpatient departments (HOPDs) and ambulatory surgical
   centers (ASCs) that will assist in leveling the playing field across all sites-of-service. (Reaffirm
   HOD Policy)

3. That our AMA reaffirm Policy H-400.957, which encourages CMS to expand the extent and
   amount of reimbursement for procedures performed in the physician office, to shift more
   procedures from the hospital to the office setting, which is more cost effective, and to seek to
   have practice expense relative value units reflect the true cost of performing office procedures.
   (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-400.966, which directs the AMA to aggressively promote the
   compilation of accurate data on all components of physician practice costs, and the changes in
   such costs over time, as the basis for informed and effective advocacy concerning physician
   payment under Medicare. (Reaffirm HOD Policy)

5. That our AMA support Medicare payment policies for outpatient services that are site-neutral
   without lowering total Medicare payments. (New HOD Policy)

6. That our AMA support Medicare payments for the same service routinely and safely provided
   in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on
   sufficient and accurate data regarding the real costs of providing the service in each setting.
   (New HOD Policy)

7. That our AMA urge CMS to update the data used to calculate the practice expense component
   of the Medicare physician fee schedule by administering a physician practice survey (similar to
   the Physician Practice Information Survey administered in 2007-2008) every five years, and
   that this survey collect data to ensure that all physician practice costs are captured. (New HOD
   Policy)
8. That our AMA encourage CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. (New HOD Policy)

9. That our AMA collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (Directive to Take Action)

Fiscal Note: $100,000 to $200,000
REFERENCES

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3 Congressional Budget Office. Estimate of the Budgetary Effects of HR 1314, the Bipartisan Budget Act of 2015, as reported by the House Committee on Rules on October 27, 2015. Available at: https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr1314.pdf.
4 Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare program; Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. Federal Register. July 27, 2018.
10 Ibid.
16 Ibid.
21 Office of Inspector General. Medicare and Beneficiaries Could Save Billions if CMS Reduces Hospital Outpatient Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates. April 2014.
22 Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Medicare program: Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2018; Medicare shared savings program requirements; and Medicare diabetes prevention program. Final rule. Federal Register 82, no. 219 (November 15).
23 Ibid.
24 Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. Medicare program: Revisions to payment policies under the physician fee schedule and other revisions to Part B for CY 2019; Medicare shared savings program requirements; Quality payment program; and Medicaid promoting interoperability program. Federal Register. July 27, 2018.
25 Ibid.
27 Ibid.
EXECUTIVE SUMMARY

The Council on Medical Service and the Council on Science and Public Health present this joint report to expand upon prior studies of access to and coverage for preventive services and other high-value health care services. A factor mitigating patient concerns about the cost of preventive care is the Affordable Care Act’s (ACA) requirement that health plans cover select preventive services without any patient cost-sharing (zero-dollar). The ACA requirement of coverage for select preventive services without cost-sharing has been a popular and successful step in promoting access to preventive care, but more could and should be done to facilitate and incentivize high-value care. Value-Based Insurance Design (VBID) is a potential partial solution consistent with long-standing American Medical Association (AMA) policy. This report highlights the utilization of preventive services under ACA’s mandated zero-dollar coverage, key challenges posed by the ACA mandated coverage, legal and regulatory obstacles, examples of how VBID has been used successfully to better align incentives for high-value care, and opportunities for expanded use of VBID.

The Councils recommend reaffirmation of existing AMA policy, as well as new policy to promote alignment of clinical and financial incentives for high-value care. Building on AMA policy regarding VBID, the Councils recommend that the AMA support: VBID plans designed in accordance with the tenets of “clinical nuance;” implementing innovative VBID programs in Medicare Advantage plans; and legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services, and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services. To enhance the effectiveness of VBID, the Councils recommend that the AMA support initiatives to align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform. Additionally, recognizing the critical role that physicians of all specialties should play in shaping effective VBID programs, the Councils recommend that the AMA encourage national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

In addition, the Councils recommend three ways to protect and improve access to zero-dollar preventive care. First, the Councils recommend that the AMA continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing on patients. Second, the Councils recommend that the AMA develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding regarding what will be covered at given cost-sharing levels. Finally, the Councils recommend that the AMA develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.
The Council on Medical Service and the Council on Science and Public Health present this joint report to expand upon prior studies of access to and coverage for preventive services and other high-value health care services. The Councils decided to pursue this report in light of: (a) the confusion among provider, patient, and payer communities in paying for preventive services; and (b) a common goal of improving affordable access to “high-value” services (as described below).

One factor mitigating patient concerns about the cost of preventive care is the Affordable Care Act’s (ACA) requirement that health plans cover select preventive services without any patient cost-sharing (zero-dollar). The Councils previously considered preventive services in the Council on Medical Service and Council on Science and Public Health Joint Report at the 2017 Annual Meeting, “Value of Preventive Services.” As detailed in the A-17 report, the ACA required all private, non-grandfathered health insurance plans to provide zero-dollar coverage for the preventive services recommended by four expert organizations: the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Women’s Preventive Services Initiative, and Bright Futures. The report also described the varied methods used by those four organizations for developing preventive service guidelines. The report established Policy H-460.894, which encouraged those organizations to develop their recommendations with transparency, clarity and specificity. Given the significant challenges that have arisen as the health care industry strives to provide zero-dollar coverage for the expert organizations’ recommendations, further study was warranted to explore additional policy options for promoting access to preventive interventions.

The ACA requirement of coverage for select preventive services without cost-sharing has been a popular and successful step in promoting access to preventive care, but more could and should be done to facilitate and incentivize high-value care. Value-Based Insurance Design (VBID) is a potential partial solution consistent with long-standing American Medical Association (AMA) policy. This report highlights the utilization of preventive services under ACA’s mandated zero-dollar coverage, key challenges posed by the ACA-mandated coverage, legal and regulatory obstacles, examples of how VBID has been used successfully to better align incentives for high-value care, and opportunities for expanded use of VBID. Finally, this report makes several policy recommendations.
BACKGROUND

Health care affordability is determined not just by the cost of insurance coverage (e.g., the premium), but also by the amount of cost-sharing required (e.g., deductibles, co-payments, and coinsurance). The median level of liquid assets among nonelderly American households was below the cost-sharing requirements of many health insurance plans and significantly below the maximum out-of-pocket limits allowed for private insurance in 2016, indicating potential challenges, especially for families with low incomes and/or significant medical bills.

Concerns about the cost of care have caused some Americans to delay or skip necessary health care. In a recent poll (n=1,302), more than a third of Americans indicated that they made health care decisions in the past year based on costs, including 44 percent who reported not going to the doctor when they were sick or injured, 40 percent who reported going without a routine physical or other preventive care, 40 percent who reported skipping a medical test or treatment, and 32 percent who reported either not filling a prescription or taking less than the prescribed dose.

Patients and physicians alike encounter a dilemma when an ACA-designated preventive service that is provided without patient cost-sharing identifies early stage illness, and subsequent medical interventions can impose significant out-of-pocket costs on patients. At the same time, such interventions can be characterized as “high-value” care -- they potentially minimize human suffering, maximize the opportunity for beneficial medical intervention, save the health care system the costs of treating advanced disease, and save society the costs of losing productive individuals. Inherently, “high-value” care is subjective and challenging to define -- the same service can be life-saving for one patient and over-treatment for another patient. Accordingly, rather than restricting “high-value” care with one specific definition, experts explain that the key is for the health care system to embrace the concept that not all care provides equal value. It is not necessary for all to agree which services must always be considered “high-value.” Instead, simply building consensus around some selected services and aligning payer, provider, and patient incentives around those services is beneficial. This report explores opportunities to identify high-value care, some of the ways in which incentives are currently misaligned, methods already being used successfully to promote more optimal alignment, and policy recommendations to advance progress in this space.

SUCCESSES AND CHALLENGES IN IMPLEMENTING THE ACA PREVENTIVE SERVICES BENEFITS

The ACA’s mandated zero-dollar coverage for select preventive services enjoys strong bipartisan support. A recent poll found that the ACA provision eliminating out-of-pocket costs for certain preventive services was favored by 83 percent of Americans (n=1,202) surveyed, including 89 percent of Democrats, 83 percent of Independents, and 77 percent of Republicans. Prior to the ACA it was estimated that Americans received only about half of the preventive services that are recommended. While it is estimated that 71 million Americans received expanded coverage of one or more preventive services in 2011 and 2012 as a result of the ACA, studies examining the utilization of preventive services over a limited time horizon post-ACA have found mixed results. For example, among adults (age 18 to 64), the ACA was associated with an increase in physicians’ provision of preventive cardiovascular services, including the use of diabetes screening, tobacco use screening, hypertension screening, and aspirin therapy in men. It was also associated with increases in up-to-date rates of routine checkups and flu vaccinations. However, changes in blood pressure checks, cholesterol checks, and certain cancer screenings were not associated with the ACA. A review of studies focused on the ACA’s impact on cancer screening found mixed results. While studies indicated that some cancer screening (pap smear test, mammography, and colorectal
cancer screening) did not increase post-ACA implementation, other studies found statistically significant increases in earlier diagnosis of certain cancers associated with Medicaid expansion and parents’ ability to maintain insurance coverage for their children up to age 26. Multiple studies also have found evidence of substantial positive impacts among low-socioeconomic status groups and groups subject to high cost-sharing prior to the ACA. While such initial studies are informative, additional research across longer time horizons is necessary to fully understand the impact of the ACA benefit that removed cost-sharing for select preventive services on utilization and health outcomes.

Similarly, even with cost-sharing barriers removed, additional barriers to provision of preventive services still exist and may include inconsistently applied definitions of key terminology, limited knowledge of preventive service guidelines, and limited time with patients. For example, the classification of a service as “screening,” “diagnostic,” or “therapeutic” can be unclear. Some of this confusion can be traced back to legal definitions of “preventive care.” As explored in greater detail below, preventive care takes on legal significance in the context of health savings accounts (HSAs) associated with eligible high deductible health plans (HDHPs), as these plans generally cannot cover medical items or services until the deductible is met. A preventive care safe harbor via Section 223(c)(2)(C) of the Internal Revenue Code provides an exception to this rule for certain preventive care. However, preventive care is not clearly defined by law. Given the significant inconsistency and confusion that persists when referring to preventive services, this report will avoid use of the commonly confused terms. Additionally, patients are not familiar with the preventive services that are available to them without cost-sharing. Three and half years after the ACA took effect, less than half the population (43 percent) reported being aware that the ACA eliminated out-of-pocket expenses for preventive services.

Underinsurance & Cost-Related Non-Adherence (CRN): While increasing access to health insurance has been beneficial to patients, it is nevertheless critical to recognize the challenges posed by underinsurance and CRN. Rates of underinsurance – defined as out-of-pocket costs that are high relative to income – have risen, with 13 percent of adults underinsured in 2005, and 28 percent of adults underinsured in 2016. Even when a service is covered by a health plan, patients may incur significant costs in the form of co-payments, coinsurance, and/or large medical bills that they must pay before meeting their deductible. Such costs have been shown to cause people, especially those in low-income and vulnerable populations, to forgo not only unnecessary but also necessary care. In fact, as little as a $10 rise in co-payments has been associated with a significant decline in outpatient visits and a concurrent increase in hospital utilization among an elderly population. Similarly, CRN refers to a state in which patients are unable to pursue recommended medical care due to financial barriers. Sub-optimal use of evidence-based medical services can lead to negative clinical outcomes, increased disparities, and in some cases, higher aggregate costs. CRN has been identified across the entire continuum of clinical care -- physician visits, preventive screenings, prescription drugs, etc. -- and it is especially problematic for vulnerable populations, such as those with multiple chronic conditions, and for socioeconomically and racially disparate populations. For example, greater out-of-pocket costs for medication to treat certain chronic conditions has been found to reduce initiation and adherence, lower the likelihood of achieving desired health outcomes, and sometimes, increase utilization of acute care services. At the same time, studies have demonstrated that reducing or eliminating cost-sharing leads to improvements in medication adherence and reductions in socioeconomic and racial disparities.

Both underinsurance and CRN can be exacerbated in the context of the rising prevalence of HDHPs. HDHPs are insurance plans associated with lower premiums, higher deductibles and greater cost-sharing requirements as compared with traditional health plans. An HDHP is frequently combined with a personal health account, a combination referred to as a “consumer-
A personal health account can either be a HSA or health reimbursement arrangement (also known as a health reimbursement account or HRA). HSAs are tax-free accounts used to pay for qualified medical expenses, and they must be paired with an HDHP. HRAs are employer-funded accounts used to reimburse employees for qualified medical expenses. HRAs need not be paired with an HDHP. While employees can keep unspent money in an HSA and accumulate savings from year to year, unspent HRA funds are forfeited to the employer at the end of a calendar or benefit year. Enrollment in HDHPs by individuals younger than 65 years who have private health insurance has increased sharply – from 25.3 percent of the population studied in 2010, to 47.0 percent in the first three months of 2018. Moreover, the size of deductibles has increased dramatically. In 2003, only one percent of adults enrolled in a private plan had a deductible of $3,000 or more, but by 2016, that percentage rose to 13. HDHPs appear to reduce health care costs by decreasing the use of both appropriate care (such as recommended cancer screenings) and inappropriate care (such as low-severity emergency department visits). Greater consumer cost-sharing is frequently used as a lever to minimize the growth of health insurance premiums. Studies have found that families who have members with chronic disease and who are enrolled in HDHPs are more likely to go without care due to cost and/or face substantial financial burdens, such as trouble paying bills, than families enrolled in traditional plans. Another study found that enrollment in an HDHP, combined with an HRA or HSA, led to significant increases in out-of-pocket spending, with more than half of the enrollees with lower-incomes and more than one-third of the enrollees with chronic conditions facing “excessive financial burden.”

At the same time, patients’ deductibles are only a fraction of their total out-of-pocket spending. Once coinsurance and co-payments are also factored in, a recent study of individuals enrolled in large employer health plans (n=between 1.05 and 15.3 million per year) found that total out-of-pocket spending rose by 54 percent between 2006 and 2016, from an average of $525 in 2006 to an average of $808 in 2016. Moreover, individuals in the top 15 percent of health spenders (who account for 79 percent of total health spending), had out-of-pocket costs averaging $2,837 in 2016. Exacerbating this challenge is the fact that while out-of-pocket health care costs have been rising in recent years, wages have been relatively stagnant.

In light of these significant financial concerns, it is especially important that patients understand the availability of certain preventive services without any cost-sharing. Moreover, as described later in this report, efforts are underway to remove legislative and regulatory barriers to innovative insurance plan designs that could better align incentives around high-value services.

Coding, Billing, and Payment Challenges: The mismatch between the clinical intent of expert organizations’ evidence-based recommendations and the ACA’s mandated insurance coverage of recommended preventive services has added complexity to billing and payment practices, sometimes resulting in unexpected, and perhaps unintended, patient cost-sharing. Some specific challenges include:

- When a patient receives a designated preventive service, a private health insurance plan may still impose cost-sharing if: (1) the provider bills the services and the visit separately; or (2) the preventive service was not the primary purpose of the visit. Moreover, guidance is not clear regarding who determines what constitutes the primary purpose of a visit.
- If the expert organization does not specify the “frequency, method, treatment or setting” for a service, private health plans may use “reasonable medical management techniques” and “the relevant evidence base” to shape coverage/coverage limitations.
- A private health plan may impose cost-sharing for treatment that is needed subsequent to a designated preventive service.
• Certain USPSTF recommendations apply only to “average risk” or certain “high-risk” populations. As a result, only those patients are entitled to receive the preventive service without cost-sharing. Federal guidance has clarified that the designation of “high-risk” is left to the attending provider. However, it can be unclear how a health plan is to know when a service was provided to a patient who is entitled to the service at no cost-share. Current Procedural Terminology (CPT) modifier 33 can be used when billing for ACA-designated preventive services. The addition of modifier 33 communicates to a commercial payer that a given service was provided as an ACA preventive service. While modifier 33 does not apply to Medicare patients, the CPT modifier was developed to indicate that a colonoscopy that was scheduled as a screening was converted into a diagnostic or therapeutic procedure. Nevertheless, review of the literature indicates that confusion and inconsistency persist among providers and payers in coding and paying these claims and may be contributing to the misaligned expectations observed throughout the health care industry.

• It is unclear what state and federal systems are in place to monitor and ensure enforcement of the ACA requirements. Even if individuals know they are entitled to receive certain preventive services without cost-sharing, they may not know how to seek redress if they are charged for these services.

EXPANDING ACCESS TO HIGH-VALUE SERVICES

In addition to the implementation challenges described above, patients and physicians find themselves challenged when findings from a zero-dollar preventive service lead to very expensive subsequent medical care. Furthermore, preventive interventions not designated by ACA that are deployed to prevent significant morbidity may be associated with significant patient cost-sharing. Accordingly, health plan financial incentives for patients do not always support the goal of proactively managing medical risk and preventing serious morbidity.

The juxtaposition of legitimate patient financial concerns and the high value of many preventive interventions highlights significant misalignment of clinical and financial incentives that pervades our health care system. While designation by expert organizations of preventive services to be provided without cost-sharing is a start, an initial designated service may be insufficient to achieve broader clinical goals. Instead, subsequent necessary steps can require significant financial outlays by the patient. In these cases, the clinical impact of a recommended service may not fulfill its potential if patients are unable to follow through on their physicians’ guidance due to financial barriers. Several of the current system’s misaligned incentives are illustrated below.

Misaligned Incentives – More Invasive Services: For clinical and economic reasons, it can make sense to promote less expensive, less-invasive screening as a first step, and progress to invasive tests when medically indicated. However, the current system sometimes incentivizes the opposite, when lower cost-sharing levels sometimes apply to more expensive, more invasive procedures. For example, consider a primary care physician who wants to follow the USPSTF’s recommendation and encourage a 55 year-old patient to receive colorectal cancer screening. The physician discusses the recommendation with the patient, and the patient refuses to receive a colonoscopy (citing fear of the bowel preparation, fear of anesthesia, etc.). The physician and the patient agree that for this patient, Cologuard®, a non-invasive stool test, is an appropriate initial method of screening. The Cologuard® is provided to the patient without cost-sharing. However, when the results of the Cologuard® are positive, the physician advises that a colonoscopy is necessary to complete the colorectal cancer screening. While this colonoscopy would have been provided without cost-sharing had it been chosen as the first screening method, a colonoscopy that follows a positive stool test sometimes results in imposition of a significant cost-sharing burden on the patient. The
potential cost burden, in addition to the patient’s already established concerns regarding colonoscopy, may dissuade the patient from completing the screening process.

Misaligned Incentives – Individual Risk Factors: In striving to prevent advanced disease, physicians often identify individual risk factors that subject their patients to a greater than average risk of various diseases. Some may be at higher risk for breast cancer, and others at higher risk for diabetes, and some may be at heightened risk for multiple serious diseases. Ideally, financial incentives would encourage patients to receive high-value services that are most likely to help them as individuals, and prioritize those over services that are less aligned with their individual risk profile. However, under our current health care system, individuals at heightened risk can be precluded from cost-sharing incentives for some high-value services.

For example, the USPSTF recommends breast cancer screening mammography for asymptomatic women who are not at high risk for breast cancer. Women at high risk include those who have preexisting breast cancer, a previously diagnosed high risk breast lesion, a known underlying genetic mutation (such as a BRCA1 or BRCA2 gene mutation or other familial breast cancer syndrome), or a history of chest radiation at a young age. A biannual mammogram will be free of cost-sharing to a woman at average risk. However, women who are at heightened risk, who need the test most frequently, and for whom the test may more often be positive, must share in often significant costs. While screening mammography is not provided without cost-sharing to patients at increased risk for breast cancer, the USPSTF recommends that “for women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.” Thus, a patient at increased risk for breast cancer may receive risk-reducing medications without cost-sharing, but must share in the costs of mammography.

Misaligned Incentives – Detection vs. Monitoring, Treatment, and Continuing Prevention: When physicians choose to screen their patients for a given disease, their goal is not to simply provide a diagnosis, but rather to help their patients manage risk and promote long-term health. Under our current health care system, risk can be identified without cost-sharing, but the management of that risk can burden patients with significant financial costs.

For example, the USPSTF recommends that fair skinned young adults, adolescents, children, and parents of young children receive counseling regarding minimizing exposure to ultraviolet radiation to reduce their risk of skin cancer. Counseling would be covered without patient cost-sharing. However, consider a situation where the counseling primary care physician refers a fair skinned young adult to a dermatologist for a visual skin examination. A visual skin exam by a dermatologist may help prevent or detect skin cancer. However, the USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of visual skin examinations by clinicians and whether such exams reduce skin cancer-related morbidity and mortality. A visual skin exam conducted by a dermatologist would likely result in patient cost-sharing, which may be significant, especially if the patient has not yet met their plan deductible. If the dermatologist decides to biopsy a mole, the procedure and pathology may incur significant cost-sharing for the patient. If the biopsy indicates early stage malignancy, removing the mole may prevent serious morbidity, but it may result in substantial additional cost-sharing. Finally, to ensure that subsequent disease is prevented and/or eradicated before it becomes invasive, a treating physician would want to incentivize this patient to practice on-going preventive habits such as purchasing and utilizing sunscreen and committing to follow-up visits with a dermatologist. However, since the purchase of sunscreen and dermatologist visits are outside the scope of the USPSTF, these valuable items and services will impose significant lifetime costs on the patient.
One can anticipate how similar misaligned incentives pervade our current system, in attempts to prevent morbidity from cancer, mental illness, and many other chronic diseases. For example, the USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Moreover, the USPSTF encourages clinicians to offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. However, an array of evidence-based services to prevent onset of diabetes (e.g., community health worker diabetes prevention programs (DPPs) and combined diet and physical activity promotion programs) and/or to prevent disease advancement and morbidity (e.g., insulin to keep blood glucose well-managed, regular eye and foot examinations, etc.) are outside the scope of the ACA’s mandated zero-dollar benefit and subject to significant patient cost-sharing. While studies have found savings of approximately $1,300 for every Medicare Advantage (MA) patient who completed a diabetes education program, insured patients may, due to cost-sharing, expend hundreds of dollars to participate. Consider this in the context of the finding, described above, that even a $10 increase in co-payments has been associated with a significant decline in outpatient visits and a concurrent increase in hospital utilization among an elderly population. Recognizing the value of prevention programs, some payers interpret the USPSTF recommendation broadly and/or develop a commitment to covering DPPs as an evidence-based preventive program that mitigates rising risk. Such payers, including commercial health plans, as well as some Medicare and Medicaid programs, offer DPPs as a preventive service without patient cost-sharing.

An additional facet of misaligned incentives arises when patients find themselves “penalized in the form of high cost-sharing simply because of their biology.” For example, consider patients with major depressive disorder. Some patients may respond well to generic medications that are subject to the lowest level of cost-sharing. Other patients, though, may not achieve the desired clinical outcome with the less expensive medication, and to prevent disease progression, those patients may require medication that is only available at a higher level of cost-sharing. This higher level of cost-sharing, however, can disincentivize medication initiation and adherence.

Consistent with long-standing AMA policy that promotes testing individuals and population groups only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified, high-value services clearly span a broad spectrum of care. Great value can be achieved by preventing adverse consequences that could arise from early stage or more advanced disease. The challenges in effectively describing “value” to optimally promote it through regulations contribute to the misaligned incentives observable across the spectrum of care.

VALUE-BASED INSURANCE DESIGN AS A METHOD FOR ALIGNING INCENTIVES AROUND HIGH-VALUE SERVICES

To ensure that people get the medical care they need, they must be able to afford treatment associated with identified risk factors and diagnosed disease. More Americans are afraid of the costs associated with a serious illness than of the illness itself. Accordingly, while zero-dollar screenings are a significant advance, health insurance must also provide access to affordable ongoing care for patients at higher risk for serious disease and/or advancement of existing disease.

Aligning Incentives Across Supply and Demand Sides: As outlined in Council on Medical Service (CMS) Report 9-A-16 and CMS Report 10-A-17 and consistent with Policy H-385.913, the AMA recognizes the continuing importance of alternative payment models (APMs) and the roles physicians should play in developing APMs. Provider-facing initiatives such as payment reform (including APMs), health information technology, and practice redesign operate on the supply side of the health care economic market. On the supply side, some financial incentives are aligned...
between payers and providers around quality metrics. The other critical piece of the health care
economic model, of course, is the consumer demand side, which includes health care literacy
programs, shared decision making, price transparency, and benefit design. With benefit design,
financial incentives are created between patients and third-party payers, and these incentives
impact what care patients will pursue. While both payment reform and benefit design may
theoretically be working toward the same goal of “quality” health care, unless those supply side
and demand side incentives are actually, intentionally aligned, it can be excessively and unfairly
challenging for patients, providers, and payers to achieve their shared goal of quality. For example,
a quality metric for primary care physicians may be the extent to which their patients’ blood
glucose is within an acceptable range. To help their patients manage uncontrolled blood glucose,
primary care physicians may wish to refer their patients to an endocrinologist and/or to a DPP.
However, if the patients’ insurance benefits impose significant cost-sharing for specialist visits
and/or for DPP enrollment, the patients may not have the financial means to follow through with
their primary care physicians’ advice. As a result of these misaligned incentives, the system may
face: (a) primary care physicians who cannot meet their quality metrics due to patient non-
compliance; (b) patients who forgo high-value care due to financial barriers and subsequently
become sicker; (c) employers that lose productivity due to employee illness; and (d) payers that
ultimately pay more money to care for sicker patients. Clearly, this is an avoidable result that
benefits no one. Accordingly, in considering actions that can be taken to improve access to high-
value care, it is imperative to look at both the supply side (payment reform) and the demand side
(benefit design) and ensure that both systems are designed to support each other and incentivize
consistent behavior across the health care economy. Moreover, services established as quality
metrics (eg, by the National Quality Forum or the National Committee for Quality Assurance) can
be strong examples of “high-value” services around which patient, provider, and payer financial
incentives could be aligned.

Value-Based Insurance Design (VBID): Health plans can apply VBID principles to design benefits
that reduce financial barriers to and incentivize use of high-value care. VBID was designated as a
federal policy priority in the ACA, and the AMA has long supported VBID, with the Council on
Medical Service issuing a report at the 2013 Annual Meeting that set forth principles to guide
implementation of VBID initiatives. As explained in CMS Report 2-A-13, traditional health
insurance benefit designs use patient cost-sharing primarily as a way to control health care costs. In
contrast, VBID uses cost-sharing as a tool to encourage the use of specific health care services
based on “value,” which is defined as the clinical benefit gained for the money spent. While
traditional benefit designs apply a standard set of cost-sharing requirements to all services and all
patients, VBID determines coverage and cost-sharing rules based on an assessment of the clinical
value of individual health care treatments or services. VBID plans vary patients’ out-of-pocket
costs, such as co-payments, coinsurance, and deductibles, based on the value of specific services.
Specifically, VBID plans are designed in accordance with the tenets of “clinical nuance,”
recognizing that (1) medical services may differ in the amount of health produced; and (2) the
clinical benefit derived from a specific service depends on the person receiving it, as well as when,
where, and by whom the service is provided.

Applying “clinical nuance,” health plans can address some of the misaligned incentives. Returning
to the example of a patient with uncontrolled blood glucose introduced above, to prevent
complications associated with diabetes, and to incentivize adherence to evidence-based measures, a
VBID plan may choose to reduce the cost-sharing associated with critical diabetes items or services
such as insulin therapy or vision exams. VBID principles can be applied to prescription drug
formularies according to a “reward the good soldier” or “step edit with co-pay relief” strategy. Under such models, if a patient tries a first-line lower-cost therapy, and that therapy proves to be
ineffective in achieving the desired clinical outcome for that patient, the patient would be able to
access an otherwise more expensive therapy at a lower cost-sharing level. A recent systematic literature review found that using a VBID approach to decreasing cost-sharing for targeted prescription drug classes was significantly associated with improved medication adherence, and limited evidence also indicated improvement in clinical outcomes and quality. Moreover, there was no effect on total health care spending, suggesting that the increased spending on prescription medication was offset by decreased spending on other medical items or services.

**VBID Program Expansion:** Currently, hundreds of private self-insured employers, public organizations, nonprofits, and insurance plans have designed and tested VBID programs, and VBID experts believe the design method has reached a “tipping point.” The recently enacted Bipartisan Budget Act of 2018 incorporates the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 and requires expansion of the Medicare Advantage Value-Based Insurance Design Model to all 50 states by no later than January 1, 2020. The model allows MA plans the flexibility to reduce cost-sharing or offer supplemental benefits to enrollees with specified chronic conditions, focusing on the services that are of highest clinical value to them.

In addition to the MA VBID model, the federal government continues to embrace VBID by supporting expanded application of VBID principles by public and private payers. The Centers for Medicare & Medicaid Services MA Final Rule for contract year 2019 provides greater flexibility around the MA uniformity requirement to allow for the implementation of VBID principles throughout the MA program. This flexibility gives MA plans new tools to improve care and outcomes for enrollees by allowing MA plans to reduce cost-sharing for certain covered benefits, offer specific tailored supplemental benefits, and offer different deductibles for beneficiaries who meet specific medical criteria. TRICARE is also working to improve health outcomes and enhance the experience of care for US Armed Forces military personnel, military retirees, and their dependents through VBID pilot programs. The 2017 National Defense Authorization Act (NDAA) commissioned a pilot program to demonstrate and test the feasibility of incorporating VBID into the TRICARE program, and the 2018 NDAA further incorporates VBID principles into the TRICARE Pharmacy Benefits Program.

Connecticut implemented a collectively bargained state-based VBID program for its state employees that is one of the first to apply VBID to not only prescription drugs, but to reduce cost-sharing for enrollees across the spectrum of care, including medical services for chronic diseases. Moreover, this Connecticut program both removed financial barriers to services known to be clinically valuable and instituted requirements that enrollees obtain certain preventive services, with the goal of encouraging enrollees to participate in their preventive and chronic disease care. Connecticut implemented its program in 2011, and early results were published in 2016. While more research is needed to inform optimal design of VBID plans, early evidence is encouraging. Highlights of the Connecticut model include:

- Enrollees overwhelmingly chose to enter and stay in the VBID plan. While participation in the plan was voluntary, first year enrollment exceeded 98 percent and about 98 percent of the enrollees were deemed compliant with the plan requirements at the end of each of the first two years of the program.
- There were significant gains in preventive office visits and nearly all of the targeted preventive screenings in both the first and second years of the program.
- The total number of emergency department visits without a resulting hospital admission decreased significantly in both the first and second years of the program.
- For the chronic diseases studied, there were significant increases in physician office visits and medication possession ratios, relative to a comparison group.
Connecticut’s experience suggests that payers considering VBID programs should proactively weigh the benefits of potentially improved health and productivity against the potential for higher costs that can be associated with increased use of high-value services. Connecticut’s program also highlights critically intertwined drivers of health care spending: (a) the majority of overall health care spending is dedicated to chronic disease; (b) most chronic diseases have evidence-based quality metrics; (c) evidence indicates suboptimal performance on those quality metrics; and (d) patient out-of-pocket spending is a significant contributor to underutilization of care. Other payers could replicate the Connecticut plan’s focus on chronic conditions.

Centers for Disease Control and Prevention (CDC) 6|18 Initiative: The CDC’s 6|18 initiative is another example of efforts underway to align purchasers, payers, and providers to improve health and control costs through increased coverage of evidence-based preventive interventions. The initiative focuses on preventing chronic and infectious disease by increasing coverage, access, utilization, and quality. The CDC is specifically targeting six common and costly health conditions – tobacco use, high blood pressure, health care-associated infections, asthma, unintended pregnancies, and diabetes. Eighteen evidence-based interventions have been identified as a starting point of discussions with purchasers, payers, and providers. The CDC is providing technical assistance to state Medicaid programs and public health departments to implement the prioritized interventions and to private payers to help them identify interventions that will help their beneficiaries.

Barriers to VBID Expansion: Obstacles will likely prevent optimal customization of VBID plans in the short-term, as there are significant administrative burdens associated with identifying which services are highest value for which plan beneficiaries. However, plans should be encouraged to experiment with innovative plan designs that implement discrete elements of VBID, and legislative and regulatory changes would facilitate this goal.

HSA-HDHPs are among the fastest-growing plan types in the United States, and while current Internal Revenue Service (IRS) regulations permit a “safe harbor” that allows for coverage of specified preventive services prior to satisfaction of the plan deductible, that safe harbor is significantly limited. IRS regulations state that clinical services meant to treat “an existing illness, injury, or condition” cannot be included in pre-deductible coverage. Thus, even if a health plan would like to develop an HSA-HDHP according to VBID principles, many essential clinical services used to manage chronic illness could not be covered in HSA-HDHPs before the entire deductible is met. However, when HSA-HDHP enrollees with existing conditions or risk factors are required to pay out-of-pocket for necessary services prior to meeting the plan deductible, the results can be lower utilization of care, potentially resulting in poorer health outcomes and higher costs.

VBID experts refer to a natural evolution from the current HSA-HDHP system to a “High-Value Health Plan” (HVHP) system that grants insurers the flexibility to provide pre-deductible coverage for high-value services across the spectrum of clinical care. Legislative and regulatory barriers should not prevent this evolution, and bipartisan efforts are underway to remove these barriers. The bipartisan, bicameral “Chronic Disease Management Act of 2018” (S.2410, H.R.4978) was introduced in February 2018, and if enacted, would permit HDHPs “to provide chronic disease prevention services to plan enrollees prior to satisfying their plan deductible.” VBID experts explain that this strategy would lower US health care expenditures and provide millions of Americans expanded plan options that better meet their clinical needs and contribute to their financial well-being. America’s Health Insurance Plans has also explained that this approach would improve the value of HSA-qualified plans for consumers and improve access to care for chronic conditions.
While VBID is not a panacea to singlehandedly expand access to and utilization of all critical high-value preventive interventions, it is a powerful tool. Other tools include literacy programs, health-information technology interventions and alternative clinician payment models, all of which are consistent with AMA policy.

AMA POLICY

The AMA has extensive policy supporting evidence-based preventive services. Policy H-165.840 advocates for evidence-based prevention to be covered for all patients. Policy H-425.997 supports coverage for evidence-based, cost-effective preventive services; Policy H-165.848 supports a requirement that preventive health care be included as minimal coverage and Policy H-390.849 supports providing patients with information and incentives to encourage appropriate utilization of preventive services. Regarding alignment of covered benefits, Policy H-425.994 emphasizes the importance of only pursuing testing in patients when adequate treatment and follow-up can be arranged for identified abnormal conditions and risk factors and Policy D-385.966 encourages reasonable payment for mandated benefits in health insurance policies. Additionally, Policy H-165.846 sets forth principles to guide the evaluation of the adequacy of health insurance coverage options.

Moreover, Policy H-425.986 encourages communication and cooperation among physicians and public health agencies to address challenges in preventive medicine. Policies D-330.967 and H-425.987 support continued collaboration with national medical specialty societies and interest groups to encourage coverage for evidence-based recommendations regarding preventive services, especially for populations at high risk for a given condition. Policy H-440.875 emphasizes the AMA’s commitment to collaborating to assure access to ACIP-recommended vaccines. Policy H-425.988 supports continuing collaboration with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services. Similarly, Policy D-330.935 states that the AMA will collaborate with relevant stakeholders, including appropriate medical specialty societies, to actively promote to the public and the profession the value of Medicare-covered preventive services and support the expansion of first-dollar coverage for a preventive visit and required tests anytime within the first year of enrollment in Medicare Part B. Policy H-425.992 advocates for revision of current Medicare guidelines to include coverage of appropriate preventive medical services.

Various AMA policies call for coverage with no cost-sharing, including: Policy H-185.969 regarding immunizations, Policy D-330.935 regarding Medicare preventive service benefits, and Policy H-290.972 for preventive coverage for HSA holders in the Medicaid program. Policy D-425.992 expresses concern regarding the effect that USPSTF recommendations can have on limiting access to preventive care for Americans (e.g., regarding access to screening mammography and prostate specific antigen screening) and encourages the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study.

Finally, AMA policy strongly supports APMs, VBID, and innovative insurance design. Policy H-385.913 sets forth principles to guide physician-focused APMs. Policy H-450.938 has principles to guide physician value-based decision-making and emphasizes that physicians should seek opportunities to integrate prevention services into office visits. Policy H-155.960 supports value-based decision-making and reducing the burden of preventable disease as broad strategies for addressing rising health care costs. Moreover, this policy recognizes the role of physician leadership and collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives. The policy...
encourages third-party payers to use targeted benefit design, whereby patient cost-sharing is
determined based on the clinical value of a health care service or treatment, with consideration
given to further tailoring cost-sharing to patient income and other factors known to impact
compliance. Policy H-185.939 broadly supports flexibility in the design and implementation of
VBID programs and outlines a series of guiding principles including that VBID explicitly consider
the clinical benefit of a given service or treatment when determining cost-sharing or other benefit
design elements. Consistent with calls to remove legislative and regulatory barriers to innovation in
HSA-HDHP plan design, Policy H-165.856 states that the regulatory environment should enable
rather than impede private market innovation in product development and purchasing
arrangements. At the same time, Policy H-165.856 states that benefit mandates should be
minimized to allow markets to determine benefit packages and permit a wide choice of coverage
options.

AMA ACTIVITY

In addition to the substantial volume of related AMA policy, AMA activities regarding high-value
services have included:

- Serving as a liaison to expert organizations including the USPSTF, the ACIP, and Bright
  Futures.
- At the 2018 Annual Meeting, Policy H-185,960 was modified to specify that the AMA will
develop a coding guide regarding colorectal cancer screening services to promote common
understanding among health care providers, payers, health care information technology
vendors, and patients.
- At the 2018 Annual Meeting, Resolution 226-A-18 regarding routine preventive prostate
cancer screening was referred, and the Council on Medical Service is preparing a report for
the 2019 Annual Meeting.
- As part of its strategic focus on improving health outcomes, the AMA has partnered with
the CDC and DPPs to prevent type 2 diabetes and supports key legislation to prevent type
2 diabetes and improve care for current patients. As a part of these efforts, the AMA has
also urged both private and public health care payers to offer DPPs under their health plans
to give more people access to these proven programs.87
- To address significant barriers to colorectal cancer screening for the Medicare population,
AMA advocacy efforts supported requiring Medicare to waive the coinsurance for
colorectal screening tests, regardless of whether therapeutic intervention is required during
the procedure.
- Various AMA advocacy efforts have supported expansion of the MA VBID Model,
including support for flexibility in MA uniformity (which would allow plan sponsors to
target enhanced benefit design to certain patients) and support for the Bipartisan Budget
Act of 2018 (which incorporates the CHRONIC Care Act of 2017, which includes
expansion of the MA VBID Model to all 50 states).
- In July 2018, the AMA sent a letter to Chairman Kevin Brady and Ranking Member
Richard Neal of the House of Representatives Committee on Ways and Means supporting
H.R. 6301, “to amend the Internal Revenue Code of 1986 to provide high deductible health
plans with first dollar coverage flexibility.” H.R. 6301 would expand the access and
enhance the utility of HSAs by offering health plans some flexibility in their plan design
while still maintaining eligibility for HSA contributions.
- To help AMA members better understand the USPSTF’s methods for making evidence-
based recommendations on clinical preventive services and how VBID can be used to
expand affordable access to high-value services, the AMA held a continuing medical
education session at the 2018 Annual Meeting.
DISCUSSION

Stakeholders throughout the health care community -- providers, payers, community health professionals, and patients -- can benefit from common understanding of which preventive services are covered without patient cost-sharing, and how such services should be coded. Moreover, stakeholders throughout the health care community should contribute to patient education regarding both the health care and economic value of zero-dollar preventive services so that patients can make well-informed decisions about their care. Physicians must be well-aware of recommended services available without cost-sharing so that they can have optimally productive consultations with their patients. The fact that these services are evidence-based and available at no cost to the patient may help physicians communicate the value of these services and help patients understand that cost should not be a barrier to this care. At the same time, proactive conversations between physicians and their patients about how a zero-dollar preventive service can lead to additional items or services that will incur cost-sharing will foster trust and understanding, and avoid unexpected medical bills. Additionally, public health organizations and payers (eg, employers and health plans) should be encouraged to educate the public/their members about recommended preventive services and their availability without cost-sharing. Such educational initiatives will empower patients to have productive conversations with their physicians about whether these services are appropriate for them.

The AMA can play a critical leadership role in building needed common understanding. The AMA, as the authority on CPT, is in a unique position to issue educational materials that can be seen as a source of truth in aligning recommended preventive services with the proper CPT codes for billing. Accordingly, the Councils recommend that the AMA develop coding guidance to help physicians correctly bill, and help payers correctly pay for, recommended preventive services. Additionally, the Councils recommend that the AMA develop physician education tools that help physicians prepare for conversations with their patients about the scope of preventive services provided without cost-sharing. This physician education can be designed to address two needs. First, these educational tools can address underutilization of zero-dollar preventive services by helping physicians communicate the clinical and financial value of these services to their patients. Second, these educational tools can address the patient experience of unexpected medical bills by preparing physicians (and their staff) to have proactive conversations about what is and is not provided within the scope of zero-dollar preventive services.

The USPSTF and the other ACA-designated expert organizations cannot reasonably be expected to develop recommendations on every risk-reducing course of action for every disease. At the same time, it is difficult to rationalize why some individuals at heightened risk for some diseases receive valuable preventive interventions without cost-sharing and others do not. To supplement the work being done by the expert organizations, health plans can choose to incorporate VBID principles to better align patients’ clinical and financial incentives, and thereby enhance access to high-value care.

As described above, the AMA has strong policy supporting APMs and VBID. The Councils recommend supporting initiatives that align provider-facing financial incentives created through payment reform, such as APMs, with patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for items and services that are tied to provider quality metrics. Additionally, the Councils recommend reaffirming Policy H-155.960 which supports VBID principles, Policy H-185.939 which supports flexibility in VBID program design, and Policy H-165.856 which supports a regulatory environment that enables private market innovation in product development and purchasing arrangements.
It may be challenging to reasonably limit what qualifies as a high-value service designated for reduced cost-sharing. Similarly, the full costs and benefits of VBID plans may only be evident over extended time horizons, so the evidence base will continue to evolve. Accordingly, rather than recommending any single plan design, it is important to support the creation of a legal and regulatory environment that cultivates innovation and freedom to experiment with transformational plan designs. At the same time, innovations in plan design should be consistent with the principles of adequacy of health insurance coverage outlined in Policy H-165.546. Specifically, the AMA should support: removing legal and regulatory barriers to innovative plan designs that seek to encourage high-value care with reduced costs to patients; promoting not only screenings to identify risk, but also high-value care to help patients manage that risk and prevent advanced disease; and allowing HSA-HDHPs to provide pre-deductible coverage for preventive and chronic care management services. In addition, the Councils recommend that as health plans experiment with innovative VBID plans, these plans incorporate the tenets of “clinical nuance” to recognize individual variation and to respect individual needs.

While continuing to advocate for legal change, there are concrete actions physicians can currently take to apply VBID principles. As plans continue to innovate around VBID, organized medicine and physicians will have a critical role in helping plans understand the highest value care they want to encourage. The exact same service may be highly valuable for some patients, but constitute over-treatment for other patients, and the physician community can lead the way in shaping policies that recognize and embrace this approach to payment reform and benefit design. Continuing with the breast cancer prevention example introduced above, for some women, the USPSTF recommended screening mammography may be all that is needed to effectively manage breast cancer risk. For other women, however, more frequent imaging can be life-saving, high-value care. While these services could be expensive in the short-term, they can prevent more likely cases of deadly (and expensive) disease.

Accordingly, it will be incumbent upon organized medicine, specifically national medical specialty societies, to collaborate with payers, educating them about the circumstances under which their specialties are providing especially high-value care, care that is most clinically important to incentivize. Physicians can work to identify and highlight the items and services within their areas of specialty that are of highest value, such as those that promote proactive healthy behaviors and/or manage risk or chronic conditions. For example, in looking to evidence-based quality metrics as indicators of high-value care, physicians of all specialties can play a critical role in shaping VBID programs to come. National medical specialty societies should collaborate with payers to shape the designation of “high-value” services and the financial and other incentives that would promote their access and utilization.

RECOMMENDATIONS

The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-155.960, which: supports “value-based decision-making” and reducing the burden of preventable disease as broad strategies for addressing rising health care cost; recognizes the important role of physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives; and encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment,
with consideration given to further tailoring cost-sharing requirements to patient income and 
other factors known to impact compliance. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-185.939, which supports flexibility in the design and 
implementation of Value-Based Insurance Design (VBID) programs and outlines guiding 
principles including that VBID explicitly consider the clinical benefit of a given service or 
treatment when determining cost-sharing or other benefit design elements, and that practicing 
physicians, including appropriate specialists, must be actively involved in the development of 
VBID programs. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.856, which supports a regulatory environment that 
enables rather than impedes private market innovation in product development and purchasing 
arrangements. (Reaffirm HOD Policy)

4. That our AMA support VBID plans designed in accordance with the tenets of “clinical 
nuance,” recognizing that (1) medical services may differ in the amount of health produced, 
and (2) the clinical benefit derived from a specific service depends on the person receiving it, 
as well as when, where, and by whom the service is provided. (New HOD Policy)

5. That our AMA support initiatives that align provider-facing financial incentives created 
through payment reform and patient-facing financial incentives created through benefit design 
reform, to ensure that patient, provider, and payer incentives all promote the same quality care. 
Such initiatives may include reducing patient cost-sharing for the items and services that are 
tied to provider quality metrics. (New HOD Policy)

6. That our AMA develop coding guidance tools to help providers appropriately bill for zero-
dollar preventive interventions and promote common understanding among health care 
providers, payers, patients, and health care information technology vendors regarding what will 
be covered at given cost-sharing levels. (Directive to Take Action)

7. That our AMA develop physician educational tools that prepare physicians for conversations 
with their patients about the scope of preventive services provided without cost-sharing and 
instances where and when preventive services may result in financial obligations for the 
patient. (Directive to Take Action)

8. That our AMA continue to support requiring private health plans to provide coverage for 
evidence-based preventive services without imposing cost-sharing (such as co-payments, 
deductibles, or coinsurance) on patients. (New HOD Policy)

9. That our AMA continue to support implementing innovative VBID programs in Medicare 
Advantage plans. (New HOD Policy)

10. That our AMA support legislative and regulatory flexibility to accommodate VBID that 
(a) preserves health plan coverage without patient cost-sharing for evidence-based preventive 
services; and (b) allows innovations that expand access to affordable care, including changes 
needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide 
pre-deductible coverage for preventive and chronic care management services. (New HOD 
Policy)
11. That our AMA encourage national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (New HOD Policy)

Fiscal Note: $6,000
REFERENCES


3 American Medical Association interview with A. Mark Fendrick, July 10, 2018.


48 United States Preventive Services Task Force, Final Recommendation Statement, Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening. Available at:


APPENDIX

Policies Recommended for Reaffirmation

H-155.960 Strategies to Address Rising Health Care Costs

Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote “value-based decision-making” at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.

**H-165.856 Health Insurance Market Regulation**

Our AMA supports the following principles for health insurance market regulation:

1. There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.

2. State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.

3. Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.

4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.

5. Insured individuals should be protected by guaranteed renewability.

6. Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.

7. Guaranteed issue regulations should be rescinded.

8. Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.

9. Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.

10. The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.


**H-185.939 Value-Based Insurance Design**

Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.

b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.

c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.

d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.

f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices.

g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.

h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.

i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).

Whereas, Under Section 1115 of the Social Security Act, the Secretary of Health and Human Services may approve state waivers for demonstration projects that are experimental in nature;\(^1\) and

Whereas, Section 1115 demonstrations allow states to use federal Medicaid funds for costs that would not otherwise be covered, amounting to approximately one-third (over $100 billion) of Medicaid spending in 2015;\(^1,2\) and

Whereas, States have used these waivers to expand coverage, change delivery systems, alter benefits and cost sharing, modify provider payments, and extend coverage in emergency situations;\(^3\) and

Whereas, Final evaluations of demonstrations have historically been required by the Centers for Medicare & Medicaid Services (CMS) only after the final expiration of the demonstration, rather than at the end of each three-to five-year demonstration cycle;\(^3\) and

Whereas, Demonstrations may be renewed for multiple three-to five-year demonstration cycles, resulting in demonstrations running for decades without proper analyses and data reporting;\(^3\) and

Whereas, An interim report submitted by the state of Massachusetts to CMS in 2016 regarding a demonstration initially approved in 1997 lacked data measuring the effectiveness of nearly $700 million used to create and fund new hospital Medicaid payment delivery systems;\(^3\) and

Whereas, Massachusetts currently spends approximately 40% of its state budget on Medicaid services, and CMS has previously encouraged the state to move to more aggressive accountability measures;\(^4,5\) and

Whereas, Recent interim evaluations of demonstrations in Arkansas and Arizona lacked important information necessary for proper assessment of those demonstrations as well;\(^3\) and


Whereas, In ten states, including Arizona, over 75% of the Federal Medicaid Expenditures go towards Section 1115 demonstrations; and

Whereas, The U.S Government Accountability Office (GAO) published a study in January 2018 showing that state-led evaluations of demonstrations had limited usefulness for federal decision-making due to the temporal gaps in comprehensive results, and CMS officials acknowledge this fact; and

Whereas, The GAO has made the following recommendations to CMS: (1) establish written procedures for requiring final evaluation reports at the end of each demonstration cycle, (2) issue criteria for when it will allow limited evaluations of demonstrations, and (3) establish a policy for publicly releasing findings from federal evaluations of demonstrations; and

Whereas, CMS officials have said that the agency plans to require appropriate evaluation at the end of each demonstration cycle, but still lacks any written procedures for implementing these requirements; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Medicare & Medicaid Services to establish written procedures that require final evaluation reports of Section 1115 Demonstrations at the end of each demonstration cycle, regardless of renewal status.

(New HOD Policy)

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

Date Received: 9/21/18

RELEVANT AMA POLICY:

Medicaid Waivers for Managed Care Demonstration Projects H-290.987
(1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.
Citation: (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.
Citation: Res. 802, I-17; Reaffirmation: A-18

Medicaid Expansion Options and Alternatives H-290.966
1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.
2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations.
3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults.
4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.
Citation: CMS Rep. 5, I-14; Reaffirmed: CMS Rep. 02, A-16
Whereas, Recent presentations by CMS Secretary Verma have stressed moving Medicare  
Shared Savings ACO’s to reduce the number of upside only Medicare Shared Savings ACO’s  
(MSSP ACO’s) by moving them to a two-track model and reducing the length of time that  
existing MSSP ACO’s can remain in the program to two years and lowering their share of  
savings to 25%. Telemedicine initiatives were offered as a way to offset the risks. The rationale  
is that new risk based ACO’s will be able to move to Value Based Care as outlined in MACRA.  
The risk based ACO’s will have to remain in the program for 5 years starting in 2020; and  

Whereas, Given that 15 of the 18 Next Gen (risk based ACO’s) have prior MSSP experience  
and are huge organizations with prior experience with integration and cost reductions, the fact  
that they only saved 1.7% is alarming. Eliminating the MSSP prevents new organizations from  
acquiring the experience in a lower risk environment. (Infrastructure costs, etc. for an ACO). It  
reinforces the fact that smaller organizations and private practitioners will have no access to  
APM’s and the bonuses related to Value Based Care; and  

Whereas, Recent results from CMS MSSP ACO’s viewed on the whole do not show consistent  
“significant savings” for many organizations, and many others show no savings. Thus, making  
the losses associated with the move to involve “downside risk” even more likely and the  
pathway more treacherous. (CMS Report 2017). 3 This will limit the number of risk-based  
oraganizations to only very large previously integrated and well capitalized healthcare systems;  
and  

Whereas, Recent publications (NEJM 9/5/18), four which have done subgroup analyses of the  
results, have shown a differential in savings when MSSP ACO’s owned by physicians are  
reviewed versus hospital integrated systems. The physician owned systems have substantially  
greater savings; and  

Whereas, Risk based ACO’s require prior ACO experience, organizational infrastructure, linked  
health information technology (HIT), and business resources. Large amounts of capital are  
necessary to form and run a given system. The necessary funds are only available to large well  
capitalized health care systems. These requirements create a vulnerability which will lead to  
further consolidation of medical practices given the need for capital needed to allow them to  
participate in Advance Payment Models (APM’s). Thus, it will also expose integrated healthcare  
systems to takeovers by financial firms or other larger systems; and
Whereas, consolidation of physicians’ practices has not led to greater savings. Further consolidation forced by eliminating the MSSP ACO program may cause some systems to drop out of the MSSP program. This will likely further raise costs while making it impossible for smaller groups of physicians and rural physicians to participate in ACO’s. The opportunity to participate in value-based care (APM’s) to receive bonuses in MACRA will not be accessible. Elimination and/or modification of MIPS makes the opportunity for bonuses based on superior physician performance impossible; therefore be it

RESOLVED, That our American Medical Association advocate for the continuation of upside only risk Medicare Shared Savings ACO (MSSP ACO) program as an option from the Centers for Medicare and Medicaid Services, particularly for physician owned groups (New HOD Policy); and be it further

RESOLVED, That our AMA develop educational resources and business analytics to help physicians complete due diligence in evaluating the performance of hospital integrated systems before considering consolidation. Specific attention should be given to the evaluation of transparency on past savings results, system finances, quality metrics, physician workforce stability and physician job satisfaction, and the cost of clinical documentation software (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate the characteristics of successful physician owned MSSP ACOs and participation in alternative payment models (APMs) to create a framework of the resources and organizational tools needed to allow smaller practices to form virtual ACOs that would facilitate participation in MSSP ACOs and APMs. (Directive to Take Action)

Fiscal Note: Estimated cost of $30,000 to implement resolution.

Received: 09/25/18

References
1. Announcing the Next Gen ACO Results
2. AMA Accountable Care Principles 2017
3. Was the Medicare Accountable Care Savings Program Successful in 2017
5. Ready or not for Quality Based Re-imbursement
6. Use of EHR’s does not reduce Administrative Costs
7. Hospital Consolidation linked to higher healthcare costs
8. MACRA
9. How the Next Gen ACO’s compared on savings in 2016
10. The Impact of Hospital Consolidation on Medical Costs
11. The Hidden Cost of Provider Consolidation
12. Next Gen Model Saves 62 Million
13. Scholarly Articles on Consolidation of Medical Practices
Whereas, “Dense breast” tissue makes it harder to identify cancer on a mammogram, especially if there are no calcifications present within the cancer; and

Whereas, Patients with “dense breast” tissue are also associated with an increased risk of breast cancer (i.e., the risk is estimated to be four times greater for women with extremely dense breasts versus women with fatty breasts); and

Whereas, A “negative” screening mammography result does not reliably rule out cancer in women with dense breasts; and

Whereas, These women with “dense breast” tissue often have higher stage cancers upon detection due to the fact that they are not discovered until they are larger and symptomatic; and

Whereas, Ultrasound and MRI have been shown to reduce interval cancers in women with “dense breasts”; and

Whereas, Approximately 30 states have adopted laws requiring notification to patients with “dense breasts”; and

Whereas, The decision to pursue additional screening should be a result of the conversation between individual patients and their physician-led health care team; and

Whereas, Insurance companies are not required to pay for additional screening; therefore be it

RESOLVED, That our American Medical Association support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician. (New HOD Policy)

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

Screening Mammography H-525.993

Our AMA:

a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer.
b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis.
c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations.
d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available.
e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography.
f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient.
g. encourages physicians to inquire about and update each patient’s family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate.
h. supports insurance coverage for screening mammography.
i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy.
j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

Citation: (CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02; Modified: CSAPH Rep. 6, A-12)

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Whereas, Onerous administrative requirements can reduce practice efficiency and contribute to physician burnout, without improving patient care; and

Whereas, Fee for service payers including Medicare and Medicaid have historically advised that clinical documentation for outpatient services should be completed in a “timely manner” (or within some other non-specific timeframe); and

Whereas, A new Alaska Medicaid regulation arbitrarily imposes a “72 hour” rule, prohibiting payment for any outpatient claim unless documentation for the provided service had been substantively completed within three days of the visit (including weekends/holidays); and

Whereas, Neither government nor private health insurers should unilaterally impose burdensome documentation requirements without at least some evidence that the new rules will improve patient outcomes; and

Whereas, Alaska’s new regulation also includes a provision that the three day requirement shall be waived if a provider’s professional body has adopted policy specifying that a longer time period for documentation is appropriate; therefore be it

RESOLVED, That our American Medical Association agree that documentation for outpatient physician services should be completed in a timely manner (New HOD Policy); and be it further

RESOLVED, That for circumstances in which more specific definitions of timeliness are required, AMA policy is that documentation for outpatient services should be completed, when possible, within 14 days of a provided service (New HOD Policy); and be it further

RESOLVED, That our AMA work with government health plans and private insurers to help them better understand the unintended consequences of imposing documentation rules with unrealistically short timeframes, and that our AMA oppose the use of such rules or regulations in determining whether submitted claims are valid and payable. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Whereas, Current AMA policy declares that it is a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days (H-190.959); and

Whereas, The AMA is still working to ensure that the 14-day prompt payment objective is achieved; and

Whereas, Advances in automation and technology enable insurance companies and managed care plans to pay clean claims on the day received; therefore be it

RESOLVED, That American Medical Association policy H-190.959 be amended by addition and deletion to read as follows:

Physician Reimbursement by Health Insurance and Managed Care Companies

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.

2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.

3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment. (Modify Current HOD Policy)

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

Received: 09/27/18
RELEVANT AMA POLICY

Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959
1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.
2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.
3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.
Citation: (Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res 132, A-14; Reaffirmed: Sub. Res. 715, A-15)
Resolved, That our American Medical Association advocate for removal of arbitrary limits on telemedicine visits by medical practitioners in nursing facilities and instead base them purely on medical necessity, and collaborate with AMDA – The Society for Post-Acute and Long-Term Care Medicine to effect a change in Medicare’s policy regarding this matter under the provisions of Physician Fee Schedule (PFS) and Quality Payment Program (QPP) (New HOD Policy); and be it further

Resolved, That our AMA work with AMDA-The Society for Post-Acute and Long-Term Care Medicine and other stakeholders to influence Congress to broaden the scope of telemedicine care models in post-acute and long-term care and authorize payment mechanisms for models that are evidence based, relevant to post-acute and long-term care and continue to engage primary care physicians and practitioners in the care of their patients. (Directive to Take Action)

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

Received: 10/03/18
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-18)

Introduced by: American College of Emergency Physicians

Subject: Emergency Department Copayments for Medicaid Beneficiaries

Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Copayments (copays) for emergency department services have been shown to create a significant barrier to necessary emergency care for Medicaid enrollees; and

Whereas, Many Medicaid programs utilize the current federally allowed copay up to eight dollars for emergency department services determined to be non-emergent; and

Whereas, For the purposes of determining non-emergency, and therefore imposition of copays for Medicaid enrollees, many states use the Emergency Severity Index (ESI) triage levels or final diagnoses rather than the Prudent Layperson Standard as directed in the CMS guidance for implementation of such copays; and

Whereas, Our AMA Policy H-130.970 opposes implementation of policies that violate the Prudent Layperson Standard of determining when to seek emergency care; and

Whereas, States are using Section 1115 Medicaid waiver demonstrations to implement emergency department copays of increasing amounts and to apply such emergency department copays even for emergent services; and

Whereas, Medicaid programs that have copays for non-emergent use of the emergency department do not decrease such non-emergent use and do not decrease overall Medicaid costs; and

Whereas, The calculated effect of Indiana’s increased Medicaid emergency department copay ($25), allowed by a 2015 CMS Medicaid waiver demonstration, used a retrospective definition of “emergency,” disregarding the federal Prudent Layperson Standard; and

Whereas, Copays requested at the time of registration in the emergency department could intimidate patients from receiving a mandated medical screening exam, thus placing the hospital at risk for an EMTALA violation; therefore be it

RESOLVED, That our American Medical Association oppose imposition of copays for Medicaid beneficiaries seeking care in the emergency department. (New HOD Policy)

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

Received: 10/10/18
RELEVANT AMA POLICY

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
   (A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
   (B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)
   (C) All health plans should be prohibited from requiring prior authorization for emergency services.
   (D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.
   (E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an “emergency medical condition” as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.
   (F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.
   (G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.
   (H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.
   (I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care.


References:
6 Mortensen, K. Copayments did not reduce Medicaid enrollees’ nonemergency use of emergency departments. Health Affairs. 2010; 29(9), abstract http://content.healthaffairs.org/content/29/9/1643.abstract
8 Emergency Medical Treatment and Labor Act - 42 United States Code (U.S.C.) 1395dd
Whereas, The delegation of Tennessee has reviewed Policy H-185.940, adopted A-12, “Beers or Similar Criteria And Third-Party Payer Compliance Activities”; and
Whereas, There is evidence of fiscal harm to physicians and damage to their professional reputations by the improper application of Beers Criteria within compliance activity; and
Whereas, A health insurance company doing business in Tennessee has expanded this practice regionally to other states; therefore be it
RESOLVED, That our American Medical Association identify and establish a workgroup with insurers that are inappropriately applying Beers or similar criteria to quality rating programs and work with the insurers to resolve internal policies that financially penalize physicians (Directive to Take Action); and be it further
RESOLVED, That our AMA study and report back to the House of Delegates the 2019 Interim Meeting, the potential inappropriate use of Beers Criteria by insurance companies looking at which companies are involved and the effect of the use of these criteria on physicians’ practices (Directive to Take Action); and be it further
RESOLVED, That our AMA provide a mechanism for members to report possible abuses of Beers Criteria by insurance companies. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Beers or Similar Criteria and Third Party Payer Compliances Activities H-185.940
Our AMA adopts policy: (1) discouraging health insurers, benefit managers, and other payers from using the Beers Criteria and other similar lists to definitively determine coverage and/or reimbursement, and inform health insurers and other payers of this policy; and (2) clarifying that while it is appropriate for the Beers Criteria to be incorporated in quality measures, such measures should not be applied in a punitive or onerous manner to physicians and must recognize the multitude of circumstances where deviation from the quality measure may be appropriate, and inform health insurers and other payers of this policy.
Citation: (BOT Rep. 14, A-12)
Whereas, Clinical trials are often a patient’s best clinical option for combating disease progression; and

Whereas, Guaranteed access to clinical trials is an important part of high-quality care that should be available to all patients with life-threatening conditions regardless of financial circumstances; and

Whereas, Sixty percent of the U.S. population resides at or below 400 percent of the federal poverty level (FPL); therefore, a significant proportion of patients with cancer may be vulnerable to financial toxicity related to the cost of their care;¹ and

Whereas, Nearly 73.4 million people were enrolled in Medicaid and CHIP as of June 2018²; and

Whereas, Costs related to clinical trial participation include those of new drugs or interventions as well those related to routine clinical care; and

Whereas, Routine costs include the non-experimental costs of treating a patient who is participating in a clinical trial, such as physician visits and laboratory studies; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) issued a Medicare National Coverage Determination (NCD) for the Routine Costs in Clinical Trials effective July 9, 2007³ which provided for coverage of these routine costs; and

Whereas, The Patient Protection and Affordable Care Act (ACA) prohibits private health plans or insurers from limiting or denying coverage of routine costs to patients who participate in clinical trials⁴; and

Whereas, Medicaid statutes do not require state Medicaid programs to provide coverage for the routine costs of clinical trials; and


Whereas, State Medicaid programs which do cover the routine costs of patients on clinical trials have policies that vary significantly by state; and

Whereas, Minorities are not well represented in clinical trials, and Medicaid serves a large portion of under-represented minorities; and

Whereas, Reducing participant burdens in clinical trials is advantageous to recruiting minority populations, which helps to address unacceptable health disparities in cancer; and

Whereas, Several studies demonstrate that providing coverage for the routine costs of clinical trials have a minimal effect on overall care costs; therefore be it

RESOLVED, That our American Medical Association actively lobby for and support federal legislation that guarantees coverage of routine patient care costs for Medicaid enrollees who participate in clinical trials. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

Increasing Minority Participation in Clinical Research H-460.911

1. Our AMA advocates that:
   a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
   b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
   c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:
   a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
   b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
   c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
   d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and

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e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

Citation: BOT Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18

7.1.1 Physician Involvement in Research

Biomedical and health research is intended to contribute to the advancement of knowledge and the welfare of society and future patients, rather than to the specific benefit of the individuals who participate as research subjects.

However, research involving human participants should be conducted in a manner that minimizes risks and avoids unnecessary suffering. Because research depends on the willingness of participants to accept risk, they must be able to make informed decisions about whether to participate or continue in a given protocol.

Physician researchers share their responsibility for the ethical conduct of research with the institution that carries out research. Institutions have an obligation to oversee the design, conduct, and dissemination of research to ensure that scientific, ethical, and legal standards are upheld. Institutional review boards (IRBs) as well as individual investigators should ensure that each participant has been appropriately informed and has given voluntary consent.

Physicians who are involved in any role in research with human participants have an ethical obligation to ensure that participants interests are protected and to safeguard participants welfare, safety, and comfort.

To fulfill these obligations, individually, physicians who are involved in research should:

(a) Participate only in those studies for which they have relevant expertise.
(b) Ensure that voluntary consent has been obtained from each participant or from the participants legally authorized representative if the participant lacks the capacity to consent, in keeping with ethics guidance. This requires that:
   (i) prospective participants receive the information they need to make well-considered decisions, including informing them about the nature of the research and potential harms involved;
   (ii) physicians make all reasonable efforts to ensure that participants understand the research is not intended to benefit them individually;
   (iii) physicians also make clear that the individual may refuse to participate or may withdraw from the protocol at any time.
   (c) Assure themselves that the research protocol is scientifically sound and meets ethical guidelines for research with human participants. Informed consent can never be invoked to justify an unethical study design.
   (d) Demonstrate the same care and concern for the well-being of research participants that they would for patients to whom they provide clinical care in a therapeutic relationship. Physician researchers should advocate for access to experimental interventions that have proven effectiveness for patients.
   (e) Be mindful of conflicts of interest and assure themselves that appropriate safeguards are in place to protect the integrity of the research and the welfare of human participants.
   (f) Adhere to rigorous scientific and ethical standards in conducting, supervising, and disseminating results of the research.

AMA Principles of Medical Ethics: I,II,III,V

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016
Whereas, The Centers for Medicare & Medicaid Services (CMS) announced that Medicare Advantage (MA) plans will have the choice of implementing step therapy to manage Part B drugs beginning January 1, 2019; and

Whereas, This proposal is part of the agency’s ongoing activities to deliver on the Trump Administration’s American Patients First Blueprint and overall drug pricing initiative; and

Whereas, Step therapy delays patient access to proper treatments by requiring patients to try and fail on lower cost medications before they can access the appropriate medication prescribed by their physician; and

Whereas, In life-threatening illness, including many cancers, step therapy could require use of drug not recommended by the patient’s physician, and that failure to optimize treatment at the outset could harm the patient’s chances for successful treatment; and

Whereas, Due to the individualized nature of modern cancer treatment and lack of interchangeable clinical options, step therapy policies are inappropriate for use in oncology treatment; and

Whereas, Our AMA’s Prior Authorization and Utilization Management Reform Principles emphasize the importance of clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions in order to ensure patient access to appropriate care while reducing the administrative burden associated with policy compliance;¹ and

Whereas, Step therapy is not an effective utilization management policy and hinders access to high-quality, high-value care; therefore be it

RESOLVED, That our American Medical Association continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019. (Directive to Take Action)

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

Received: 10/11/18

RELEVANT AMA POLICY

Prescription Drug Plans and Patient Access D-330.910
Our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.
Citation: (Res. 135, A-14)

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18

Medicare Pharmaceutical Benefit H-330.899
Our AMA utilizes the following principles in evaluating legislative proposals for the addition of a Medicare pharmaceutical benefit:
(1) Any pharmaceutical benefit should be fully funded by additional budgetary allocations, separate from existing budget provisions. The benefit should provide for adequate accounting so that drug program expenditures can be tracked separately from all other expenditures.
(2) The pharmaceutical benefit should be targeted to reduce hardship for those with low-incomes and those with catastrophic costs.
(3) Any legislation should provide a pharmaceutical benefit that is equal across geographic regions.
(4) A pharmaceutical benefit should be designed in a way that allows for benefits options under both the traditional Medicare fee-for-service program and any version of the Medicare program that relies on the private marketplace. Different levels of drug benefits for different products would be permissible.
(5) A pharmaceutical benefit should include a tiered deductible and co-payment structure that encourages economically responsible behavior.
(6) Any pharmaceutical benefit should be designed to prevent adverse selection.
(7) Any pharmaceutical benefit should be designed in a manner that prevents interference with clinical decision-making and physician prescribing decisions.
(8) Any pharmaceutical benefit should be designed in a manner that minimizes the administrative burden placed on physicians.
(9) Any pharmaceutical benefit should be designed in a manner that ensures beneficiary access to local pharmacies, and not be limited to mail order pharmacies.
(10) In the implementation of any Medicare drug benefit, employers are highly encouraged to preserve existing coverage, and for Medicare beneficiaries with existing drug coverage, any Medicare benefit should be supplemental to and coordinated with that existing coverage.
Citation: BOT Rep. 27, A-00; Reaffirmed: Res. 103, A-01; Modified: CMS Rep. 11, A-02; Modified: CMS Rep. 9, A-03; Appended: Res. 723, I-03; Reaffirmation I-04; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16
Emerging Trends in Utilization Management H-320.958  
The AMA will: (1) maintain a leadership role in coordinating private sector efforts to develop and refine utilization management and quality assessment programs; (2) **establish an active role in the development of any national utilization management and quality assessment programs** that are proposed in the ongoing health system reform debate; and (3) advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.  
Citation: CMS Rep. 9, I-93; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmation: A-17; Reaffirmation: I-17

Eliminate Fail First Policy in Addiction Treatment H-320.941  
Our AMA will advocate for the elimination of the "fail first" policy implemented at times by some insurance companies and managed care organizations for addiction treatment.  
Citation: Res. 802, I-16
Whereas, According to Pentagon figures, over 200,000 women are in the active-duty US military, including 74,000 in the Army, 53,000 in the Navy, 62,000 in the Air Force, and 14,000 in the Marine Corps in 2011; and

Whereas, According to the 2012 Committee Opinion on “Health care for women in the military and women Veterans” from the American College of Obstetricians and Gynecologists (ACOG), “military service is associated with unique risks to women’s reproductive health .... Obstetrician-gynecologists should be aware of high prevalence problems (e.g., posttraumatic stress disorder, intimate partner violence, and military sexual trauma) that can threaten the health and well-being of these women;” and

Whereas, Both men and women in our US military can suffer from infertility, sometimes directly as a result of blast traumas and spinal cord injuries; and

Whereas, The US Department of Defense currently covers the cost of in vitro fertilization (IVF) and infertility services for certain injured active duty personnel; and

Whereas, Under current Tricare policy, active-duty military personnel and their dependents have some limited coverage for infertility care and oocyte cryopreservation services (with use by only 7181 over 5 years) at seven specific military treatment facilities: Walter Reed National Military Medical Center in Bethesda MD; Womack Army Medical Center at Fort Bragg in Fayetteville NC; San Antonio Military Medical Center in San Antonio TX; San Diego Naval Medical Center in San Diego CA; Tripler Army Medical Center in Honolulu HI; Wright-Patterson Air Force Base Medical Center in Dayton OH; and Madigan Army Medical Center in Seattle-Tacoma WA); and

Whereas, This critical medical service is not fully available to active duty members of the military and those working with the DOD; and

Whereas, In 2016, our AMA passed policy H-510.984 “infertility Benefits for Veterans” which states in part that:

3) “Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits through TRICARE and the VA at pre-deployment and during the medical discharge process.

4) Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.”; and
Whereas, Unfortunately, many active-duty military personnel are not aware of their infertility benefits under current Tricare policy; therefore be it
RESOLVED, That our American Medical Association work with the Department of Defense, the American Society for Reproductive Medicine and other interested organizations to inform beneficiaries regarding the current availability of low-cost infertility care and gamete cryopreservation services at military treatment facilities for active-duty military personnel under Tricare (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and the American College of Obstetricians and Gynecologists (ACOG) and the American Urological Association (AUA)) and other interested organizations to encourage Tricare to fully cover infertility diagnosis and treatment for active-duty military personnel and others covered by Tricare (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the American Society for Reproductive Medicine (and ACOG and AUA) and other interested organizations to encourage Tricare to fully cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on this issue at the 2019 Interim Meeting. (Directive to Take Action)

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

Received: 10/11/18

References:
2 Department of Veterans Affairs, Office of Public Affairs, Fact Sheet, accessed at: http://www.va.gov/WOMENVET/docs/WomenVeteransPopulationFactSheet.pdf on 10/25/15
5 “Access to Infertility Care: Challenges and Potential Solutions”, by Enn Kramer (ASRM staff), ASRM 10/8/18
6 AMA policy H-510.984 on “Infertility Benefits for Veterans” (below)

RELEVANT AMA POLICY

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

Citation: CMS Rep. 01, I-16
Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.
Citation: (CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09)

Health Care for Veterans and Their Families D-510.994
Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.
Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990
Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).
Citation: (Sub. Res.115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Ensuring Access to Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
Citation: (Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15)

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.
Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Supporting Awareness of Stress Disorders in Military Members and Their Families H-510.988
Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs.
Citation: Sub. Res. 401, A-10; Reaffirmed in lieu of: Res. 001, I-16
Whereas, The harm to patients caused by delayed implementation of prescribed treatment or compromise in treatments or testing prompted by payers that result in switching for reasons other than efficacy or toxicity cannot be quantified because its role cannot be coded by our current ICD system; and

Whereas, Other contributors to patient and public health harm are identified by the mining of data from ICD administrative codes, including but not limited to infections, poisons, assaults, insect bites, trauma, infections and lifestyle factors; therefore be it

RESOLVED, That our American Medical Association support the creation and implementation of an ICD code(s) to identify administrator or payer influence that affects treatment and leads to or contributes to, directly or indirectly, patient harm. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 10/10/18
Whereas, Indiana law defines direct primary care (DPC) as: (1) agrees to provide primary care health services to the individual patient for an agreed-upon fee and time; 2) does not bill any third parties on a fee-for-service basis; 3) charges a periodic fee for services; and 4) may charge a per-visit charge only if the charge is less than the monthly equivalent of the periodic fee; and

Whereas, Health savings accounts (HSAs) are unusable for DPC memberships under current Internal Revenue Code (IRC) provisions; and

Whereas, There is currently a bill in Congress, The Primary Care Enhancement Act (H.R. 6317), which clarifies HSA provisions regarding DPC in the tax code. The bill states DPC is not a health plan under IRC. DPC is a medical service and allows individuals with HSAs to pay for DPC services with HSAs; therefore be it

RESOLVED, That our American Medical Association seek federal changes to the Internal Revenue Code allowing health savings accounts to be used with direct primary care. (Directive to Take Action)

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

Received: 10/09/18
Whereas, Medical providers and hospitals were successful in the 2018 Indiana legislative session in getting some prior authorization (PA) relief through HEA 1143 (P.L.77-2018); and

Whereas, That bill addressed only PA hassles and inconsistencies in commercial health plans; and

Whereas, The same hassles and burdensome PA requirements are routinely applied in Medicaid and Medicaid managed care plans, as well as Medicare Advantage plans; and

Whereas, There is a need to request relief equally from all health plans; therefore be it

RESOLVED, That our American Medical Association support legislation that would apply the following legislative processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- Listing services that require a PA on a website.
- Notifying providers of any changes at least 45 days prior to change.
- Standardizing a PA request form.
- Not denying payment for PA that has been approved unless fraudulently obtained or ineligible at time of service.
- Defining a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans (New HOD Policy); and be it further

RESOLVED, That our AMA apply these same legislative processes and parameters to PA for Medicaid and Medicaid managed care plans and Medicare Advantage plans, to include:

- Medications already working when a patient changes health plans cannot be changed by the plan without discussion and approval of the ordering physician.
- Minimizing PA requirements as much as possible within each plan.
- Making an easily accessible and reasonably responsive direct communication tool available to resolve disagreements between plan and ordering provider. (New HOD Policy)

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

Received: 10/09/18
RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18

Prescription Drug Plans and Patient Access D-330.910
Our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.
Citation: (Res. 135, A-14)

https://policysearch.ama-assn.org/policyfinder/search/medicare%20advantage/relevant/1/
Whereas, Physicians increasingly are using an electronic medical record; and

Whereas, A much-touted part of that record is communication with the patient electronically, as initiated either by the physician or the patient; and

Whereas, Patients are typically expecting a quick turnaround on questions they send, as well as other information coming from the physician’s office. This expectation is now becoming a quality measure that forces physicians to log on and review messages in the evening and sometimes on the weekends and holidays; and

Whereas, Patients can initiate a new communication at any time, with some patients messaging multiple times a week; and

Whereas, It can be argued that instructions about lab results and complaints voiced in the office should be covered by the salary paid for an office visit. However, new after-hour and weekend messages from patients are typically not addressed in employment contacts from the standpoint of compensation for those services to the physician. The result is uncompensated labor that can run several hours a day and multiple days a week. This is unfair to the physician and contributes to physician burnout and dissatisfaction with their practice situation; therefore be it

RESOLVED, That our American Medical Association adopt policy that physicians should be compensated for reviewing and responding to new after-hour patient messages. (New HOD Policy)

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

Received: 10/09/18
RELEVANT AMA POLICY

11.3.1 Fees for Medical Services

Physicians are expected to conduct themselves as honest, responsible professionals. They should be knowledgeable about and conform to relevant laws and should adhere to professional ethical standards and sound business practice. Physicians should not recommend, provide, or charge for unnecessary medical services. Nor should they make intentional misrepresentations to increase the level of payment they receive or to secure noncovered health benefits for their patients.

With regard to fees for medical services, physicians should:

(a) Charge reasonable fees based on the:
   (i) kind of service(s);
   (ii) difficulty or uniqueness of the service(s) performed;
   (iii) time required to perform the service(s);
   (iv) skill required to perform the service(s);
   (v) experience of the physician;
   (vi) quality of the physician's performance.

(b) Charge only for the service(s) that are personally rendered or for services performed under the physicians direct personal observation, direction, or supervision. If possible, when services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately. When physicians have professional colleagues assist in the performance of a service, the physician may pay a reasonable amount for such assistance and recoup that amount through fees charged to the patient, provided the patient is notified in advance of the financial arrangement.

(c) Itemize separately charges for diagnostic, laboratory, or clinical services provided by other health care professionals and indicate who provided the service when fees for others’ services cannot be billed directly to the patient, in addition to charges for the physician’s own professional services.

(d) Not charge excessive fees, contingent fees, or fees solely to facilitate hospital admission. Physicians must not charge a markup or commission, or profit on services rendered by other health care professionals.

(e) Extend professional courtesy at their discretion, recognizing that it is not an ethical requirement and is prohibited in many jurisdictions.

AMA Principles of Medical Ethics: II, VI

Issued: 2016

Definition of "Usual, Customary and Reasonable" (UCR) H-385.923

1. Our AMA adopts as policy the following definitions:
   (a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
   (b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
   (c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.

Citation: (Res. 109. A-07; Appended: Res. 107, A-13)
Physician Choice of Practice H-385.926
Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.


Payment for Physicians' Services H-385.990
Our AMA:
(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.
(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.
(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.
(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.

Whereas, Advantage plans have been a popular choice for 19 million seniors because of lower premium cost and the expectation that members were being given extra perks, such as gym membership, vision and dental insurance; and

Whereas, Seniors are lured to these advantage plans by misinformation and confusing sales techniques; and

Whereas, Administrative costs have run as high as 10 percent. In comparison, CMS administers the traditional Medicare plan at a cost of 3 percent or less; and

Whereas, Inadequacies of the plan have produced poor service for some members with lower quality scores due to difficulties with physical therapy and rehab services. The number of days approved has tended to be too short and the extent of rehab services too limited. There has also been a delay in nursing home placement for some members, resulting in a delay of hospital discharge and an increase in hospital costs; therefore be it

RESOLVED, That our American Medical Association investigate the deficiencies of Medicare Advantage plans, with the goal of improving nursing home, rehab and physical therapy benefits. Full transparency about the cost and coverage of the plan, as well as communication about plan limitations, should be required (Directive to Take Action); and be it further

RESOLVED, That our AMA issue an opinion on whether Medicare Advantage plans should be limited to healthier seniors with both a short problem list and short medication list, and whether there should be a cap on administrative costs for these plans. (Directive to Take Action)

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

Received: 10/09/18

RELEVANT AMA POLICY

https://policysearch.ama-assn.org/policyfinder/search/medicare%20advantage/relevant/1/
Whereas, The number of Hoosiers with mental health disorders appears to be growing over time, and yet, it is more and more difficult to refer these patients to a psychiatrist because of low numbers of practicing psychiatrists in most Indiana communities and low reimbursement to psychiatrists. Some psychiatrists will not even see Medicare patients due to reimbursement issues; and

Whereas, Untreated or inadequately treated psychiatric disease increases the risk of hospitalization but also crime, arrest and incarceration. A significant portion of the homeless population has chronic psychiatric conditions that are not adequately treated; and

Whereas, Most developed nations have more psychiatrists per 100,000 population than the United States. Monaco has 41 psychiatrists per 100,000 population; Norway has 29.7 psychiatrists per 100,000 population, while Indiana has fewer than 9 per 100,000 with the lowest rate in Muncie. Fort Wayne has 4.2 psychiatrists per 100,000 population; therefore be it

RESOLVED, That our American Medical Association support increasing reimbursement for psychiatric services through direct funding adjustments or via the relevant specialties pursuing a coding change through the established CPT Editorial Panel process. (New HOD Policy)

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

Received: 10/09/18

RELEVANT AMA POLICY

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983
Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.
Citation: (Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15)
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-18)

Introduced by: Indiana
Subject: Drug Pricing Transparency
Referred to: Reference Committee J
(Steven Chen, MD, Chair)

Whereas, Indiana has an increasing number of diabetic patients struggling to access medications due to high costs; and

Whereas, The prices of insulin in Indiana and across the nation have increased exponentially over the past two decades, including an increase of more than 1,000 percent in Humalog; and

Whereas, States have produced legislation aimed at tracking unreasonable price increases in essential medications; therefore be it

RESOLVED, That our American Medical Association advocate to the U.S. Surgeon General for federal legislation that investigates all drug pricing. (Directive to Take Action)

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

Received: 10/09/18

RELEVANT AMA POLICY

https://policysearch.ama-assn.org/policyfinder/search/drug%20pricing/relevant/1/.
Whereas, Oncologists currently purchase chemotherapeutic agents for in-office administration to patients and bill Medicare for the purchase cost plus an additional 6 percent of the cost of the chemotherapeutic agent as reimbursement for the infusion or injection of said agent; and

Whereas, The 6 percent reimbursement becomes 4.3 percent with prompt pay discounts; and

Whereas, The time and attention required to administer one chemotherapeutic agent compared to another has no relation to its cost; and

Whereas, The current Medicare reimbursement strategy poses financial risks to practices and creates a perverse incentive to prescribe a newer, more expensive drug when an older, less expensive drug may be equally effective; and

Whereas, It also drives up the medical costs of administering chemotherapy without adding value; and

Whereas, The failings of the buy-and-bill system impact all oncologists, but small independent practices shoulder the greater burden; and

Whereas, The very existence of small independent practices is threatened, and with it access to care for many of our most vulnerable patients; and

Whereas, “Freeing oncologists from dependency on drug revenues while keeping outpatient oncology viable requires a focus on reimbursement for services that are uncompensated or undercompensated in the current system;” therefore be it

RESOLVED, That our American Medical Association amend policy H-55.994 by addition to read as follows:

Coverage of Chemotherapy in Physicians' Offices H-55.994
The AMA: (1) supports adequate reimbursement for outpatient oncology office visits that recognizes the complexity of the patient’s care management; and (2) advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized (Modify Current HOD Policy); and be it further
RESOLVED. That our AMA advocate for a change to the Medicare reimbursement formula such that the costs of chemotherapeutic agents are covered, plus an unrelated flat fee to cover the cost of the infusion or injection of said agents. (Directive to Take Action)

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

Received: 10/10/18

RELEVANT AMA POLICY

Coverage of Chemotherapy in Physicians' Offices H-55.994
The AMA advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized.
Whereas, USA Today has reported on seriously deleterious physician hiring practices in the Veterans Health Administration; and

Whereas, These deleterious hiring practices include subjecting our nations’ veterans to care by physicians who have faced dozens of malpractice cases, and who have been sanctioned and, in some cases, have lost their licenses to practice in at least one state; and

Whereas, The U.S. Government Accountability Office has recently reported that the U.S. Department of Veterans Affairs failed to report 90 percent of potentially dangerous medical providers in recent years to a national database; and

Whereas, USA Today has found that oversight of the Veteran’s Administration is so lax that the Veterans Administration had no idea how many medical workers had been reported or if they had been reported at all; and

Whereas, The U.S. Government Accountability Office has discovered that at one facility, officials failed to report six providers to the national practitioner database because the officials were unaware that they had been delegated responsibility for reporting; and

Whereas, Patients receiving care in non-Veterans Health Administration institutions would not be subjected to similar substandard care; therefore be it

RESOLVED, That our American Medical Association amend policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows:

Ensuring Access to Safe and Quality Care for our Veterans H-510.986

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.

2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.

3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.

4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the
registry be made available to the veterans in their community and the local Veterans Administration.

5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains first-rate, competent, and ethical physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

6. Our AMA will engage the Veterans Health Administration in dialogue on accreditation practices by the Veterans Health Administration to assure they are similar to those of hospitals, state medical boards, and insurance companies.

((Modify Current HOD Policy)

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

Received: 10/10/18

RELEVANT AMA POLICY

Ensuring Access to Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
Citation: (Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15)

Expansion of US Veterans' Health Care Choices H-510.983
1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.

9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.

10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.

Citation: CMS Rep. 06, A-17

Fixing the VA Physician Shortage with Physicians D-510.990

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.

2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.

3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.

Citation: Res. 1010, A-16

Support for VA Health Services for Women Veterans H-510.981

Our AMA recognizes the disparity in access to care for women veterans, and encourages research to address this population's specific needs to improve patient outcomes.

Citation: Res. 825, I-17

Access to Health Care for Veterans H-510.985

Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Health Care for Veterans and Their Families H-510.989

Our AMA supports the recommendations of the President's Commission on Care for America's Wounded Warriors report "Serve, Support, Simplify."

Citation: BOT Rep. 6, A-08; Reaffirmed: BOT Rep. 09, A-18
Health Care for Veterans and Their Families D-510.994
Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.
Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Health Care Policy for Veterans H-510.990
Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).
Citation: (Sub. Res.115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.
Citation: (CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09)

Requiring The Joint Commission to Conduct Root-Cause Analysis to Determine How its Surveys Allowed Veterans Administration Hospitals to Cause Delay in Treatment and Harm Veterans D-510.991
Our AMA supports The Joint Commission making public its findings following its resurveying of Veterans Health Administration (VHA) facilities to ensure quality of care and patient safety.
Citation: (Sub. Res. 709, A-15)

Budgetary and Management Needs of the Veterans Health Administration H-510.995
Our AMA urges Congress and the President to provide the VHA: (1) with funding sufficient to allow its hospitals and clinics to provide proper care to the patients the VHA is mandated to treat; and (2) with maximum flexibility in eliminating unneeded or duplicative services and in closing clinics or hospitals.
Citation: (BOT Rep. EE, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10)
Whereas, The current medical economic environment is creating many changes in the configurations of medical practices, as well as impacting how physicians decide whether to group together or work alone; and

Whereas, The hassle factors associated with accepting insurances represents a major cost to practices and causes frustration for physicians; and

Whereas, Physicians have no control over which insurances their patients subscribe to; and

Whereas, Physicians have no control over the divergent requirements of each individual insurance company; and

Whereas, An increasing subset of physicians have chosen to no longer accept insurance; instead, choosing to pursue rapidly growing models of primary care referred to as direct primary care and concierge medicine; and

Whereas, Some medical practices charge a membership fee which allows them to offer a complete range of primary care services, including those that insurance coverages do not allow; and

Whereas, Current Internal Revenue Service (IRS) rules and interpretations present barriers that impede individual participation in direct primary care and concierge medicine models; and

Whereas, These impediments include restrictions and prohibitions on the use of funds from health savings accounts to pay for certain fees attributed to membership in these care delivery models, as well as prohibiting an individual who has an arrangement with a direct primary care practice from contributing to a health savings account; therefore be it

RESOLVED, That our American Medical Association actively lobby for revision to the U.S. tax code to allow funds from health savings accounts to be used for concierge medicine and direct primary care without incurring a tax penalty. (Directive to Take Action)

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

Received: 10/10/18
RELEVANT AMA POLICY

Direct Primary Care H-385.912
Our AMA supports: (1) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (2) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
Citation: Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18