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EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 701, “Employed Physician Bill of Rights.” Resolution 701-A-18 was introduced by the Illinois Delegation and asked our AMA to adopt an extensive Employed Physician’s Bill of Rights. The HOD also referred Resolution 702-A-18, “Basic Practice Professional Standards of Physician Employment,” which was introduced by the Indiana Delegation and asked our AMA to adopt a series of best practices for physician employment contracts.

Testimony on Resolutions 701 and 702-A-18 suggested that much of the content of the resolutions is already addressed by AMA policy, and that in some cases the proposed policy positions might be inconsistent with existing AMA policy. This report compares these resolutions to the existing body of AMA policy on physician employment and related matters and provides recommendations accordingly.

The Board’s analysis found that most of the concepts set forth in Resolutions 701 and 702-A-18 are already addressed in AMA policy, and the Board recommends reaffirmation of these policies. In some cases, the proposed policies are inconsistent with existing policy. Finally, the Board’s analysis identified two themes in Resolutions 701 and 702-A-18 not addressed by existing policy—academic freedom for employed physicians and appropriate levels of administrative and clinical support—and recommends adoption of new policy in these areas.
INTRODUCTION

At the 2018 Annual Meeting, the House of Delegates (HOD) referred Resolution 701, Employed Physician Bill of Rights. Resolution 701 was introduced by the Illinois Delegation and asked our AMA to adopt an extensive Employed Physician’s Bill of Rights. The HOD also referred Resolution 702, Basic Practice Professional Standards of Physician Employment, which was introduced by the Indiana Delegation and asked our AMA to adopt a series of best practices for physician employment contracts. These resolutions are reproduced in full in the appendix.

Testimony on Resolutions 701 and 702-A-18 suggested that much of the content of the resolutions is already addressed by AMA policy, and that in some cases the proposed policy positions might be inconsistent with existing AMA policy. This report compares these resolutions to the existing body of AMA policy on physician employment and related matters and provides recommendations accordingly.

BACKGROUND

AMA policy on physician employment matters dates back more than two decades and covers an extensive range of issues. In 2012, recognizing the growing number of physicians becoming employed, the AMA consolidated and expanded this guidance in the form of the AMA Principles for Physician Employment (Policy H-225.950), which have since been updated a handful of times. As noted in the original preamble, the Principles “are intended to help physicians, those who employ physicians, and their respective advisors identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment.” In addition to this body of policy, the AMA has developed a variety of resources to help physicians navigate physician-employer relations, most notably its model employment agreements.

RESOLUTION 701-A-18, EMPLOYED PHYSICIAN BILL OF RIGHTS

The first resolve of Resolution 701-A-18 asks the AMA to adopt an “Employed Physician Bill of Rights,” the provisions of which are delineated in resolves 2-11. We discuss below the asks of each resolve with respect to the AMA Principles for Physician Employment and other AMA policy.

Resolve 2 asks “That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational
endeavors and preparation, committee participation, student/resident activities and administrative responsibilities.”

Resolve 2 is addressed by Policy H-225.997, “Physician-Hospital Relationships,” which is also more nuanced than the proposed policy position:

“(4) Hospital-associated medical specialists, as well as all members of the medical staff, are expected to contribute a reasonable amount of their time, without compensation, to participation in hospital staff committee activities for the purpose of improving patient care; providing continuing education for the benefit of the medical staff; and assisting in the training of physicians and allied health personnel. Physicians who provide teaching or other services in excess of those ordinarily expected of members of the attending staff are entitled to reasonable compensation therefore.”

Resolve 3 asks “That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits.”

While existing policy recognizes several areas in which employed physicians should have “freedom,” it does not explicitly address academic freedom. We therefore propose an amendment to Policy H-225.950, “AMA Principles for Physician Employment,” as follows:

“(1)(b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.”

Resolve 4 asks “That this bill of rights include the principle that physicians should not be solely responsible for data entry, coding and management of the use of electronic medical record systems.”

Current AMA policy does not explicitly address administrative burden on employed physicians. While physicians must ultimately take responsibility for the care of their patients, which includes documentation and other uses of the electronic medical record, they should not be burdened with such tasks to the detriment of patient care. We therefore recommend adoption of new AMA policy as follows:

Employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

Resolve 5 asks “That this bill of rights include the principle that clinical activity should be evaluated only through the peer review process and judged only by clinicians, not corporate executives.”

Resolve 5 is addressed by Policy H-225.950, “AMA Principles for Physician Employment,” and H-225.942, “Physician and Medical Staff Member Bill of Rights:”
H-225.905: “(5)(c) Peer review of employed physicians should be conducted independently of
and without interference from any human resources activities of the employer. Physicians—not
lay administrators—should be ultimately responsible for all peer review of medical services
provided by employed physicians.”

H-225.942: “(IV)(d) “individual medical staff members have “the right to be evaluated fairly,
without the use of economic criteria, by unbiased peers who are actively practicing physicians
in the community and in the same specialty.”

Resolve 6 asks “That this bill of rights include the principle that physician activities performed
outside of defined employed-time boundaries are the sole prerogative of the individual physician
and not the employer organization unless it directly conflicts with or increases risk to the
organization.”

AMA Policy H-225.950, “AMA Principles for Physician Employment,” recognizes two important
points related to Resolve 6: First, that employed physicians do in fact owe a duty of loyalty to their
employers, which may reasonably limit their rights to engage in activities that conflict with the
financial or other interests of the employer—for example, moonlighting at a competing hospital:

“(1)(a) A physician’s paramount responsibility is to his or her patients. Additionally, given that
an employed physician occupies a position of significant trust, he or she owes a duty of loyalty
to his or her employer. This divided loyalty can create conflicts of interest...which employed
physicians should strive to recognize and address.”

At the same time, the policy states that “employed physicians should be free to engage in volunteer
work outside of, and which does not interfere with, their duties as employees.”

We believe that these two statements taken together appropriately addresses the matter of
“physician activities performed outside of defined employed-time boundaries” and recommend no
amendments to existing policy. Physicians are encouraged to carefully negotiate their contract to
ensure their desired level of independence outside the context of employed time is protected.

Resolve 7 asks “That this bill of rights include the principle that conflict-of-interest disclosures
should be limited to physician activities that directly affect the organization and should only be
disclosed to entities that directly reimburse the physician during their employed time period.”

Resolve 7 is addressed by two provisions of Policy H-225.955, “Protection of Medical Staff
Members' Personal Proprietary Financial Information,” to which we recommend a clarifying edit:

“(1)(a) Physicians should be required to disclose personal financial information to the
hospital/health system only if they are serving or being considered to serve as a member of the
governing body, as a corporate officer, or as an employee/contractor of the hospital/health
system; and such information should be used only so that other individuals understand what
conflicts may exist when issues are discussed and when recusal from voting or discussion on
an issue may be appropriate.”

“(2) Medical staff members' personal financial information shall remain confidential except for
disclosure to those with a bona fide need for access to such information. The security and
storage of such information, including electronic and paper-based, should be at the same level
as that afforded to other data and files in the hospital, such as patient and peer review
information that enjoy confidentiality and privacy protections, including restricted access, password protection and other protective mechanisms.”

Resolve 8 asks “That this bill of rights include the principle that restrictive covenants should be limited only to physicians with partnership stakes in the organization and should not apply to salary-based physicians.”

Resolve 8 is addressed by Ethical Opinion 11.2.3.1, “Restrictive Covenants,” and Policy H-225.950, “AMA Principles for Physician Employment,” both of which discourage physicians from entering into employment contracts that contain restrictive covenants, regardless of status as a partner or salaried employee:

Code of Medical Ethics 11.2.3.1: “Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms. Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Physicians should not enter into covenants that: (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) Do not make reasonable accommodation for patients’ choice of physician.”

H-225.950: "(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment."

Resolve 9 asks “That this bill of rights include the principle that resources should be appropriately allocated by the organization for continuing medical education as defined by state licensure guidelines.”

Resolve 9 is inconsistent with Policy H-300.982, “Maintaining Competence of Health Professionals,” which places on the physician the burden of the cost of completing continuing medical education:

“(1) Health professionals are individually responsible for maintaining their competence and for participating in continuing education; all health professionals should be engaged in self-selected programs of continuing education. In the absence of other financial support, individual health professionals should be responsible for the cost of their own continuing education.”

We note also that compensation or reimbursement for CME is a fairly common benefit of employment which physicians should consider carefully as they negotiate employment contracts. Refer to the AMA annotated model physician employment agreements for guidance.1

Resolve 10 asks “That this bill of rights include the principle that employed physicians have the right to the collective bargaining process as outlined in the National Labor Relations Act of 1935 (The Wagner Act).”

Given that collective bargaining is largely toothless without the specter of a strike, resolve 10 is arguably inconsistent with Ethical Opinion 1.2.10, “Political Action by Physicians,” and Policy H-383.998, “Resident Physicians, Unions and Organized Labor,” which discourage physicians

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1 These and other resources on employment contracts are available at ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts.
from withholding essential medical services from patients or otherwise disrupting patient care as a bargaining tactic:

Code of Medical Ethics 1.2.10: “Physicians who participate in advocacy activities should: (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised; (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice; (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians’ primary and overriding commitment to patients; (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.”

H-383.998: “Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA’s Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.”

Resolve 11 asks “That this bill of rights include the principle that all physicians be empowered to first be the patient’s advocate and be allowed to adhere to the spirit of the Hippocratic Oath allowing patient privacy, confidentiality and continuity of a patient’s health care and dignity.”

Resolve 11 is addressed by Policy H-225.950, “AMA Principles for Physician Employment:”

H-225.950: “(2)(a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.”

H-225.950: “(1)(b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.”

Additionally, as noted in the AMA’s history of its Code of Medical Ethics, the Code “is rooted in an understanding of the goals of medicine as a profession, which dates back to the 5th century BCE and the Greek physician Hippocrates, to relieve suffering and promote well-being in a relationship of fidelity with the patient.”

RESOLUTION 702-A-18, BASIC PRACTICE PROFESSIONAL STANDARDS OF PHYSICIAN EMPLOYMENT

Resolution 702-A-18 identifies a set of “best practices” related broadly to physician employment and asks our AMA to support specific contract provisions that might improve the physician experience in the employed settings:
That our American Medical Association support best practice for physician employment that will promote improved work-life balance and maximum employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

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

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

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

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

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

While none of these aims is objectionable on its face, the creation of such a list would seem to be inconsistent with an overarching theme of AMA employment-related policy: that physicians must be free to and should exercise self-determination in employment contracting. Specifically, Policy H-225.950, “AMA Principles for Physician Employment,” avers that “Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession” (emphasis added). Furthermore, “physicians should never be coerced into employment” and “employment agreements between physicians and their employers should be negotiated in good faith,” with “both parties [being] urged to obtain the advice of legal counsel experienced in physician employment matters….”

Individual physicians must determine for themselves what they seek in employment arrangements and how they weigh these various desires. For example, some physicians may choose to forego work flexibility or smaller workload in exchange for greater compensation; others may choose to forego additional compensation to work for an organization that provides a higher level of administrative support. So long as they balance these desires in a manner that does not compromise the ethical principles of the medical profession, physicians should be free to negotiate their contracts as they see fit. Physicians are encouraged to use AMA resources in this regard, such as the AMA’s model physician employment agreements. These valuable resources include a thorough description of basic contract terms typically found in an employment agreement, an in-depth explanation of the significance of such provisions and language that benefits the physician employee, and important examples of language that may be problematic to the physician employee.

Finally, we note that some sections of Resolution 702-A-18—in particular, items 1-3—raise an issue discussed earlier in this report: appropriate levels of support for employed physicians. While physicians should be free to negotiate for their desired level of staffing, AMA should ensure that physicians are provided at least the level of staffing needed to ensure that they can deliver safe,
high-quality care to their patients. We therefore recommend adoption of new AMA policy as follows (and as presented in the discussion on Resolve 4 of Resolution 701-A-18):

Employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

CONCLUSION

The concepts set forth in Resolution 701-A-18, “Employed Physician Bill of Rights,” and Resolution 702-A-18, “Basic Professional Standards of Physician Employment,” are for the most part addressed by a variety of existing AMA policies. We recommend reaffirmation of these policies. In a few instances, the concepts set forth in Resolutions 701 and 702-A-18 are inconsistent with current policy, in which case we recommend no change in policy. Finally, we have identified two themes not addressed by existing policy—academic freedom for employed physicians and appropriate levels of administrative and clinical support—and we recommend adoption of new policy in these areas.

RECOMMENDATIONS

The Board of Trustees recommends the following be adopted in lieu of Resolution 701-A-18 and Resolution 702-A-18, and the remainder of the report be filed:

1. That our AMA reaffirm the following policies:

   - H-225.950, AMA Principles for Physician Employment,
   - H-225.997, Physician-Hospital Relationships,
   - H-225.942, Physician and Medical Staff Member Bill of Rights,
   - H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information,
   - H-300.982, Maintaining Competence of Health Professionals, and
   - H-383.998, Resident Physicians, Unions and Organized Labor. (Reaffirm HOD Policy)

2. That our AMA amend policy H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information:

   “(1)(a) Physicians should be required to disclose personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or as an employee/contractor of the hospital/health system; and such information should be used only so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate.” (Modify Current HOD Policy)

3. That our AMA amend policy H-225.950, AMA Principles for Physician Employment:

   “(1)(b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical
research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.” (Modify Current HOD Policy)

4. That our AMA advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients. (New HOD Policy)

Fiscal Note: Less than $500.
Appendix

Resolution 701-A-18, “Employed Physician’s Bill of Rights”

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

RESOLVED, That this bill of rights include the principle that compensation should be based on the totality of physician activities for the organization, including but not limited to educational endeavors and preparation, committee participation, student/resident activities and administrative responsibilities; and be it further

RESOLVED, That this bill of rights include the principle that physicians have academic freedom, without censorship in clinical research or academic pursuits; and be it further

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region.
REPORT 15 OF THE BOARD OF TRUSTEES (A-19)
Physician Burnout and Wellness Challenges
Physician and Physician Assistant Safety Net
Identification and Reduction of Physician Demoralization
(Reference Committee G)

EXECUTIVE SUMMARY


The AMA is committed to addressing the issues of physician, resident, and medical student burnout, stress and suicide. This report addresses the overarching topic, each resolution as it relates to the issue, and the concerns raised at the 2018 Annual Meeting.

This report discusses the numerous efforts underway at the AMA to help identify and provide solutions to the issue and presents recommendations to amend existing HOD Policy related to the issues discussed throughout the report.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-19

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

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2017 Interim Meeting, three resolutions (601-I-17, “Physician Burnout and Wellness Challenges,” 604-I-17, “Physician and Physician Assistant Safety Net,” and 605-I-17, “Identification and Reduction of Physician Demoralization”) with shared components of a central issue were referred for report back together at the 2018 Annual Meeting and presented in BOT Report 31-A-18. Based on testimony in Reference Committee G asking for further clarifications, BOT 31-A-18 was referred back for a report at the 2019 Annual Meeting. This report addresses the overarching topic, each resolution as it relates to the issue, and the concerns raised at the 2018 Annual Meeting, and presents recommendations accordingly.

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

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

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

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BACKGROUND

Today’s physicians are experiencing burnout at increasing rates, expressing feelings of professional demoralization, and feeling professionally under-valued and overburdened by an ever-changing health care system.1-3 Forty-four percent of practicing physicians report experiencing at least one symptom of burnout, compared to 54 percent in 2014 and 45 percent in 2011.4 Practicing physicians are not alone in reported symptoms of burnout; resident and medical student burnout is also on the rise. It is recognized that with growing numbers of physicians, residents and medical students experiencing burnout, health care quality will decline and patient safety will suffer.5 Physician suicide rates have been found to be historically higher than the general population.6 Stress, depression and burnout can lead to suicidal ideation and sometimes suicide. Resources such as safety nets and hotlines are available for individuals experiencing suicidal ideation and are available from a number of national and reputable sources.

AMA POLICY

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

The AMA supports programs to assist physicians in early identification and management of stress. The programs supported by the AMA concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, as well as when to seek professional assistance for stress-related difficulties (Policy H-405.957, “Programs on Managing Physician Stress and Burnout”). AMA policy and the Code of Ethics acknowledge that when physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided (Code of Ethics 9.3.1, “Physician Health & Wellness”). In recognizing the importance of access to health and wellness-focused resources, AMA policy encourages employers to provide, and employees to participate in, programs on health awareness, safety and the use of health care benefit packages (Policy H-170.986, “Health Information and Education”). The AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness (Policy H-405.961, “Physician Health Programs”).

Educating physicians about physician health programs is greatly important to the AMA. The AMA will continue to work closely with the Federation of State Physician Health Programs (FSPHP) to educate its members about the availability of services provided by state physician health programs to ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. The AMA, in collaboration with the FSPHP, develops state legislative guidelines to address the design and implementation of physician health programs, as well as messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training (Policy D-405.990, “Educating Physicians About Physician Health Programs”). The AMA will continue to collaborate with other relevant organizations on activities that address physician health and wellness.
The AMA recognizes physical or mental health conditions that interfere with a physician’s ability to engage safely in professional activities can put patients at risk, compromise professional relationships and undermine trust in medicine. While protecting patients’ well-being must always be the primary consideration, physicians who are impaired are deserving of thoughtful, compassionate care (Code of Ethics 9.3.2, “Physician Responsibilities to Impaired Colleagues”). AMA policy defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities. In the same policy, the AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians and to develop case finding mechanisms for all types of physicians (Policy H-95.955, “Physician Impairment”).

Access to confidential health services for medical students and physicians is encouraged by the AMA to provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services. The AMA will continue to urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, only focus on current impairment by mental illness or addiction, and to accept “safe haven” non-reporting for physicians seeking licensure or re-licensure who are undergoing treatment for mental health or addiction issues to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety. The AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would: (a) be available to all medical students on an opt-out basis; (b) ensure anonymity, confidentiality, and protection from administrative action; (c) provide proactive intervention for identified at-risk students by mental health and addiction professionals; and (d) inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation. The AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and, (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. The AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education (Policy H-295.858, “Access to Confidential Health Services for Medical Students and Physicians”).

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

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

The AMA partnered with the RAND Corporation in 2013 to identify and study the factors that influence physician professional satisfaction, as well as understand the implications of these factors for patient care, health systems, and health policy. This seminal work informed subsequent initiatives and a long-term strategy for AMA’s Professional Satisfaction and Practice Sustainability (PS2) unit. This dedicated AMA unit is focused on institutional and system-level solutions that aim to resolve root causes of burnout and demoralization, rather than solely focusing on improving individual resilience to alleviate symptoms experienced by dealing with a dysfunctional health system.

Through the PS2 unit, the AMA supports and carries out research efforts aimed at understanding and identifying solutions to the system-level issues that lead to physician demoralization and burnout. In 2017 and 2018 the AMA partnered with leading academic institutions to conduct follow-up research to its 2011 and 2014 national studies on physician burnout and satisfaction, seeking to learn if the rates of burnout have changed over the past 7 years. The AMA has studied how physicians spend their time to quantify the administrative burdens during and after a physicians’ workday. The AMA has also completed significant research on the burdens of EHRs, including the time to complete tasks, the usability of products, and the process of EHR development. Furthermore, the AMA has researched the impacts of physician burnout, including the effects on a physician’s innate sense of calling and implications for the physician workforce. All of this research has been published in leading peer-reviewed journals to build the evidence base for the factors that cause physician dissatisfaction and burnout and their impacts. This body of knowledge has been a powerful tool for advocating to legislators, regulators, and industry executives to make improvements to address the issues that cause physician dissatisfaction.

The AMA continues to convene members of the research community at the bi-annual American Conference on Physician Health and International Conference on Physician Health. To provide hands-on, real-world demonstration of practice-level solutions, the AMA hosts boot camps that help physicians learn how to plan and implement effective strategies to improve their practice to reduce the amount of time they spend on administrative and clerical work, ultimately improving physician satisfaction and reducing reports of burnout.

A number of key accomplishments and offerings have been realized through AMA’s launch of the free, online STEPS Forward™ practice transformation platform. This online resource offers over 50 modules of content developed by subject matter experts and is specifically designed for physicians, practices, and health systems. The STEPS Forward platform has been openly shared with leadership of many state and specialty societies, as well as presented to their memberships in various forums. In addition, the AMA has partnered with health systems, large practices, state
medical societies, state hospital associations and graduate medical education programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment. The assessment offers organizations a validated instrument that provides an organizational score for burnout, along with two subscale measures for “Supportive Work Environment” and “Work Pace and EMR Frustration.” In addition to the organizational dashboard, the assessment is able to provide a comprehensive data analysis complete with medical specialty and clinic level benchmarking. The trends and findings from the assessment are shared and targeted interventions are recommended to the surveying organization. The interventions and suggested solutions are curated from existing STEPS Forward content and through specific best practices identified through AMA collaborators.

The AMA is also developing the AMA Practice Transformation Initiative: Solutions to Increase Joy in Medicine. This initiative will support research to advance evidence-based solutions and engage health care leaders to improve joy in medicine through the use of validated assessment tools, a centralized, integrated data lab, grant-funded practice science research, and field-tested information dissemination and implementation support. It will build the evidence base for private and public investment in clinician well-being as a means of achieving the Quadruple Aim. The focus of the AMA Practice Transformation Initiative is distinct from and complementary to other national initiatives addressing clinician well-being. For example, the work of the National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience is focused on building awareness. This AMA initiative will move beyond awareness to filling the knowledge gaps that exist regarding effective systemic interventions to reduce burnout. In a similar manner, the 1999 Institute of Medicine (now renamed the National Academy of Medicine) report “To Err is Human” raised awareness of patient safety issues. It was then up to other organizations to build further evidence and disseminate effective interventions. In this vein, the AMA Practice Transformation Initiative will be positioned to lead the medical community in building momentum and disseminating evidence-based solutions to reduce burnout and improve satisfaction. This effort is currently in the pilot phase with broader expansion planned for mid- to late-2019.

Resolution 601-I-17 asks the AMA to advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness, and for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. In addition to HOD policy that affirms the importance of physician health and education about wellness, the AMA has been actively and directly engaged with health care organizations, including state and county medical societies, to build awareness and support for addressing physician burnout. The Physicians Foundation funded an effort to develop a manual on how to create a Physician Wellness Program (PWP) for medical societies called LifeBridge. In addition to a toolkit, the manual includes research and background supporting the need for such a program. Having medical societies provide local, onsite counseling is the cornerstone of the program, in addition to including other aspects of physician wellness resources such as professional coaching, educational topics, resource centers, and ways to address health system barriers and advocate for employer change. With this resource, numerous state and county medical societies are developing and launching physic program with in-person support. Hundreds of physicians have accessed these resources to date.

The mission of the Federation of State Physician Health Programs (FSPHP) is to support physician health programs in improving the health of medical professionals, thereby contributing to quality patient care. One of FSPHP’s top priorities is the development of a Performance Enhancement and Effectiveness Review program called PEER™. The goal of PEER is to empower physician health programs (PHPs) to optimize effectiveness. At the same time, they are developing a Provider Accreditation program that will accredit specialized treatment centers and other providers in the care of physicians and other safety-sensitive professionals. These programs will ensure quality care
and ensure PHPs select providers that have proven compliance with objective standards. The AMA has provided grant funding toward this new effort and has provided a designee to serve on FSPHP’s Accreditation Review Council (ARC) that will oversee the strategy and policies of the developing PEER program.

Concerns have been raised that physicians who access wellness programs may be stigmatized if they report feelings of demoralization or burnout. This could subject a physician to loss of employment or to state medical licensing board actions, including loss of license. It is imperative that strategies be developed by state medical associations to encourage physicians to participate in health programs without fear of loss of license or employment. Assuring that de-stigmatization of physician burnout is addressed at the local, state and national levels is an important first step in ensuring those who need support can receive it without fear of adverse consequences.

Resolution 604-I-17 asks the AMA to study a safety net, such as a national hotline, that all United States physicians and physician assistants can call when in a suicidal crisis. Testimony heard in the reference committee hearing further clarified the request for a task force to research, collect, publish and administer a repository of information about programs and strategies that optimize physician wellness. The AMA, through its ongoing work in the Professional Satisfaction and Practice Sustainability (PS2) strategy unit, acknowledges the importance of addressing and supporting physician mental health and has developed and published numerous resources to help physicians manage stress and prevent and reduce burnout. Since its inception in 2011, the activities have been aided by a PS2 Advisory Committee composed of a diverse membership representing the AMA physician membership as well as the business of medicine. Meeting quarterly, the PS2 Advisory Committee provides strategic insight and direct feedback to the PS2 staff on activities ranging from practice transformation and burnout to digital health, payment and quality. The composition of the PS2 Advisory Committee ensures the committee provides content expertise in the subject matter areas on which the PS2 group focuses.

While an online search indicates there is no current, easily identifiable suicide prevention line exclusively for physicians or health care workers, there are many national, state and locally operated hotlines available that are open to all individuals regardless of profession. A list of many of these resources is available in the STEPS Forward module “Preventing Physician Distress and Suicide.” The AMA is evaluating Employee Assistance Program (EAP) service providers to explore the option of piloting a service to AMA members as a membership benefit. Some EAP services provide participants with 24/7 telephone or video access to qualified and trained counselors, wellness services, and critical incident support. This evaluation is in early stages and a decision to pursue various options will be considered. In addition, the AMA will continue to update the list of available suicide prevention resources in its related STEPS Forward module.

The AMA is also developing a dynamic education module that will help physicians, physicians in training, and medical students learn about the risks of suicide for physicians, identify characteristics to look for in patients who may be at risk of harming themselves, and recognize the warning signs of potential suicide risk in colleagues. The module, to be offered with continuing medical education credit on the AMA’s Education Center, will also provide tools and resources to guide learners in supporting patients and colleagues at risk for suicide.

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

Current efforts and strategic priorities demonstrate that the AMA recognizes the importance of assessment and attention to depression in physicians, residents and medical students, as well as the relationship that depression can have with suicidal ideation. Current AMA research and strategic initiatives are focused on enhancing workflows within the system and clinical setting with the intent to increase efficiency and reduce feelings of burnout among physicians. The AMA’s role in sharing burnout and depression screening data is to assist physician employers in understanding individual physician burnout and connecting physicians with employee assistance resources. Considering the AMA’s current efforts and ongoing commitment to providing resources on the topics of burnout, distress and suicide prevention, stress reduction, and wellness, convening an exclusive task force separate from the AMA staff already dedicated to this work would be duplicative. Making existing relevant AMA resources available to physicians seeking help can be accomplished and is part of current AMA practices. The AMA will continue to direct physicians to its current resources and those that are being developed by state and county medical associations to learn about strategies, programs and tools related to this topic, and will further explore options for providing more direct assistance for physicians in need.

Feedback from the reference committee at A-18 expressed concern about the earlier report’s lack of proposals for prevention and treatment programs to address physician burnout. By its current policies, through the work of AMA business units, and in the Code of Medical Ethics, the AMA recognizes the importance of programs that prevent and treat stress, depression and other conditions that can lead to burnout. We also realize that the AMA is not a direct provider of health care services; however, the AMA supports and will continue to encourage the development of and participation in programs to assist physicians in early identification and management of stress, burnout and demoralization.

Resolution 605-I-17 asks the AMA to (1) recognize that physician demoralization is a problem among medical staffs; (2) advocate that hospitals be required by accrediting organizations to confidentially survey physicians to identify factors that may lead to physician demoralization; and (3) develop guidance to help hospitals and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff wellness. Testimony in the reference committee hearing recognized that “burnout” is a commonly used term favored by many physicians, and while there is some preference for the use of another term instead of “burnout,” there was no consensus on what that term should be. The AMA recognizes that burnout is characterized by emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness. These feelings can result from a multitude of driving factors, such as administrative burden, excessive EHR documentation and systemic cultural deficiencies. The term “burnout” is often used to encompass the multiple driving factors of physician dissatisfaction as well as the resultant feelings and behaviors associated with being overworked, excessively scrutinized and overburdened with unnecessary tasks. As the term “burnout” is used broadly, this allows for many variations in the interpretation of its meaning. The AMA does not define the term “burnout” as an individual “resilience deficiency” or character flaw.
The AMA supports and voices a position that burnout is derived from system and environmental issues, not from the individual physician. In other words, physician burnout is a symptom of system dysfunction. This position is evidenced by AMA resources and services targeted at system-level approaches to intervention.

The AMA has numerous efforts underway to address the system-driven sources of physician demoralization and burnout, such as the increasing volume of administrative requirements like quality reporting and prior authorization, the lack of transparency and interoperability with EHRs, and the complex and ever-changing payment environment. The AMA, as part of its prior authorization reform initiatives, convened a workgroup of 17 state and specialty medical societies, national provider associations and patient representatives to develop a set of Prior Authorization Principles. The AMA has used these principles to spur conversations with health plans about “right-sizing” prior authorization programs. One outcome of these discussions was the January 2018 release of the Consensus Statement on Improving the Prior Authorization Process by the AMA, American Hospital Association, America’s Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. The consensus document reflects an agreement between national associations representing both providers and health plans on the need to reform prior authorization programs in multiple ways, including advancing automation to improve transparency and efficiency. The AMA, in addition to providing an evidence-base demonstrating the need for prior authorization reform, offers multiple resources to help physicians understand prior authorization laws and improve processes within the practice.

It is well-documented that the use of EHRs is a source of dissatisfaction for physicians. The AMA’s research includes multiple time-motion studies to determine how much and in what ways physicians spend time completing tasks in their EHRs. This research demonstrates evidence highlighting the need for system-level changes in the demands placed on the EHR as a tool for reporting and patient care. The AMA has also published eight EHR usability priorities, which outline and support the need for better usability, interoperability, and access to data for both physicians and patients. If followed, these priorities will enable the development of higher-functioning, more efficient EHRs, contributing to a reduction in the burden that EHR use places on patient care. Multiple collaborations are in place to help foster better EHR design and innovative HIT solutions to help make the EHR user experience better and more efficient. The AMA has established partnerships with the SMART Initiative, AmericanEHR Partners and Medstar Health’s National Center for Human Factors in Healthcare to help foster innovative HIT design and transparent testing solutions which will ensure EHRs are designed and implemented with physicians and patients in mind. In addition, the AMA actively participates in The Sequoia Project, Carequality, and the CARIN Alliance, all aimed at enhancing interoperability in health care. The AMA is also working to address specific cost drivers, such as connecting to clinical data registries and prohibitive fees that amount to data blocking. The AMA’s Physician Innovation Network is connecting physicians and health care technology entrepreneurs to ensure that the physician voice is integrated into health care technology solutions coming to market. Finally, the AMA is working with other high-profile stakeholders, including five EHR vendors, to develop a Voluntary EHR Certification framework which will help catalyze an industry wide shift to higher-quality EHR systems that enable better, more efficient use.

Another source of discontent for physicians are the myriad changes in payment models and quality reporting requirements facing practices. The AMA recently published a follow-up study to its 2014-2015 RAND research on the effects of payment models on physician practices in the U.S. The findings of the 2017-2018 study help the AMA, other industry stakeholders, and policymakers understand that the challenges experienced in practice due system complexity continue, and much
improvement is still needed. To help physicians and practices navigate these challenges, particularly those spurred by the MACRA Quality Payment Program, the AMA offers a variety of educational resources and practical tools, including step-by-step tutorials on QPP reporting, a MIPS Action Plan, and several others. Additional resources are in development to help physicians navigate the changing payment system that is increasingly putting an emphasis on cost and quality measurement.

Physicians who work irregular or long hours, or physicians in certain specialties, may experience a lack of work-life balance, which can further exacerbate burnout and professional dissatisfaction.\(^\text{15}\) Forty percent of physicians report not feeling that their work schedule leaves enough time for personal and/or family life.\(^\text{9}\) Furthermore, female physicians are more likely to be dissatisfied with work-life balance.\(^\text{15}\) To help physicians improve work-life balance, the AMA Women Physicians Section is working together with the American Academy of Pediatrics to explore the workforce issues and help physicians find practice options that work best for them and their families. For example, a physician may consider reducing work hours to accommodate their schedule. The AMA provides a self-assessment tool that helps physicians explore work/practice options and address career goals. The AMA hosts a series of educational resources that offer strategies on how to increase practice efficiency, understand physician burnout and how to address it, as well as develop a culture that supports physician well-being. Examples of education include online CME modules: “Creating the Organizational Foundation for Joy in Medicine™: Organizational changes lead to physician satisfaction,” “Creating Strong Team Culture: Evaluate and improve team culture in your practice,” “Physician Wellness: Preventing Resident and Fellow Burnout,” “Preventing Physician Burnout: Improve patient satisfaction, quality outcomes and provider recruitment and retention,” and “Improving Physician Resiliency: Foster self-care and protect against burnout.”

In addition, the AMA will continue to advocate for organizations to confidentially survey physicians to understand local levels of burnout and opportunities for strategic improvement. It should be noted that the AMA’s Mini-Z Burnout Assessment is deployed confidentially and takes protective safeguards very seriously to ensure accurate and safe reporting of results. To date, numerous health systems, physician practices, and residency programs have completed AMA’s burnout measurement program. This program will continue to be marketed and scaled to expand the use of measuring physician dissatisfaction and burnout. Through leveraging ongoing AMA media channels, hosting educational webinars, live speaking engagements, and the Transforming Clinical Practices Initiative (TCPI) grant through the Centers for Medicare and Medicaid Services (CMS), the AMA is striving to scale awareness and intervention to advance physician satisfaction and help address the burnout epidemic.

CONCLUSION

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

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

1. That our American Medical Association reaffirm the following policies:
   1. H-170.986, “Health Information and Education”
   2. H-405.957, “Programs on Managing Physician Stress and Burnout;”
   3. H-405.961, “Physician Health Programs;”
   5. H-95.955, “Physician Impairment;” and

2. That our American Medical Association amend existing Policy H-405.961, “Physician Health Programs,” to add the following directive (Modify Current HOD Policy):
   1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
   2. Our AMA encourages state medical societies to collaborate with the state medical boards to a) develop strategies to destigmatize physician burnout, and b) encourage physicians to participate in the state’s physician health program without fear of loss of license or employment.

3. That our AMA amend existing Policy D-310.968, “Physician and Medical Student Burnout,” to add the following directives (Modify Current HOD Policy):
   1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
   2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
   3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
   4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
   5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
   6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify factors that may lead to physician demoralization.

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

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

Fiscal note: Minimal – Less than $500
REFERENCES


5. Dyrbye, L.N., et al., Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care. NAM Perspectives, 2017.


REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-19

Subject: Non-Payment and Audit Takebacks by CMS
(Resolution 704-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 704-A-18, “Non-Payment and Audit Takebacks by CMS,” for report back at the 2019 Annual Meeting. This resolution was introduced by the New York Delegation and asked that:

Our American Medical Association (AMA) seek through legislation and/or regulation policies opposing claim nonpayment due to minor wording or clinically insignificant documentation inconsistencies;

Our AMA seek through legislation and/or regulation policies opposing extrapolation of overpayments based on minor inconsistencies; and

Our AMA seek through legislation and/or regulation policies opposing bundled payment denial based on minor wording or clinically insignificant documentation inconsistencies.

This report discusses the broader concept of medical record documentation, the administrative burden of documentation, and related AMA policy.

BACKGROUND

Medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record is a chronological reflection of the care of the patient and is an important element contributing to the quality of care. In addition, the medical record documentation serves as evidence of the provision of services, who provided the care, the medical necessity, and the quality of care. The original medical documentation must be filed in the patient’s medical record at that facility. The documentation of medical record can also be used by payers and oversight entities to deny or recoup payment for inadvertent mistakes.

While Congress, federal agencies, and states have made unprecedented investments in improving oversight and program integrity, significant challenges remain. Efforts to fight health care fraud or identify areas of waste or abuse have a tangible impact on physician practices. To comply with the federal program integrity and documentation requirements, physicians proactively conduct internal audits and adopt compliance programs at their own cost.

Broad-brush requirements that impose burdens on all physicians, rather than focusing on those providers who have demonstrated a propensity to commit fraud or abuse, inequitably affect
physicians and providers who are good actors, and result in unnecessary costs to the health care system. This fact is especially true in pre- and post-payment review. The number of reviews and types of reviewers are confusing, add unwarranted physician burden and unnecessary costs, and disrupt and distract from delivering patient-centered care. Furthermore, some contractors audit and attempt to recoup against services that Medicare does not require, do not adhere to CMS requirements surrounding the approval of Local Coverage Determinations (LCD), or are for minor, clinically insignificant errors.

The regulatory burden placed on physicians is also a major component of physician burnout. Physicians often must spend too much of their time on administrative tasks rather than providing care to patients. The evolving health care system needs easier enrollment, more rational program integrity rules, and fewer reporting requirements.

RELATED POLICIES

Our AMA has extensive policy opposing the imposition of inappropriate actions for minor documentation errors by the federal government and private payers. Physicians must be protected from allegations of fraud, waste and abuse, and penalties and sanctions due to the differences in interpretation and or inadvertent errors in coding. Moreover, AMA policy directs our AMA to oppose efforts to punish or harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services.

AMA policy also already directs our AMA to pursue legislative, regulatory, or other avenues to eliminate fines for inadvertent Medicare billing errors and to remove a physician from a potential review if there is proof that the error is only related to a clerical mistake. It is also AMA policy that insufficient documentation or inadvertent errors in the patient record do not constitute fraud or abuse and that there should be no medical documentation requirements for the inclusion of any items unrelated to the care provided. Furthermore, our AMA policy supports the elimination or improvement on the use of extrapolation in Medicare post-payment audits including RAC audits.

DISCUSSION

Our AMA has strong existing policy (see appendix) regarding the opposing of claim nonpayment for inadvertent, unintentional, or clerical errors. Our AMA is already working with the federal government to reduce administrative burden through regulatory relief efforts including areas involving inadvertent, unintentional, or clerical errors in documentation. Moreover, our AMA has stated multiple times that unnecessary administrative tasks undercut the patient-physician relationship. For example, studies have documented lower patient satisfaction when physicians spend more time looking at the computer and performing clerical tasks. Moreover, for every hour of face-to-face time with patients, physicians spend nearly two additional hours on administrative tasks throughout the day. The increase in administrative tasks is unsustainable, diverts time and focus away from patient care, and leads to additional stress and burnout among physicians. Furthermore, our AMA has already stated that CMS should review sub-regulatory guidelines, which create additional burdens on physicians, and reduce the number of sub-regulatory guidance documents that are issued.

While our AMA has policies, and has taken action in regard to inadvertent errors, the Board of Trustees believes that AMA policy could be more specific in addressing the concerns surrounding minor wording errors or clinically insignificant inconsistencies and their relationship to potential nonpayment, extrapolation of overpayments, and bundled payment denials. Although the original
resolves of Resolution 704-A-18 call for our AMA to “seek through legislation and/or regulation,”
the Board of Trustees believes that our AMA should have flexibility in addressing this issue and
not be required to only seek reform through legislation or regulation. Instead, in addition to these
avenues, our AMA should also be seeking reform through sub-regulatory guidance and other payer
policies.

Our AMA believes that eliminating and/or streamlining reporting, monitoring, and documentation
requirements will improve the health care delivery system and make the health care system more
effective, simple, and accessible. By reducing administrative burden, CMS can support the patient-
physician relationship and allow physicians to focus on an individual patient’s welfare and, more
broadly, on protecting public health.

RECOMMENDATION:

The Board of Trustees recommends that the following recommendation be adopted in lieu of
Resolution 704-A-18 and the remainder of the report be filed:

That our American Medical Association advocate to oppose claim nonpayment, extrapolation
of overpayments, and bundled payment denials based on minor wording or clinically
insignificant documentation inconsistencies. (New HOD Policy)

Fiscal Note: Less than $500

REFERENCES

1 E.g., CMS, Medicare Learning Network Fact Sheet: Complying with Medical Record Documentation
MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf; MSSNY, Basics of E/M
Coding: A Handbook for Physician Offices (2009), https://www.mssny.org/Documents/2016/Practice%20Resources/Coding_Handbook.doc_6-16-09-
Revised_8-14-09-add.pdf.

2 Physicians face pre-payment and postpayment scrutiny from a variety of government entities and
contractors including CMS, Medicare Administrative Contractors (MAC), Recovery Audit Contractors
(RAC), Unified Program Integrity Contractors (UPIC) (combining program safeguard, zone program
integrity, and Medicaid integrity contractors), Quality Improvement Organizations (QIO), Comprehensive
Error Rate Testing (CERT), and Supplemental Medical Review Contractors (SMRC).

3 Fraud and Abuse Within the Medicare System, (H-175.981).

4 Kennedy-Kassebaum: Fraud and Abuse, H-175.985.

5 Due Process for Physicians, H-175.982.


7 Medicare Guidelines for Evaluation and Management Codes, H-70.952.

8 Id.


10 Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991.

11 E.g., AMA Letter to CMS, Medicare and Medicaid Programs: Regulatory Provisions To Promote

12 Street RL et al., Provider Interaction with the Electronic Health Record: The Effects on Patient-Centered
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APPENDIX: AMA POLICIES

Policy H-175.981, “Fraud and Abuse Within the Medicare System”
(1) Our AMA stands firmly committed to eradicate true fraud and abuse from within the Medicare system. Furthermore, the AMA calls upon the DOJ, OIG, and CMS to establish truly effective working relationships where the AMA can effectively assist in identifying, policing, and deterring true fraud and abuse.
(2) Physicians must be protected from allegations of fraud and abuse and criminal and civil penalties and/or sanctions due to differences in interpretation and or inadvertent errors in coding of the E&M documentation guidelines by public or private payers or law enforcement agencies.
(3) The burden of proof for proving fraud and abuse should rest with the government at all times.
(4) Congressional action should be sought to enact a "knowing and willful" standard in the law for civil fraud and abuse penalties as it already applies to criminal fraud and abuse penalties with regard to coding and billing errors and insufficient documentation.
(5) Physicians must be accorded the same due process protections under the Medicare audit system or Department of Justice investigations, that are afforded all US citizens.

Policy H-175.982, “Due Process for Physicians”
It is the policy of the AMA to review current legislation governing fraud and abuse investigations and propose additional legislation and/or regulations as necessary and be prepared to take legal action in order to assure physicians due process in the conduct of fraud and abuse investigations. Our AMA requests the United States Department of Justice to establish a specific procedure for audit of a physician's office records which includes, but is not limited to, the following:
(1) Patient care in the physician's office must not be interrupted during the course of the audit;
(2) Patient ingress and egress must not be hindered during the course of an audit;
(3) Normal telephonic communication must not be interrupted during the course of an audit; and
(4) Normal routine of physician's care of patients in hospital or at home must not be interrupted.
AMA policy is to pursue legislative, regulatory or other avenues to eliminate fines for inadvertent Medicare billing errors.

Policy H-175.985, “Kennedy-Kassebaum: Fraud and Abuse”
Our AMA: (1) will work to alleviate the oppressive, burdensome effects on physicians of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
(2) opposes efforts to repeal provisions in Health Insurance Portability and Accountability Act of 1996 (HIPAA) that would alter the standard of proof in criminal and civil fraud cases or that would eliminate the ability of physicians to obtain advisory opinions regarding anti-kickback issues; and thoroughly evaluate and oppose other fraud and abuse proposals that are inappropriately punitive to physicians;
(3) will ensure that any proposed criminal fraud and abuse proposals retain the current intent standard of “willfully and knowingly” to be actionable fraud; and that the AMA oppose any effort to lower this evidentiary standard;
(4) will vigorously oppose efforts by the Department of Justice to punish and harass physicians for unintentional errors in Medicare claims submissions and the legitimate exercise of professional judgment in determining medically necessary services;
(5) continues its efforts to educate the entire Federation about the AMA's successful amendment of the Health Insurance Portability and Accountability Act (also commonly referred to as the Kassebaum-Kennedy bill) which resulted in language being added so that physicians cannot be
prosecuted or fined for inadvertent billing errors, absent an intent to "knowingly and willfully" defraud;
(6) educates the public and government officials about the distinction under the law, between inadvertent billing errors and fraud and abuse; and
(7) responds vigorously to any public statements that fail to distinguish between inadvertent billing errors and fraud and abuse.
Reaffirmation I-01 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, A-12

Policy H-175.979, “Medicare ‘Fraud and Abuse’ Update”
Our AMA seeks congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors.
BOT Rep. 34, I-98 Reaffirmation A-99 Reaffirmation A-00 Reaffirmation I-00 Reaffirmation I-01

Policy H-70.952, “Medicare Guidelines for Evaluation and Management Codes”
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services;
(2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse;
(3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians;
(4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS);
(5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines,
(6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS,
(7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations;
(8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and
(9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.
Sub. Res. 801, I-97 Reaffirmation I-00 Reaffirmed: CMS Rep. 6, A-10

1. Our AMA will urge the Centers for Medicare and Medicaid Services (CMS) to create an expedited process to review minor clerical errors on enrollment applications that result in CMS deactivating the physician's billing privileges.
2. Our AMA will urge CMS to remove a physician from a potential fraud and abuse review if there is proof that the error is only related to a clerical mistake.
3. Our AMA will urge CMS to create a process that not only reactivates a physician's billing privileges but also retroactively applies the effective date to the initial date when the minor clerical error occurred and applies no penalty to payments due for care provided to Medicare beneficiaries during this time frame.

Res. 222, A-16

Policy D-320.991, “Creating a Fair and Balanced Medicare and Medicaid RAC Program”

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.

2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.

3. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.

4. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.

5. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.

6. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.

7. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

Citation: Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I13; Reaffirmed: Res. 223, I-13
EXECUTIVE SUMMARY

At the 2018 Annual Meeting Policy D-225.974, “Impact of the High Capital Cost of Hospital EHRs on the Medical Staff,” was adopted by the House of Delegates (HOD). The policy asks the American Medical Association (AMA) to study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to its impact on downsizing of medical staffs and its effect on physician recruitment and retention. This report provides the requested study of documented economic and financial impacts of procuring electronic health record systems.

Implementing or upgrading an Electronic Health Record (EHR) in a medical practice, while beneficial in many ways, comes with a variety of costs. These costs include financial, productivity, workforce/personnel, and clinician and patient satisfaction. Long-term, these costs can all have effects on a health system’s medical staff/workforce. These impacts, and the long-term economic and financial costs, are not widely studied or discussed.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 32-A-19

Subject: Impact of High Capital Costs of Hospital EHRs on the Medical Staff

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

INTRODUCTION

At the 2018 Annual Meeting Policy D-225.974, "Impact of the High Capital Cost of Hospital EHRs on the Medical Staff," was adopted by the House of Delegates (HOD). The policy asks the American Medical Association (AMA) to study the long-term economic impact for physicians and hospitals of EHR system procurement, including but not limited to its impact on downsizing of medical staffs and its effect on physician recruitment and retention.

This report provides the requested study of documented economic and financial impacts of procuring electronic health record systems.

BACKGROUND

Electronic health records (EHRs) are an integral part of the vast majority of health care delivery in the United States. In 2017, 99 percent of large, 97 percent of medium, and 93 percent of small rural non-federal hospitals had a certified EHR product in operation.1 In 2015, the most recent year for which data could be found, 84 percent of non-federal acute care hospitals had at least a basic EHR in operation, and 87 percent of office-based physicians were using an EHR.2 The benefits of EHR use are well-documented, however, so are the growing concerns with the amount of time and types of tasks required in using an EHR in practice.3, 4 There is also evidence showing the often-burdensome financial investment that implementing and maintaining an EHR system requires. Although there are several studies quantifying the financial investment, the reported costs of EHR implementation vary greatly across studies,5, 6 owing most likely to differences in geographic locations, practice size and type, and EHR type. One study estimated EHR implementation in a five-physician practice would cost $233,297, or $46,659 per physician, in the first year.7 In 2017 some hospitals and health systems reported EHR implementations costing from $25 million up to $10 billion.8 The differences in practice size and type, EHR type, health information technology (HIT) budgets, specialty, and rural/urban location, make it difficult to accurately quantify costs that are representative across health care practices in the U.S. In addition, the Centers for Medicare & Medicaid Services (CMS) has not updated the practice expense component of the resource-based relative value scale (RBRVS) physician fee schedule in nearly a decade, compounding the lack of valid comparisons and the potential underpayment to physicians for expenses required to maintain a current EHR system. Notwithstanding the challenges in quantifying costs, it is important to consider and understand the long-term impacts of the financial commitment required to implement or upgrade an EHR, including the effects on the physician and clinician workforce.

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The financial costs of implementing an EHR system comprise many factors, including software licensing, projected maintenance, fees, and costs for initial and ongoing training and labor. Some hospitals include the salaries of existing HIT staff in their cost estimates. Others may include the costs of hardware such as new computers, tablets or other devices. These costs can add up to millions, and even billions of dollars for the largest purchasers. Additional costs arise when expenses exceed budgets and when organizations invest in upgrading or optimizing their original EHR system. Other costs, sometimes attributable to EHR implementation, can occur in the form of workforce attrition that happens when organizations cut staff to reduce costs or physicians reduce work hours or leave practice due to frustrations with administrative burden created by EHRs.

Despite these challenges, EHRs will continue to be a principal component of health care delivery in the U.S. However, for the technology to be a viable and sustainable solution for practices of all sizes and types, it will be important to know the potential long-term effects the high implementation, optimization, and maintenance costs will have on the ability to sustain existing medical staff and recruit new staff to meet the growing demand of patients’ needs.

AMA POLICY

The AMA has extensive policy supporting the use of EHRs and encouraging stakeholders to implement policies, technology improvements, and utilization standards to minimize the financial burden and maximize efficiency and safety in the use of EHRs.

The AMA is committed to working with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure, so that the financial burden on physicians is not disproportionate when they implement health care technologies in their offices. The AMA also continues to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining EHRs (Policy D-478.996, “Information Technology Standards and Costs”). The AMA is working with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production (Policy D-478.973, “Principles for Hospital Sponsored Electronic Health Records”).

The AMA supports the drive for innovation in the use of EHRs to develop best practices concerning key EHR features that can improve the quality, safety, and efficiency of health care (Policy D-478.976, “Innovation to Improve Usability and Decrease Costs of EHR Systems for Physicians”). In addition, the AMA advocates for legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community-based settings of care delivery. The AMA works with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost-effective use and sharing of electronic health records across all settings of care delivery (Policy D-478.995, “National Health Information Technology”).

It is AMA policy that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules, which if represented appropriately would help offset these costs for many practices (Policy H-478.981, “Health Information Technology Principles”). Furthermore, the AMA advocates for inclusion of payment supplements in the current and proposed payment systems specifically to cover the costs of maintaining (including upgrades of) EHRs and continuously evaluates and monitors the cost to physicians and their practices of maintaining and upgrading EHRs (Policy D-478.975, “Maintenance Payments for Electronic Health Records”).
DISCUSSION

Costs of implementing or upgrading an EHR system

The costs associated with implementing and/or optimizing an EHR system have been shown to vary significantly across practices and organizations. This is based on a variety of factors, including but not limited to, practice type and size, infrastructure needs, staffing resources, and maintenance fees. Due to the variability of factors, precise costs are difficult to confirm across practice settings.

Several studies and reports have endeavored to document and estimate the immediate and ongoing costs of EHR implementation. One study estimated EHR implementation for a solo physician in practice to cost $163,765, inclusive of labor and hardware costs. In the same study, it was estimated EHR implementation in a five-physician practice would cost $233,297, or $46,659 per physician, in the first year. In 2017 some hospitals and health systems reported EHR implementations costing from $25 million up to $10 billion.

In conjunction with evaluating the costs of implementation, several studies have also described the cost-benefit analysis of EHRs in various practice settings. A 2003 study of EHR implementation in a primary care practice estimated the net benefit from using an electronic medical record for a five-year period was $86,400 per provider. Benefits resulted primarily from savings in drug expenditures, improved utilization of radiology tests, better capture of charges, and decreased billing errors. Using a five-way sensitivity analysis that accounted for variables such as proportion of capitated patients, patient panel size, and software and hardware costs, this study showed results ranging from a $2,300 net cost to a $330,900 net benefit to the organization. However, among fee-for-service patients, a large portion of the savings from improved utilization may accrue to the payer instead of the provider organization. This study was completed using data from an internally developed EMR at Partners HealthCare, an integrated network formed by Brigham and Women’s Hospital and Massachusetts General Hospital.

Another study found that implementation of EHRs in solo or small practices incurred initial costs of approximately $44,000 per FTE provider per year, including software, hardware and lost revenue from reduced productivity. Ongoing costs were estimated at $8,500 per FTE provider per year, including software and hardware maintenance or replacement, and support staff. This study also found the average practice paid for its initial and cumulative ongoing EHR costs within two and a half years, and began to see more than $23,000 in net benefits per FTE provider per year. Also of note, participants in this evaluation reported that providers worked longer hours for about four months after implementation, as they became more familiar with the system.

A 2013 projection of return on investment (ROI) five years after an EHR pilot predicted each physician would lose nearly $44,000 and only 27% of practices surveyed would achieve a positive ROI. An additional 14% would experience a net gain if they received the federal meaningful use incentive. This analysis revealed the largest difference between practices with a positive return on investment and those with a negative return would be the extent to which they used their EHRs to increase revenue, primarily by seeing more patients per day or by improved billing that resulted in fewer rejected claims and more accurate coding.

A 2014 ROI analysis found that primary care practices recovered their EHR investments within an average period of 10 months. An observed increase in the number of active patients, the increase in the active-patients-to-physician-FTE ratio, and the increase in the clinic net revenue are positively
associated with the EHR implementation, likely contributing substantially to the 10-month average break-even point.\textsuperscript{13}

In addition to initial implementation costs, upgrades and optimizations require significant resources, but can help the organization realize cost and time efficiencies. In 2017, 38 percent of health care CIOs indicated “EMR optimization” as their organization’s top item planned for capital investment through 2020.\textsuperscript{14} A 2018 case study at a Colorado hospital employed an optimization strategy that saved them between $300,000 and $500,000 per year, in addition to a 53 percent increase in cash collections since go-live, a 15 percent decrease in days in accounts receivable, assistance from time-saving tools that automatically track changes to payer rules, authorization management services that free up staff to take on high-value work, and reduced operating costs with transparent pricing that includes upgrades and interfaces.\textsuperscript{15}

Furthermore, to encourage organizations to adopt HIT technology and specifically EHR systems, the federal government provided incentives to those providers who met “meaningful use” standards through the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. As of October 2018, CMS reported payments of $38.4 billion to almost 550,000 Medicare and Medicaid providers, or approximately $65,000 per provider. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) sunset the meaningful use program for physicians participating in Medicare. Physicians and hospitals participating in CMS programs now fall under Promoting Interoperability (PI) program requirements.\textsuperscript{16} The Quality Payment Program, which replaced the Medicare meaningful use program, sunset the HITECH Act meaningful use incentives. However, PI participants in Medicaid are still eligible for incentive payments through 2021. It should be noted, however, that practices that did not implement an EHR system or were not eligible for the meaningful use program did not receive incentive payments.

Staff/workforce reductions resulting from EHR investment

Many healthcare organizations have reported reductions in workforce over recent years. The reasons for staff reductions vary from lowered reimbursements, realignment towards value-based care, optimizing operational efficiency, and EHR-related costs. Organizations citing workforce reductions related to excessive EHR costs have widely reported layoffs in the areas of general operations, administration, revenue cycle and information technology, not in the positions of direct patient care, such as physicians, advanced practice providers and nursing.\textsuperscript{17} In a recent statement from Tenet Healthcare, leadership reported the intent to offshore more than 1,000 jobs, likely in the area of corporate functions. Tenet leadership also expressly stated direct patient care employees, such as physicians and nurses, would not be affected by the change.\textsuperscript{18}

Reports of workforce reduction or job outsourcing specifically due to investments in EHR technology exist, but are few. For example, in 2015 Lahey Health in Massachusetts lost $21 million due to both lost business and expenses related to EHR implementation. The shortfall prompted Lahey to lay off 130 people, which their CEO attributed partly to unplanned training expenses connected to the EHR implementation.\textsuperscript{19} Also in 2015, Southcoast Hospital reduced its workforce by one percent after expenses related to their EHR implementation exceeded what they budgeted.\textsuperscript{20}

At the end of 2015, Brigham and Women’s Hospital reported lower financial gains than they had originally anticipated with their EHR implementation after falling $53 million short of the $121 million expectation. These losses led to the subsequent elimination of 80 open positions and 20 staff members. Hospital president Betsy Nabel, MD, credited this in part to reduced reimbursements from payers, high labor expenses among a largely unionized workforce, and high
capital costs, including those related to new facilities and their Epic implementation.\textsuperscript{21} The hospital budgeted $47 million for its implementation, but faced $27 million in unexpected costs.\textsuperscript{22} In 2017, even while finances were improving, Brigham and Women’s was still facing a shortfall, forcing them to commit to a $50 million reduction in operating expenses, including offering a buyout to more than 1,000 senior employees, including nursing staff.\textsuperscript{23}

In 2017, MD Anderson Cancer Center cut between 800 and 900 administrative positions after experiencing significant losses after EHR implementation. MD Anderson also reported decreased patient revenues resulting from EHR implementation but did not provide details on how the EHR affected patient revenue.\textsuperscript{24} However, they reported operating margins were net positive at fiscal year-end 2017.\textsuperscript{25} Wake Forest Baptist Medical Center and Moses Cone Memorial Hospital in North Carolina have both experienced downgraded bond ratings and significant operating losses after implementing EHR systems. They have both also cut staff to make up for these losses.\textsuperscript{26}

EHR implementation was undoubtedly a major factor in the financial circumstances that prompted workforce reductions for these organizations. No one factor can be considered the sole catalyst, however, as other significant costs, such as investments in new facilities, acquisition of other practices, losses on investments, changing reimbursement rates, and increased operational costs contributed to the budget holes that forced these hospitals to take cost-saving measures.\textsuperscript{27} It is also important to consider that hospitals and health systems reduce workforce for many reasons, including forces entirely separate from EHR implementation, such as changing patient population, specialty mix, or community needs.

Considerable costs, unbudgeted expenses, unforeseen training needs, and lost productivity due to learning curves and unexpected downtime, are all known risks of implementing any new or upgraded EHR.\textsuperscript{28} Despite these accounts of losses and financial distress, some organizations implement EHRs without issue and the long-term gains outweigh the short term financial losses. It is also of note that the cases described above all involve the same EHR vendor product, therefore generalizing these adverse experiences to all EHRs is not advised.

In addition to staff/workforce reductions driven by budgetary reasons, EHR implementation is transforming the personnel needs and roles for healthcare organizations. A 2016 publication from the North Carolina Medical Journal highlights the need for new jobs to assist before, during, and after EHR implementation, such as technical software support staff, medical scribe specialists, health care quality improvement specialists, and health care data scientists.\textsuperscript{29} The most common areas of staff reduction due to EHR implementation are in the areas of medical records, transcription, and billing by replacing paper-related processes.\textsuperscript{29, 30}

An indirect cost of EHR implementation can be seen in the effects EHRs have on physicians in practice, including increasing administrative burden, reducing face-to-face time with patients, and even prompting reduction in work hours or leaving medicine altogether.\textsuperscript{31} Nearly 40 percent of doctors list EHR design as one of the two things they find least satisfying about their jobs. Fifty-six percent say the requirement has reduced efficiency and 66 percent report EHR use has reduced the amount of time they spend with patients.\textsuperscript{32} In a 2017 survey, nearly one in five physicians indicated they planned to reduce work hours within the following year. Dissatisfaction with the EHR was an independent predictor of a physician’s intent to leave practice or reduce clinical hours.\textsuperscript{31}
Implementing an EHR system is a significant undertaking for any practice or health care organization. Adequate implementation can be costly and time consuming, resulting in many organizations assuming a financial loss for a duration of time, a factor to be included in the capital planning and budgetary process. Many eligible providers received incentive payments for the adoption and use of EHRs, and the majority of eligible hospitals have demonstrated meaningful use of certified HIT through participation in the EHR incentive program.

Common drivers and challenges contribute to the financial impact of EHR implementation. During the implementation process, an increase in overall operational expenses occurs due to training of personnel and the need for additional staff, consultants, and upfront product purchases. During this time, the organization simultaneously experiences a reduction in productivity resulting in decreased patient revenue. In addition to these two factors, some organizations discover they underestimated the full costs of EHR implementation. For example, primary budgeting may only account for the cost reported by the vendor, and the organization does not consider the expenses of staff, training, infrastructure costs, and ongoing maintenance, resulting in significant unexpected costs.

Other areas of additional or unexpected costs include compliance with regulatory requirements, credit challenges, and vendor deficiencies. With the introduction of meaningful use requirements and government incentives, additional costs are often incurred to comply with regulatory requirements. Some hospitals have reported credit challenges in having adequate financial reserves to support the initial capital investment required for implementing an EHR platform. Other organizations have cited additional costs due to vendor shortcomings. For example, Mountainview Medical Center in White Sulphur Springs, Montana filed a lawsuit against NextGen for failing to install a compliant system on time.

As technology advances and regulatory requirements for data collection evolve, EHR implementation and optimization projects are becoming more comprehensive. As a result, many organizations have reported initial financial losses. However, recovery of net operating income and a return to prior productivity levels occur within a short period of time. In 2015 and 2016, Partners HealthCare, the site of the 2003 study previously discussed, implemented a new EHR system. Partners HealthCare reported a decline of $74.1 million in operating income for the last quarter of 2015 compared to the same quarter the prior year, due in part to the organization’s EHR implementation. By the second quarter of 2016, leadership reported gains in operating income, despite simultaneously experiencing costs of $18 million in EHR-related upgrades and expenses.

In the first quarter of 2016, Allegheny Health Network reported an operating loss of $17.8 million due to EHR implementation expenses, $8.1 million more than the same period in the prior year. In planning, the health system projected $9.4 million in net losses for the first quarter of the year, yet reported $20.6 million. Leadership stated that in addition to decreased patient volumes, much of the costs were attributed to a one-time investment in the EHR system.

While there is evidence that practices have incurred financial losses during EHR implementation and optimization, an extensive literature search does not identify an instance of any practice or organization closing or changing their physician recruitment and retention practices specifically due to exorbitant HIT/EHR costs. In addition, there is no requirement for medical staffs to report to a state or national database why a medical staff member decides to resign, nor is there a requirement to report the number of medical staff members and their membership status (e.g., active, courtesy, consulting, emeritus making it further difficult to quantify such effects.
Long-term economic impacts

There are very few studies available about the long-term economic impacts or effects of EHR implementation. One 2015 study attempted to examine financial and clinical work day productivity outcomes associated with the use of an EHR over nine years. The difference in net clinical revenue per provider per year did not change significantly after EHR implementation. Charge capture, the proportion of higher- and lower-level visit codes for new and established patients, and patient visits per provider remained stable, and a total savings of $188,951 in transcription costs occurred over a 4-year time period post-EHR implementation. Another 2014 study evaluated the long-term financial impact of EHR implementation in ambulatory practice. Practice productivity was tracked over two years post-EHR implementation and demonstrated that the implementation was associated with increased revenue, even after accounting for observed reduction in the number of patient visits. The AMA inquired with leadership at the American Hospital Association to determine if they had additional research, content, or resources on the subject of EHR cost impacts on hospitals and medical staffs, and they indicated they do not currently have any materials or resources available.

CONCLUSION

It is evident from the literature that the costs, break-even point, and ROI all vary dramatically depending on practice type, size, patient panel, specialty, and location. Given these disparate representations, and the limited amount of recent, rigorous long-term study, it is difficult to establish a universal ROI-focused narrative that makes a case that EHRs are either a wise or poor long-term investment for hospitals or health systems, or any practice type. While there is anecdotal evidence of physicians retiring early due to the implementation costs of EHR’s there is little to no data available to assert that investments in EHR technology will lead to subsequent reductions in medical staff. Although EHR investments have contributed to temporary financial losses for some organizations, there are no reports of hospitals or health systems forced to make sweeping reductions in medical staff or completely closing explicitly due to investments in EHR technology. One could speculate that organizations cutting or outsourcing non-direct patient care staff may not be in a financial position to add more physicians to the staff, however there is no data to support this. Although the impacts of staffing cuts inevitably affect care teams and patients, there is little to no evidence that physicians have been included in the groups of workers laid off by organizations that have made cuts.

A common theme throughout the available literature on cost-benefit analysis is that realizing the benefits and achieving a positive ROI depend heavily on the engagement with and optimization of the EHR as a tool for efficiency and process change. Simply installing the system without proper training and feature customization will slow productivity and create new problems. Partial implementation of an EHR, i.e., the continued use of paper for some record keeping, will inhibit the benefits of implementing an EHR and reduce the total return on investment. Organizational policies that promote EHR-enabled changes, such as EHR-supported clinic workflow, along with more thorough research and planning for the implementation process, could facilitate the realization of positive ROI and reduce the potential need for workforce reduction.

RECOMMENDATION

The Board of Trustees recommends that Policy D-225.974, “Impact of the High Capital Cost of Hospital EHRs on the Medical Staff,” be rescinded as having been fulfilled by this report and that the remainder of this report be filed. (Rescind HOD Policy)
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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-19

Subject: Council on Medical Service Sunset Review of 2009 AMA House Policies

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to reestablish it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

• Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.

• Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.

• For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.

• For each recommendation, the Council provides a succinct but cogent justification for the recommendation.

• The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

RECOMMENDATION

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

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated. (Directive to Take Action).
## Appendix

### Recommended Actions on 2009 Socioeconomic Policies

<table>
<thead>
<tr>
<th>Policy #</th>
<th>Policy Title</th>
<th>Recommended Action and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-165.950</td>
<td>Educating the American People About Health System Reform</td>
<td>Rescind. Superseded by Policy H-165.838.</td>
</tr>
<tr>
<td>D-165.996</td>
<td>Expanding Patient Choice in the Private Sector</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-285.995</td>
<td>Coordination of Information on Third Party Relations Activities</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-330.924</td>
<td>Reform the Medicare System</td>
<td>Retain-in-part. Policy D-330.937 has been rescinded. Policy should be amended to read:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D-330.924 Reform the Medicare System</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Our AMA will renew its commitment for total reform of the current Medicare system by making it a high priority on the AMA legislative agenda beginning in 2009 and the AMA's reform efforts will be centered on our long-standing policy of pluralism (AMA Policy H-165.844), freedom of choice (H-165.920, H-373.998, H-390.854), defined contribution (D-330.927), and balance billing (D-380.996, H-385.991, D-390.969).</td>
</tr>
<tr>
<td>D-330.930</td>
<td>Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans</td>
<td>Retain-in-part. The AMA completed the investigation into and reported to CMS any insurers claiming to have “deemed” panels of physicians who have agreed to accept Medicare Advantage private fee-for-service plan enrollees. Policy should be amended to read:</td>
</tr>
<tr>
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<td></td>
<td>Our AMA will (1) investigate, and report to the Centers for Medicare and Medicaid Services, any</td>
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<td>(2) investigate, and report to CMS.</td>
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<tr>
<th>Policy #</th>
<th>Policy Title</th>
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</thead>
<tbody>
<tr>
<td>D-330.996</td>
<td>Support for an Open Medicare Coverage Process</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-385.976</td>
<td>Published Reimbursement Schedules by Private Insurers</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>D-400.989</td>
<td>Equal Pay for Equal Work</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-130.939</td>
<td>Emergency Department Readiness to Care for Children</td>
<td>Retain-in-part. Change “Guidelines for Care of Children in the Emergency Department” to “guidelines for Pediatric Readiness in the Emergency Department” to reflect the title of the revised guidelines.</td>
</tr>
<tr>
<td>H-130.940</td>
<td>Emergency Department Boarding and Crowding</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-140.920</td>
<td>Socioeconomic Factors Influencing the Patient-Physician Relationship</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-155.957</td>
<td>Geographic Variation in Health Care Cost and Utilization</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-165.844</td>
<td>Educating the American People About Health System Reform</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-165.916</td>
<td>Government Controlled Medicine</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-180.950</td>
<td>Gender Rating and Discrimination Based on Prior Cesarean Section</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
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<tr>
<td>H-185.945</td>
<td>Medical Foods</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-185.946</td>
<td>Gender Rating and Discrimination Based on Prior Cesarean Section</td>
<td>Rescind. Superseded by Policies H-165.838 and H-165.856.</td>
</tr>
<tr>
<td>H-185.963</td>
<td>Insurance Coverage for Adults with Childhood Diseases</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-190.964</td>
<td>Electronic Claims</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-220.943</td>
<td>Medical Staff Self-Governance</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-220.961</td>
<td>Hospital Boards of Trustees</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-220.988</td>
<td>Hospital Admitting Privileges</td>
<td>Retain-in-part. Rescind (1) as it is superseded by Policy H-235.963.</td>
</tr>
<tr>
<td>H-225.953</td>
<td>Principles for Developing a Sustainable and Successful Hospitalist Program</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-225.954</td>
<td>Payment for In-House Coverage</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-235.963</td>
<td>Credentialed Physician Membership in Organized Medical Staff</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-235.967</td>
<td>Medical Staff Legal Counsel and Conflict of Interest</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-235.989</td>
<td>Medical Staff Bylaws</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-235.992</td>
<td>Legal Counsel for Medical Staffs</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-240.996</td>
<td>Cost Shifting</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-290.997</td>
<td>Medicaid - Towards Reforming the Program</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>Policy #</td>
<td>Policy Title</td>
<td>Recommended Action and Rationale</td>
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</tr>
<tr>
<td>H-330.912</td>
<td>Appropriate Medical Coverage for Medicare Beneficiaries</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-335.992</td>
<td>Modifying the Medicare Unnecessary Services Program</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-335.996</td>
<td>Spurious Medical Necessity Denials</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-375.967</td>
<td>Supervision and Proctoring by Facility Medical Staff</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-375.968</td>
<td>Supervision and Proctoring by Facility Medical Staff</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-375.974</td>
<td>Clinical Proctoring</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-385.920</td>
<td>Condemnation and Reporting of Unilateral Physician Fee Reduction by Oxford</td>
<td>Rescind. Representatives of AMA, MSSNY, CSMS and MSNJ met with Oxford to address its payment policies including frequently varied co-payments and lack of detail on its EOBs. Oxford agreed to participate in future meetings with MSSNY, CSMS and MSNJ to review the content of its EOBs; take steps to improve the transparency of its electronic and paper remittance process; review its annual co-payment change instructions; share co-payment change information with relevant state medical associations; and, develop FAQs for its web site.</td>
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<tr>
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<td>Recommended Action and Rationale</td>
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</tr>
<tr>
<td>H-385.998</td>
<td>Reimbursement for Diagnostic or Therapeutic Procedures</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-390.896</td>
<td>Payment for Case Management Services</td>
<td>Rescind. There is an assigned payment schedule for E/M.</td>
</tr>
<tr>
<td>H-400.952</td>
<td>Consolidation of Medicare Fee Schedule Areas</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-400.972</td>
<td>Physician Payment Reform</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-400.990</td>
<td>Refinement of Medicare Physician Payment System</td>
<td>Retain. Still relevant.</td>
</tr>
</tbody>
</table>
| H-406.992 | The AMA’s Medical Practice Survey Research Program                           | Retain-in-part. The AMA conducts Physician Practice Benchmark Surveys—which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week—every other year. These surveys do not collect income data. Policy should be amended to read: Our AMA: (1) continues to be the world’s leader in obtaining, synthesizing and disseminating information on medical practice to physicians by continually evaluating and considering enhancements to its Socioeconomic Monitoring System data collection program—Physician Practice Benchmark Survey; and (2) continues to monitor and study the impact of changes in the socioeconomic environment on physicians and medical practices; (3) continues to pursue proactive news management to mitigate negative
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>H-425.981</td>
<td>Reimbursement of Screening Bone Densitometry</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-510.991</td>
<td>Veterans Administration Health System</td>
<td>Retain. Still relevant.</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Most hospital markets are highly concentrated, largely due to consolidation. This report describes horizontal and vertical hospital consolidation and potential consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options).

Because hospital markets are predominantly local, states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have access to the local market-level data needed to oversee and challenge proposed mergers in their states. In addition to challenging hospital mergers outright, state strategies to address consolidation include all-payer rate setting for hospitals (Maryland, Pennsylvania and Vermont) and the Massachusetts Health Policy Commission, which are discussed in this report.

The Council reviewed an abundance of relevant American Medical Association (AMA) policy and recommends affirming that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority.

Because antitrust efforts may not be effective in hospital markets that are already highly concentrated, the Council also recommends that the AMA continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency.
At the 2018 Annual Meeting, the House of Delegates referred Resolution 235-A-18, “Hospital Consolidation,” which was introduced by the Washington Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2019 Annual Meeting. Resolution 235-A-18 asked that our American Medical Association (AMA) actively oppose future hospital mergers and acquisitions in highly concentrated hospital markets, and study the benefits and risks of hospital rate setting commissions in states where highly concentrated hospital markets currently exist.

This report discusses horizontal and vertical hospital consolidation; outlines findings from a recent AMA analysis of hospital market concentration levels; highlights the role of states; describes alternative solutions that promote competition and choice in hospital markets; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation in health care markets includes both horizontal and vertical mergers of physicians, hospitals, insurers, pharmaceutical companies, pharmaceutical benefit managers, and other entities. As stated in Council Report 5-A-17, “Hospital Consolidation,” the AMA believes that health care entity mergers—including among hospitals—should be examined individually, taking into account the case-specific variables of market power and patient needs. The AMA strongly supports health care market competition as well as vigorous state and federal oversight of health care entity consolidation. Antitrust advocacy for physicians is a longstanding AMA priority, and close monitoring of health care markets is a key aspect of AMA antitrust activity.

Horizontal Hospital Consolidation

Although the AMA’s most visible health care consolidation efforts have focused on health insurance markets, the AMA has also analyzed hospital market concentration using 2013 and 2016 data from the American Hospital Association. In a 2018 analysis, the AMA looked at 1,946 hospitals in 363 metropolitan statistical area (MSA)-level markets in 2013 and 2,028 hospitals in 387 MSAs in 2016 and found that, in most markets, hospitals (or systems) have large market shares. In terms of hospital market shares, the AMA found that in 95 percent of MSAs, at least one hospital or hospital system had a market share of 30 percent or greater in both 2013 and 2016. In 2016, 72 percent of MSAs were found to have a single hospital or system with a market share of at least 50 percent, and 40 percent of MSAs had a single hospital or system with a market share of...
70 percent or more.\textsuperscript{2} The AMA analysis also found that, in 2016, 92 percent of MSA-level markets were highly concentrated, and 75 percent of hospitals were members of hospital systems.\textsuperscript{3}

Hospital markets are concentrated largely due to consolidation. There were 1,412 hospital mergers between 1998 and 2015—with 561 reported between 2010 and 2015—and an additional 102 and 115 mergers documented in 2016 and 2017, respectively.\textsuperscript{4,5} Eleven of the transactions in 2017 were mega-deals involving sellers with net revenues of $1 billion or more.\textsuperscript{6}

There are potential benefits and harms resulting from horizontal hospital consolidation, with savings due to economies of scale and enhanced operational efficiencies cited as potential benefits. Hospitals acquiring market power through mergers may also increase prices for hospital care above competitive levels. Although not all hospital mergers impact competition, research has found that mergers in concentrated markets lead to price increases, and that the increases are significant when close competitors consolidate.\textsuperscript{7,8} Studies have found little evidence of quality improvements post-merger, and lower quality in more concentrated hospital markets.\textsuperscript{9,10} The evidence is more consistent for markets where prices are administered (e.g., Medicare). In markets where prices are market determined, consolidation can also lead to lower quality, but the evidence is more mixed.\textsuperscript{11}

Highly concentrated hospital markets may also lessen the practice options available to physicians in communities dominated by large hospital systems.

\textit{Vertical Hospital Consolidation}

A hospital acquiring a physician practice is an example of vertical hospital consolidation. The AMA closely monitors trends in hospital acquisition of physician practices—which was the focus of \textit{Council on Medical Service Report 2-A-15, “Expanding AMA’s Position on Healthcare Reform Options,”}—via biennial Physician Practice Benchmark Surveys (Benchmark Surveys), which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. In 2018, the share of physicians who worked in practices that were at least partially owned by a hospital was 26.7 percent, up from 25.4 percent in 2016, 25.6 percent in 2014 and 23.4 percent in 2012.\textsuperscript{12} The share of physicians who were direct hospital employees in 2018 was 8.0 percent, up from 7.4 percent in 2016, 7.2 percent in 2014 and 5.6 percent in 2012.\textsuperscript{13}

Vertical hospital consolidation has been found to increase prices and, in markets where prices are administered (e.g., Medicare), to increase total spending.\textsuperscript{14,15} Recent steps taken by the Centers for Medicare & Medicaid Services (CMS) to level the site-of-service playing field between physician offices and off-campus hospital provider-based departments may have diminished a crucial incentive for hospitals to purchase physician practices in the future. For many years, higher payments to hospital outpatient departments likely incentivized the sale of physician practices and ambulatory surgical centers (ASCs) to hospitals because acquired facilities meeting certain criteria (e.g., located within 35 miles of the hospital) were routinely converted to hospital outpatient departments and allowed to charge higher 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. Beginning in 2017, off-campus entities acquired after enactment of the BBA—in November 2015—were no longer permitted to bill for services under Medicare’s Outpatient Prospective Payment System (OPPS), and instead required to bill under the applicable payment system (Physician Fee Schedule). Since 2017, CMS has paid for services at non-excepted off-campus provider-based hospital departments using a Physician Fee Schedule relativity adjuster that is based on a percentage of the OPPS payment rate. CMS has since extended site-neutral payments to include clinic visits provided at off-campus provider-based hospital departments acquired prior to November 2015 that were
previously excepted from the BBA provision. The AMA will continue to monitor the impact of these changes on hospital markets.

PROMOTING COMPETITION AND CHOICE

The AMA is aware of the potential effects of hospital consolidation on physicians and patients, including concerns about the loss of physician autonomy in clinical decision-making and preserving physician leadership in large systems, and also increased hospital prices in concentrated markets. The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large hospital systems or hospital-owned practices remains an attractive practice option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.

The AMA has long been a strong advocate for competitive health care markets and antitrust relief for physicians, and maintains that health care markets should be sufficiently competitive to allow physicians to have adequate choices and practice options. AMA efforts to obtain antitrust relief for physicians, maximize their practice options, and protect patient-physician relationships include legislative advocacy; advocacy at the Federal Trade Commission (FTC) and the US Department of Justice (DOJ); and the creation of practical physician resources.

State and federal antitrust enforcement for hospital consolidation has been somewhat limited and has had mixed results over the years, with some successes and also periods of intense merger activity. Many mergers have proceeded unchallenged. Experts have also asserted that in hospital markets that are already highly concentrated, antitrust provides no remedy. Accordingly, in addition to antitrust activities, the AMA has pursued alternative solutions that promote competition and choice, including: eliminating state certificate of need (CON) laws; repealing the ban on physician-owned hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and achieving meaningful price transparency.

Eliminating State CON Laws: The AMA supports the elimination of state CON laws, which are barriers to market entry that harm competition, and supports state medical associations in their advocacy efforts to repeal them. CON laws require state boards to review all entities seeking to enter a health care market to provide care, including existing facilities seeking to offer new services or services in new locations. Thirty-five states and the District of Columbia currently administer CON programs. As stated in Policy H-205.999, the AMA believes that there is little evidence to suggest that CON programs are effective in restraining health care costs or in limiting capital investment. In the absence of such evidence, AMA policy also opposes CON laws and the extension of CON regulations to private physician offices.

Repealing the Ban on Physician-Owned Hospitals: The AMA strongly advocates that Congress repeal limits to the whole hospital exception of the Stark physician self-referral law, which essentially bans physician ownership of hospitals and places restrictions on expansions of already existing physician-owned hospitals. Repealing the ban would allow new entrants into hospital markets, thereby increasing competition. Because physician-owned hospitals have been shown to provide the highest quality of care to patients, limiting their viability reduces access to high-quality care. The AMA firmly believes that physician-owned hospitals should be allowed to compete equally with other hospitals, and that the federal ban restricts competition and choice.
Reducing Administrative Burdens: Physicians are increasingly burdened by administrative tasks that are extremely costly to practices and reduce time with patients, yet increase the work necessary to provide medical services. Examples of these burdens include abiding by state and federal rules and regulations, meeting quality reporting requirements, managing electronic health records, and navigating a plethora of payer protocols and utilization management programs. Utilization management has become so burdensome that in 2018 the average physician reported completing 31 prior authorizations per week, a process that required 14.9 hours of work or the equivalent of two business days.21 Taken together, these burdens make it difficult for physician practices—particularly smaller practices—to compete, which may lead physicians to consolidate with larger groups or hospitals.22 The AMA conducts widespread prior authorization advocacy and outreach, including promoting Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, model state legislation, the Prior Authorization Physician Survey, and the AMA Prior Authorization toolkit.

Price Transparency: The lack of complete, accurate and timely information about the cost of health care services prevents health care markets from operating efficiently. 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 delivered. The AMA supports price transparency and recognizes that achieving meaningful price transparency may help lower health care costs and empower patients to choose low-cost, high-quality care. The AMA supports measures that expand the availability of health care pricing information, enabling patients and their physicians to make value-based decisions when patients have a choice of provider or facility.

ROLE OF STATES

While it is recognized that most hospital markets are highly concentrated and do not work as well as they could, it is also recognized that hospital markets are local and that states play a significant role in regulating them. States have their own antitrust laws, and state attorneys general and other regulators have better access to the local market-level data needed to oversee and challenge proposed mergers in their states. States can take on mergers themselves or join federal antitrust efforts. Some states have approved mergers but established conditions that must be met, such as requiring merged hospitals to maintain charity care programs or capping price increases for a certain number of years. As discussed previously, states can also reduce barriers to new competitors in hospital markets by eliminating CON laws.

All-Payer Rate Setting for Hospitals (Maryland, Pennsylvania and Vermont)

The approach to fostering competition cited in referred Resolution 235-A-18 is all-payer rate setting for hospitals, under which all payers (e.g., Medicare, Medicaid, private insurers and employer self-insured plans) pay hospitals the same price for services. Although-payer rate setting was popular in the 1970s, Maryland is the only state where it remains. Building on its all-payer rate setting approach, Maryland began implementing an all-payer global budgeting model for hospitals in 2014, while Pennsylvania began a similar model for rural hospitals in 2017. Vermont has developed an all-payer model for accountable care organizations (ACOs) that enables Medicare, Medicaid and private insurers to pay ACOs differently than through fee-for-service. These more recent all-payer payment models are still in the early stages of implementation and continue to undergo refinements and ongoing evaluation. Hospitals under this model are exempt from Medicare’s inpatient and outpatient prospective payment systems and instead are paid based on fixed annual budget amounts for inpatient and outpatient hospital services that are established in advance.
A federally-funded evaluation of the first three years of Maryland’s all-payer model found that it reduced total expenditures and hospital expenditures for Medicare patients but did not impact total expenditures or hospital expenditures for privately insured patients. The evaluation further found that hospitals have adapted to global budgets without being adversely impacted financially. Other studies have looked at hospitals in eight urban counties in Maryland and the state’s earlier rural pilot program, and research is ongoing. Accordingly, the Council believes that it may be premature to draw meaningful conclusions about the potential impact of hospital rate-setting in states with highly concentrated hospital markets.

All-payer rate setting for hospitals is intended to increase price competition and lessen the bargaining power of dominant hospitals, and it moves hospitals away from fee-for-service. However, appropriate payment rates can be challenging to establish and the model can be costly for states to administer. Strong state leadership as well as an established information technology infrastructure are needed for all-payer global budgeting to be successful.

Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC) is an independent state agency that monitors health care spending growth and makes policy recommendations regarding health care payment and delivery reforms. Among other responsibilities, the HPC—established in 2012—is charged with monitoring changes in the health care market. Massachusetts regulations stipulate that health care provider organizations with more than $25 million in revenue must notify the HPC before consummating transactions for the purpose of enabling the state watchdog to conduct a “cost and market impact review.” The HPC has conducted several such reviews of proposed hospital mergers over the years and made them available to stakeholders as well as the public, thereby increasing transparency surrounding these transactions. Notably, mergers may be allowed to move forward despite criticisms from the HPC.

AMA RESOURCES

Recognizing that physicians are increasingly becoming employed by hospitals and health systems, the AMA has developed several practical tools for physicians, including the Annotated Model Co-Management Service Line Agreement, Annotated Model Physician-Hospital Employment Agreement and the Annotated Model Physician-Group Practice Employment Agreement which assist in the negotiation of employment contracts. For physicians considering a practice setting change or looking for an alignment strategy with an integrated health system, the AMA developed Joining or Aligning with a Physician-led Integrated Health System. The AMA has also made available a set of resources called “Unwinding Existing Arrangements” that guides employed physicians on how to “unwind” from their organization, factoring in operational, financial, and strategic considerations.

AMA principles for physician employment (Policy H-225.950) have been codified to address some of the more complex issues related to employer-employee relationships, and the AMA Physician’s Guide to Medical Staff Bylaws is a useful reference manual for drafting and amending hospital medical staff bylaws. The AMA has also developed a series of model state bills, available from the AMA’s Advocacy Resource Center, that are intended to address concerns expressed by employed physicians. Through these resources, the AMA is well-positioned to help employed physicians and those considering employment by hospitals or other corporations to preserve physician autonomy and independent decision-making and protect patient-physician relationships. The inviolability of the patient-physician relationship is a recurrent theme throughout theAMA Code of Medical Ethics, which also addresses mergers of secular and religiously affiliated health care institutions.
Working Toward Integrated Leadership Structures

Importantly, the AMA has always supported the ability of physicians to choose their mode of practice. The AMA promotes physician leadership in integrated structures and develops policy and resources intended to help safeguard physicians employed by large systems. The AMA has collaborated with hospitals, independent physician associations, large integrated health care systems’ leaders and payers to cultivate successful physician leadership that improves the value of care for patients. Working with these stakeholders to bring clinical skills and business insights together at the leadership level, the AMA is fostering a more cohesive and integrative decision-making process within hospitals and health care systems. To help hospitals and health care systems institute that kind of decision-making process, the American Hospital Association (AHA) and the AMA released “Integrated Leadership for Hospitals and Health Systems: Principles for Success” in June 2015. The “Principles” provide a guiding framework for physicians and hospitals that choose to create an integrated leadership structure but are unsure how to best achieve the engagement and alignment necessary to collaboratively prioritize patient care and resource management.

RELEVANT AMA POLICY

Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective health care. Antitrust relief for physicians that enables physicians to negotiate adequate payment remains a top priority of the AMA under Policies H-380.987, D-383.989, D-383.990 and H-383.992. Under Policy H-160.915, antitrust laws should be flexible to allow physicians to engage in clinically integrated delivery models without being employed by a hospital or ACO. Policy D-385.962 directs the AMA to support antitrust relief for physician-led accountable care organizations. Policy H-225.950 outlines AMA Principles for Physician Employment intended to assist physicians in addressing some of the unique challenges employment presents to the practice of medicine, including conflicts of interest, contracting, and hospital medical staff relations.

The AMA has substantial policy intended to protect medical staffs, including Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation, and that each medical staff shall develop and adopt bylaws and rules and regulations to establish a framework for self-governance of medical activities and accountability to the governing body. Policy H-215.969 provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians’ clinical privileges; (i) conflict resolution mechanisms; (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals. Policy H-215.969 also states that the AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services. Under Policy H-235.991, medical staff bylaws should include...
successor-in-interest provisions to protect medical staffs from a hospital ignoring existing bylaws and establishing new bylaws to apply post-merger, acquisition, affiliation or consolidation.

Policy H-225.947, which was established via Council on Medical Service Report 5-A-15, “Hospital Incentives for Admission, Testing and Procedures,” encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles including that: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. Policy H-225.947 also encourages continued research on the effects of integrated health care delivery models that employ physicians on patients and the medical profession. Policy H-285.931 adopts principles for physician involvement in integrated delivery systems and health plans. Policy D-225.977 directs the AMA to continue to assess the needs of employed physicians and promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures.

AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although Policy H-225.950, “Principles for Physician Employment,” discourages physicians from entering into agreements that restrict the physician’s right to practice medicine for a specified period of time or in a specified area upon termination of employment. AMA Code of Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and (b) do not make reasonable accommodation for patients’ choice of physician. This opinion also states that physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program. Under Policy H-140.984, the AMA opposes an across-the-board ban on self-referrals, because of benefits to patients including increased access and competition.

DISCUSSION

The Council shares the concerns among physicians regarding potential negative consequences for physicians and patients in highly concentrated hospital markets (e.g., increased prices, reduced choice, and fewer physician practice options). In addition to reviewing the literature, the Council received input from AMA antitrust experts during the development of this report, and notes that AMA staff are readily available to assist and advise AMA members and state medical associations with questions or concerns about physician-hospital relations or hospital consolidation. Nonetheless, the AMA does not have the resources to actively oppose all future hospital mergers in highly concentrated markets, as requested by Resolution 235-A-18. Attempting to address hospital mergers in the same manner that the AMA has addressed major health insurance mergers would place an undue burden on the organization’s resources and may alienate many valued AMA members who work for hospitals and hospital systems.

Having prepared two reports on hospital consolidation in a two-year time period, the Council has a clear understanding of ongoing AMA efforts to monitor and respond to health care consolidation,
including engaging with the FTC and the DOJ as well as state attorneys general and insurance commissioners. The Council further appreciates the abundance of AMA policy embracing competition and choice, and concludes that hospital consolidation is sufficiently addressed (and not prohibited) by existing policy. Accordingly, the Council developed a new policy recommendation that brings together existing AMA policy to affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority.

The Council also recognizes that most hospital markets are highly concentrated, and that hospital markets are predominantly local. The Council’s review of the literature found that antitrust efforts may not be effective in hospital markets that are already highly concentrated, and that alternative solutions are warranted. Accordingly, the Council recommends that the AMA continue to support actions that promote competition and choice, including: (a) eliminating state CON laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency.

Because hospital markets are local, the Council further recommends encouraging state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Having discussed the potential impact of hospital consolidation on medical staffs, and the need to protect affected medical staffs post-merger, the Council recommends reaffirmation of four policies intended to help guide medical staffs and physicians experiencing consolidation: Policy H-215.969, which provides that, in the event of a hospital merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs should be established to resolve critical issues; Policy H-220.937, which states that geographic disparities or differences in patient populations may warrant multiple medical staffs within a single hospital corporation; Policy H-225.950, which outlines AMA Principles for Physician Employment; and Policy H-225.947, which encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles that actively involve physicians in integrated leadership and preserve clinical autonomy.

The Council is intrigued by state efforts to promote competition, including Maryland’s all-payer rate setting model and Massachusetts’ HPC. The AMA will continue to monitor these and other models but, at this time, does not make recommendations regarding their widespread adoption.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 235-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority. (New HOD Policy)
2. That our AMA continue to support actions that promote competition and choice, including:
(a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned
hospitals; (c) reducing administrative burdens that make it difficult for physician practices to
compete; and (d) achieving meaningful price transparency. (New HOD Policy)

3. That our AMA encourage state medical associations to monitor hospital markets and review
the impact of horizontal and vertical health system integration on patients, physicians and
hospital prices. (New HOD Policy)

4. That our AMA reaffirm Policy H-215.969, which provides that, in the event of a hospital
merger, acquisition, consolidation or affiliation, a joint committee with merging medical staffs
should be established to resolve at least the following issues: (a) medical staff representation on
the board of directors; (b) clinical services to be offered by the institutions; (c) process for
approving and amending medical staff bylaws; (d) selection of the medical staff officers,
medical executive committee, and clinical department chairs; (e) credentialing and
recredentialing of physicians and limited licensed providers; (f) quality improvement;
(g) utilization and peer review activities; (h) presence of exclusive contracts for physician
services and their impact on physicians' clinical privileges; (i) conflict resolution mechanisms;
j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical
staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as
binding contracts between the medical staffs and the hospitals. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-220.937, which states that geographic disparities or
differences in patient populations may warrant multiple medical staffs within a single hospital
corporation, and that each medical staff shall develop and adopt bylaws and rules and
regulations to establish a framework for self-governance of medical activities and
accountability to the governing body. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-225.950, which outlines AMA Principles for Physician
Employment intended to assist physicians in addressing some of the unique challenges
employment presents to the practice of medicine, including conflicts of interest, contracting,
and hospital medical staff relations, and that discourage physicians from entering into
agreements that restrict their right to practice medicine for a specified period of time or in a
specified area upon termination of employment. (Reaffirm HOD Policy) and

7. That our AMA reaffirm Policy H-225.947, which encourages physicians who seek
employment as their mode of practice to strive for employment arrangements consistent with a
series of principles that actively involve physicians in integrated leadership and preserve
clinical autonomy. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

1 Unpublished Analysis. Hospital Market Competition: Analysis of Hospitals’ Market Shares and Market
2 Ibid.
3 Ibid.
4 Gaynor M. Examining the Impact of Health Care Consolidation: Statement before the U.S. House of
Representatives Committee on Energy and Commerce Oversight and Investigations Subcommittee. February


6 Ibid.

7 Gaynor, Supra note 4.


9 Gaynor, Supra note 4.


13 Ibid.

14 Gaynor, Supra note 8.

15 Dafny, Supra note 10.


19 Ibid.


22 Gaynor, Supra note 8.


EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 252, which was introduced by the Organized Medical Staff Section and assigned for study to the Council on Medical Service with assistance from the Council on Legislation. Resolution 252-A-18 asked: that our American Medical Association (AMA): (1) collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs); (2) educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages; and (3) reaffirm Policy H-100.956, which states in part that “Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.”

Although the Council agrees with the sentiment that the GPO safe harbor is flawed, the Council finds little empirical evidence exists to definitively assess the impact of the GPO safe harbor. Most research studies are funded by interested parties, and a limited economic model with no funding ties to GPOs, PBMs, or proponents of repeal, found that while removal of the safe harbor decreased providers’ nominal purchasing price, their total purchasing costs are the same as when the safe harbor was present. Thus, repeal would not affect any party’s profits or costs. In a broader economic model, a study found that total purchasing cost of the providers is not affected by the presence of the GPO administration fees, although providers may experience higher unit prices. Accordingly, the Council recommends reaffirming Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

Additionally, the Council is concerned that, if the GPO safe harbor is repealed, GPOs and PBMs could simply shift fees into other forms, such as rebates or other fees, rather than lose their revenue stream. Moreover, the Council believes that repeal of the GPO safe harbor could create widespread disruption of the supply chain and administrative challenges for not only hospitals (including physician-owned hospitals), but also clinics, ambulatory surgery centers, and other provider arrangements. As such, physician-owned practice settings may be adversely impacted if the viability of the GPO business model is compromised. Whatever the defects in their funding structure, the Council finds that GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care. Accordingly, the Council recommends renewing efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the GPO and PBM anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. The Council also recommends supporting efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages.
At the 2018 Annual Meeting, the House of Delegates referred Resolution 252, which was introduced by the Organized Medical Staff Section and assigned for study to the Council on Medical Service with assistance from the Council on Legislation. Resolution 252-A-18 asked:

That our American Medical Association (AMA): (1) collaborate with medical specialty partners, patient advocacy groups, and other stakeholders to seek repeal of the 1987 Safe Harbor exemption to the Medicare Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and Pharmacy Benefit Managers (PBMs); (2) educate its members on how safe harbor exemption for GPOs and PBMs affects drug prices and drug shortages; and (3) reaffirm Policy H-100.956, which states in part that “Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.”

This report provides background on GPOs, how they function, and the relevant federal anti-kickback statute; details how the GPO safe harbor is used by PBMs; outlines possible antitrust and anticompetitive concerns with the GPO safe harbor; specifies the possible legal and patient access implications of repeal of the safe harbor; and offers recommendations to refine the GPO safe harbor operations.

BACKGROUND

At the 2016 Annual Meeting, Resolution 201-A-16, “Repeal of Anti-Kickback Safe Harbor for Group Purchasing Organizations,” sponsored by the Medical Student Section, asked the AMA to support the repeal of the Anti-Kickback safe harbor for GPOs. Resolution 201-A-16 was referred for decision by the House of Delegates. The Council on Legislation discussed and provided input for the Management Report for Board Action, which recommended not adopting Resolution 201-A-16. The Board voted that Resolution 201-A-16 not be adopted.

At the 2018 Annual Meeting, concern was raised during the reference committee hearing regarding Resolution 252-A-18 that its proposed solution of repealing the GPO safe harbor could be both ineffective and counterproductive in addressing the identified problems of drug shortages and pricing. With respect to GPO pricing incentives, testimony also stated that GPO contracts are voluntary in nature, GPO customers may have the ability to purchase products and services off-contract if they find a preferable or better-priced option. Testimony further indicated that GPO customers include not only hospitals, but also clinics, ambulatory surgery centers, and other
provider arrangements. As such, physician-owned hospitals and other physician practice settings may be adversely impacted if the viability of the GPO business model is compromised.

HOW A GPO FUNCTIONS

GPOs are organizations that act as purchasing intermediaries that negotiate contracts between their customers—health care providers—and vendors of medical products. A GPO is generally made up of provider-members, and such members may receive profits from the GPO. A provider joins a GPO to “incur a lower purchasing cost . . . by buying through the GPO [rather] than by contracting for the same item directly with a manufacturer. GPOs assert that they are able to lower their provider-members’ price per unit by employing market intelligence and product expertise that no single member could afford, and by contracting for the group’s combined purchase quantity. GPOs are able to lower a provider’s contracting cost by spreading its own, presumably higher, fixed contracting cost over its many members.”¹ For example, AMA members can receive practice discounts through Henry Schein Medical for medical, surgical, pharmaceutical, and equipment purchases.² Henry Schein is partnered with GroupSource, a GPO serving the non-acute physician market, to offer physicians a wide range of products.³

GPOs earn revenue from several sources:
- Administrative fees paid by the manufacturer of products;
- Membership fees from provider-members;
- Administrative fees charged to distributors authorized to distribute products under a GPO’s contract;
- Miscellaneous service fees that are charged directly to provider-members; and
- Other sources of revenue like outside investments.

GPOs offer a variety of services that may be paid by the administration fees or through direct charging to provider members. The U.S. Government Accountability Office identifies the funding methods that GPOs reported using for the services they provided:⁴

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of GPOs offering service</th>
<th>Number of GPOs funding only through administrative fees</th>
<th>Number of GPOs funding only through charges to customers</th>
<th>Number of GPOs using both funding methods</th>
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<td>3</td>
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<td>Benchmarking data</td>
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<td>Continuing medical education</td>
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<td>Materials management outsourcing</td>
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<tr>
<td>Patient safety services</td>
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<td>Insurance services</td>
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<tr>
<td>Revenue management</td>
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<tr>
<td>Warehousing</td>
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<tr>
<td>Equipment repair</td>
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</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2</td>
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</tbody>
</table>

² Henry Schein Medical.
³ GroupSource.
The federal anti-kickback statute provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce business reimbursed under the Medicare or state health care programs. The offense is classified as a felony, and is punishable by fines of up to $100,000, imprisonment for up to 10 years, and subjects the offending party to false claims act liability. The Secretary of the US Department of Health and Human Services (HHS) delegated authority over the anti-kickback statute to the HHS Office of Inspector General (OIG).

This provision is extremely broad. The types of remuneration covered specifically include kickbacks, bribes, and rebates made directly or indirectly, overtly or covertly, or in cash or in kind. In addition, prohibited conduct includes not only remuneration intended to induce referrals of patients, but also intended to induce the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by Medicare or state health care programs.

Because of the broad reach of the statute, concern was expressed that some relatively innocuous commercial arrangements were covered by the statute and, therefore, potentially subject to criminal prosecution. In response, Congress provides statutory exceptions from illegal remuneration where the anti-kickback statute does not apply. In addition, Congress specifically required the development and promulgation of regulations, the so-called safe harbor provisions, that would specify various payment and business practices that would not be treated as criminal offenses under the anti-kickback statute, even though they may potentially be capable of inducing referrals of business under federal health care programs. In authorizing HHS to protect certain arrangements and payment practices under the anti-kickback statute, Congress intended that the safe harbor regulations be updated periodically to reflect changing business practices and technologies in the health care industry.

Accordingly, the legal framework governing the anti-kickback statute includes both statutory exceptions and regulatory safe harbors. The federal government considers the statutory exceptions and regulatory safe harbors as co-terminus, meaning that they cover the same conduct and the regulatory safe harbor is implementing the statutory safe harbor. Industry and the provider community have argued that they are distinct, separate protections. For example, a provider could receive protection under the statutory exception for discounts even if the arrangement would not fit within the counterpart regulatory safe harbor. Whether the protections are co-terminus or distinct is an open legal question that depends on the legal precedent of case law in each federal circuit (if a circuit has considered this specific issue).

This report will focus on three specific statutory exceptions and regulatory safe harbors that may cover the various funding mechanisms of GPOs: (1) GPO safe harbor; (2) discount safe harbor; and (3) personal services and management contracts safe harbor.

**GPO Statutory Exception and Regulatory Safe Harbor**

With GPOs, Congress enacted section 9321 of the Omnibus Budget Reconciliation Act of 1986, which excludes from the definition of “remuneration” certain fees paid by vendors to GPOs from prosecution under the anti-kickback statute.7 According to the legislative history, Congress believed that GPOs could “help reduce health care costs for the government and the private sector alike by enabling a group of purchasers to obtain substantial volume discounts on the prices they are charged.”8
In 1991, OIG issued a final rule implementing a GPO safe harbor to apply to payments from vendors to entities authorized to act as a GPO for individuals or entities who are furnishing Medicare or Medicaid services. The proposed safe harbor required a written agreement between the GPO and the individual or entity that specifies the amounts vendors will pay the GPO.

To qualify for protection under the GPO safe harbor, a GPO must have a written agreement with each individual or entity for which items or services are furnished. That agreement must either provide that participating vendors from which the individual or entity will purchase goods or services will pay a fee to the GPO of three percent or less of the purchase price of the goods or services provided by that vendor or, in the event the fee paid to the GPO is not fixed at three percent or less of the purchase price of the goods or services, specify the amount (or if not known, the maximum amount) the GPO will be paid by each vendor (where such amount may be a fixed sum or a fixed percentage of the value of purchases made from the vendor by the members of the group under the contract between the vendor and the GPO).

Where the entity that receives the goods or services from the vendor is a health care provider of services, the GPO must disclose in writing to the entity at least annually, and to the Secretary upon request, the amount received from each vendor with respect to purchases made by or on behalf of the entity. As explained in the preamble to the final regulations, the safe harbor is not intended to protect fees to arrange for referrals or recommendations within a single entity. Therefore, the safe harbor provides that “Group Purchasing Organization” means an entity authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services for which payment may be made in whole or in part under Medicare, Medicaid, or other federal health care programs, and who are neither wholly owned by the GPO nor subsidiaries of a parent corporation that wholly owns the GPO (either directly or through another wholly owned entity).

Thus, if a GPO meets the above requirements, it fits within the GPO safe harbor and its administrative fees will not be subject to criminal prosecution under the anti-kickback statute. Of course, these administrative fees may cover a variety of services.

Discount Statutory Exception and Regulatory Safe Harbor

The discount statutory exception applies to arrangements where there is a discount or other reduction in price that was obtained by a provider or other entity when such discounts are properly disclosed and reflected in the costs for which reimbursement could be claimed. Congress included the discount exception to “ensure that the practice of discounting in the normal course of business transactions would not be deemed illegal.”

The regulatory discount safe harbor exempts from the definition of remuneration discounts on items or services for which the federal government may pay and certain disclosure requirements are met. A discount means a reduction in the amount a buyer is charged for an item or service based on an arms-length transaction. In addition, rebates are also covered under the discount safe harbor to mean an amount that is described in writing at the time of the purchase but is not paid at the time of sale. The safe harbor also specifically excludes from the definition of a discount cash or cash-equivalents (except for rebates in the form of a check); certain swapping arrangements (e.g., induce purchasing one good for another good); exempted remuneration from other safe harbors (e.g., warranties); and other remuneration, in cash or in kind not explicitly described by the safe harbor.

The regulatory safe harbor disclosure requirements vary based on the type of entity—buyer, seller, offeror—in the discount arrangement. Moreover, a buyer’s disclosure requirements depend on
whether the entity is (1) acting under a risk contract; (2) reports costs on a cost report; or
(3) submits a claim or a request for payment is submitted for the discounted item or service and
payment may be made, in whole or in part, under Medicare, Medicaid, or other federal health care
programs.\textsuperscript{13}

Thus, a GPO’s up-front discount is covered by the statutory exception and the regulatory safe
harbor if properly disclosed, and it will not be subject to criminal prosecution under the anti-
kickback statute.

\textit{Personal Services and Management Contracts Regulatory Safe Harbor}

This safe harbor protects certain payments made by a principal to an agent as compensation for the
agents’ services. Protection applies only if certain standards are met that “limit the opportunity to
provide financial incentives in exchange for referrals.”\textsuperscript{14} These standards include that aggregate
compensation is set in advance, consistent with fair market value in an arms-length transaction, and
not determined in a manner that takes into account the volume or value of any referrals or business
generated between the parties.\textsuperscript{15}

Thus, if a GPO offers additional services that go beyond the administration fees (i.e., direct charges
to the provider-members), the GPO may be able to structure such fees under the personal services
safe harbor and receive protection from criminal prosecution under the anti-kickback statute.

\textbf{APPLICATION TO PHARMACY BENEFIT MANAGERS}

Overall, the application of the anti-kickback safe harbors and exceptions to PBMs is difficult
because PBMs and their current activities were not prevalent or existent when the safe harbors
were created.

\textit{GPO Statutory Exception and Regulatory Safe Harbor}

The OIG’s only formal pronouncement on PBMs and the GPO regulatory Safe Harbor is found in
sub-regulatory guidance: Compliance Program Guidance for Pharmaceutical Manufacturers issued
in 2003.\textsuperscript{16} “Any rebates or other payments by drug manufacturers to PBMs that are based on the
PBM’s customers’ purchases potentially implicate the anti-kickback statute.” Protection is
available by structuring such arrangements to fit in the GPO safe harbor. That safe harbor requires,
among other things, that the payments be authorized in advance by the PBM’s customer and that all
amounts actually paid to the PBM on account of the customer’s purchases be disclosed in writing
at least annually to the customer and to HHS upon request. In addition, Medicare Part D sponsors
and other entities that provide PBM services are required to report various data elements to CMS.
The statute specifies that this data is confidential and generally must not be disclosed by the
government or by a plan receiving the information.\textsuperscript{17}

The OIG potentially extended the GPO regulatory Safe Harbor, which is meant to cover
administrative fees, to include “any rebates or other payments.” Thus, PBMs can argue that fees
and rebates have protection under the GPO Safe Harbor. However, PBMs would attempt to fit non-
administrative fees within different safe harbors first and then potentially rely on GPO Safe Harbor
as a backstop.\textsuperscript{18}
Discount Statutory Exception and Regulatory Safe Harbor

On February 6, 2019, HHS issued a proposed rule to amend the safe harbor regulations concerning discounts. HHS is proposing to disallow these traditional discount/rebate arrangements for plan sponsors under Part D and Medicaid Managed Care Organizations and attempt to instead pass any price concession directly to the beneficiary at the point-of-sale of the drug. To do this, they are proposing changes to the anti-kickback safe harbor regulation concerning discounts. Under the proposal, CMS would eliminate the current safe harbor protections for discounts paid by manufacturers directly to plan sponsors and PBMs. HHS also proposes the creation of two new safe harbor protections: protection for reductions in price at the point-of-sale and protection for fixed fees paid to PBMs for services rendered to manufacturers.

In its formal response to the proposed rule, the AMA commented that OIG either needs to eliminate the application of the GPO regulatory safe harbor to PBMs or clarify its application only to administrative fees and define what services are covered. The AMA’s comments went on to state that PBMs may be able to avail themselves to existing regulatory safe harbors including the GPO safe harbor, the personal services and management contracts safe harbor, managed care safe harbor, and the proposed certain PBM services safe harbor. The AMA requested that the Department clarify what PBM fees and services apply to both the proposed and existing safe harbors. Otherwise, the AMA is concerned that the lack of clarity may provide further opportunity for exploitation.

Moreover, on May 16, 2018, Secretary Azar noted: “We would welcome the PBM industry coming forth with broader proposals for moving away from today’s system, including a plan for implementation with the pharmaceutical industry. But we also have the administrative power to end this system ourselves—to eliminate rebates and forbid remuneration from pharmaceutical companies, align interests, and end the corrupt bargain that keeps driving list prices skyward.” In his comments before the Senate Health, Education, Labor & Pensions Committee, Secretary Azar went further, noting: “Rebates are allowed under an exception to the Anti-Kickback Statute, and that’s an exception that we believe by regulation we could modify.”

In the legal community, there is debate as to whether a PBM truly meets the definition of a “buyer” under the regulatory discount safe harbor considering PBMs do not take physical possession of the drugs. That said, most discount arrangements between PBMs and drug manufacturers (or other entities) are structured to fit within the discount safe harbor.

Personal Services and Management Contracts Regulatory Safe Harbor

As with GPOs, if a PBM offers additional services that go beyond the administration fees (e.g., data analytics, disease management), the PBM may be able to structure such fees under the personal services safe harbor and receive protection from criminal prosecution under the anti-kickback statute.
ANTITRUST AND COMPETITION CONCERNS

In response to antitrust concerns in the health care area, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) from 1993-1996 issued policy statements involving mergers and various joint activities in the health care arena. Statement 7 discusses DOJ/FTC enforcement policy involving health care providers’ joint purchasing agreements, which includes GPOs. Generally, DOJ/FTC believe that most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns because the participants frequently can obtain volume discounts, reduce transaction costs, and have access to other services like consulting advice that may not be available to each participant on their own. Absent extraordinary circumstances, the agencies will not challenge any joint purchasing arrangement if it is in the “Antitrust Safety Zone.”

Two conditions must be present to enter the zone:

(1) The purchases by the health care provider account for less than 35 percent of the total sales of the purchased product or services in the relevant market.

(2) The cost of the products and services purchased jointly accounts for less than 20 percent of the total revenue from all products or services sold by each competing participant in the joint purchasing arrangements.

The agencies also listed certain safeguards that joint purchasing arrangements can adopt to minimize concerns including not requiring the use of arrangements for all services; having an independent employee or agent negotiate on behalf of the joint purchasing arrangement, and ensuring communications between the purchasing group and participants are kept confidential.

Since this guidance was issued, GPO market consolidation has increased and led to an oligopoly market structure for national GPOs. The five largest GPOs by purchasing volume have approximately 85-90 percent of the market and in 2017 the top four GPOs reported a total purchasing volume of $189 billion.

Competition concerns are also raised when it comes to contracts between GPOs and vendors including sole-source contracting, minimum purchasing requirements that may cause overspending, length of the contract (5+ years in some instances), and bundling.

- Sole-source contracts: In a GAO report, all five major GPOs reported that they do negotiate sole-source contracts when it is advantageous to their customers, though some GPOs reported negotiating a higher proportion of sole source contracts than others. One GPO said that about 18 percent of its customers’ spending through the GPO is through sole-source contracts. Three GPOs reported sole-source contracting for branded drugs and

### Summary Table

<table>
<thead>
<tr>
<th>Administrative Fees</th>
<th>GPO</th>
<th>PBM</th>
<th>Anti-Kickback Statute exception/safe harbor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>~3%</td>
<td>~4.5-5%</td>
<td>Protected by the GPO safe harbor</td>
</tr>
<tr>
<td>Type of Discount</td>
<td>Up front discount at time of purchase</td>
<td>After the purchase rebate</td>
<td>Protected by the Discount safe harbor</td>
</tr>
<tr>
<td>Other fees</td>
<td>Data analytics, market research, clinical evaluation, etc.</td>
<td>Data analytics, disease management</td>
<td>If applicable, protected by the Personal Services safe harbor</td>
</tr>
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</table>
commodities, and four GPOs reported sole-source contracting for generic drugs, including
generic injectable drugs.

- Contracts that bundle related products: GPOs report negotiating contracts that offer
discounts based on the purchase of bundled products, but restricting bundling to products
that are used together or are otherwise related in order to create efficiencies and help
standardize products for their customers.

- Long-term contracts: GPOs report awarding longer terms for certain types of products,
such as IV systems and laboratory products.

Alternatively, all GPO contracts are voluntary and the product of market negotiations. Hospitals
and other health care providers are generally not required to only contract with one GPO and may
belong to multiple GPOs. Vendors are not required to contract with GPOs and health care
providers are not required to use the contracts negotiated by GPOs with their vendors. While GPOs
may negotiate sole-source contracts, providers are generally not required to purchase through their
GPO contracts but can instead purchase supplies “off contract” by negotiating their own prices
directly with suppliers. In economic models, on-contract prices are not necessarily the lowest
available. In fact, off-contract prices are sometimes lower. However, off-contract prices could be
lower than on-contract prices because of the presence of the GPO. Without the GPO, the off-
contract price could potentially be higher.

In addition to the above concerns related to GPO contracts, PBM contracting mechanism may also
have an impact on competition. Complaints about the PBM contracting process include employers
wanting an alternative to a rebate-driven approach to managing costs, PBMs lacking transparency
about how they generate revenue, contracts being complicated and including clauses that benefit
the PBM at the expense of the employer or patient, and rebates contributing to misaligned
incentives that put PBM interests before patients or employers (no fiduciary obligation).

**Contributing Factors to Drug Shortages**

Drug shortages remain an ongoing public health concern in the United States. Although the rate of
new shortages has decreased, long-term active and ongoing shortages have not been resolved and
critical shortages continue to impact patient care and pharmacy operations. Several commonly used
products required for patient care are in shortage including sterile infusion solutions (e.g., saline,
amino acids, dextrose), as well as diazepam, lidocaine, hydromorphone, and morphine.

Proponents supporting the repeal of the GPO Safe Harbor state the root cause of drug shortages is
the existence of the GPO Safe Harbor. However, the drug shortage issue is multi-factorial and
complex. Ongoing supply challenges of certain medications, typically injectable products that are
off-patent and have few suppliers, persist. Causes of these shortages continue to remain largely
unchanged:

- Quality problems – drug shortages are mostly triggered by quality problems during
  manufacturing processes which causes manufacturers to slow or halt production to address
  these problems.

- Limited inventory – widespread use of just-in-time inventory practices can increase the
  vulnerability of the supply chain to shortages.

- Regulatory approval – new manufacturers may not be able to quickly enter the market to
  produce a drug in shortage because the U.S. Food & Drug Administration’s (FDA)
  approval is required. Existing manufacturers also need FDA approval of changes to
  manufacturing conditions or processes.
• Production complexity – costly, specialized equipment is required to manufacture drugs and maintaining sterility throughout the production process is challenging and may require facilities dedicated solely to those drugs.

• Constrained manufacturing capacity – in the generic sterile injectable market, the industry is concentrated and has limited manufacturing capacity. The pressures to produce many drugs on only a few manufacturing lines can leave manufacturers with little flexibility when one manufacturer ceases production of a particular drug.

With respect to GPOs, a 2014 GAO report in examining causes of drug shortages was inconclusive and, importantly, did not mention the GPO safe harbor as a causal factor of drug shortages. Accordingly, while the presence of the GPO safe harbor may be a factor in drug shortages, drug shortages are multi-factorial, no consensus exists as to what percentage, if any, the safe harbor contributes to drug shortages, and no empirical evidence exists that the safe harbor is the root cause of drug shortages.

**Contributing Factors to Drug Pricing**

Proponents supporting the repeal of the GPO Safe Harbor also state that the safe harbor causes unprecedented drug price spikes. While impacted by supply chain dynamics, other contributing factors to pharmaceutical pricing include the type of pharmaceutical (generic, brand, biologic), level of negotiation authority of the purchasing entity, and market exclusivity and manipulations. At the front-end, pharmaceutical manufacturers set a drug’s list price, which does not include discounts or rebates. The list price is set to cover costs of production, research and development, and profits. Patients who are uninsured and in high-deductible health plans have greater exposure to the list price; for other patients who are insured, it more represents a starting price in the distribution chain from wholesalers to pharmacies to patients, ultimately impacting patient cost-sharing levels. While concerns have been raised that the rebate process between pharmaceutical companies and PBMs results in list prices above what they would be absent rebates, other key factors foundationally impact a drug’s list price.

When addressing the pricing of brand-name drugs, such factors include the number of individuals expected to use the drug, development costs, and competition in the marketplace. Brand-name drugs have 20 years of patent protection from the date of filing, and also enjoy a period of market exclusivity, depending on the type of drug. Orphan drugs – drugs to treat rare diseases or conditions affecting less than 200,000 individuals in the U.S., or affecting more than 200,000 individuals but for which there is not a reasonable expectation that the sales of the drug would recover the costs – have seven years of market exclusivity. Drugs deemed to be innovative products that include an entirely new active ingredient – a new chemical – have five years of market exclusivity. Six months of exclusivity are added to existing exclusivity periods once studies on the effects of a drug upon children are submitted for FDA review and meet the statutory requirements.

Currently, biologic manufacturers have 12 years of market exclusivity for innovator products. Innovator biologics also have additional patent protection that generally exceeds the market exclusivity period by a few years. Overall prices for biologics are higher resulting from the high risk and expense of manufacturing these products, the special handling and administration required, and an overall lack of competition in the marketplace. Biosimilars can offer some cost savings in comparison with their originator equivalents, but thus far not at the level seen between traditional brand-name and generic drugs.
Brand-name drug manufacturers have also used various techniques to delay competition in the marketplace or lengthen patent protection. In reverse-payment patent litigation settlements, also known as “pay-for-delay” settlements, a brand-name drug manufacturer pays a potential generic competitor to abandon its patent challenge and delay offering a generic drug product for a number of years. Brand-name manufacturers can also attempt to effectively extend the term of patent protection for a single product by creating a patent portfolio, composed of patents with staggered terms for modified forms of the same drug, new delivery systems for that drug, or other variations of the original product, a practice known as “evergreening.” Examples of evergreening include reformulating a drug as extended release or changing the mix of chemical isomers. In situations where a newer version of an existing brand-name drug enters the marketplace, brand-name manufacturers can also choose to take the older drug off the market or restrict access to the older drug, including by limiting its distribution through select specialty pharmacies.

Several factors can impact the prices of generic drugs, including drug shortages, supply disruptions, limits in manufacturing capacity, and generic drug industry mergers and acquisitions. In addition, generic drug companies may transition to manufacture drugs recently off patent to gain early market share, while others have chosen to manufacture generic drugs that have been on the market for some time and no longer have ample competition.

Patient out-of-pocket costs for the same prescription drug can vary based on the health plan in which they are enrolled. Certain government programs, including Medicaid, the Veterans Affairs and Department of Defense, secure discounts and/or rebates on the price of prescription drugs. In most other coverage situations, patient cost-sharing levels result from insurer/PBM-pharmaceutical company negotiations, and depend on whether drugs are on their health plan formulary, and if so, at what cost-sharing tier.

Our AMA policies on drug shortages and pricing advocate pursuing a collaborative approach focused on finding the root causes of problems. Blaming GPOs for the complicated drug shortage problem risks compromising this solution-oriented strategy, especially without a current policy consensus on this point. With respect to GPO pricing incentives, it is important to keep in mind that GPO contracts are voluntary in nature. GPO customers retain the ability to purchase products and services off-contract if they find a preferable or better-priced option.

DISCUSSION

Throughout the evolution of this report, the Council on Medical Service welcomed input from the Council on Legislation and thanks the Council on Legislation for its thoughtful comments throughout the drafting process. The Council on Medical Service is confident that the collaboration between the Councils was essential to the formulation of a measured report on a highly complex subject and the nuances therein.

The GAO has expressly declined to call for eliminating the safe harbor as the appropriate solution, noting that “a repeal of the safe harbor provision would require a clearer understanding of the impact of the GPO funding structure.” GAO emphasized, and the Council agrees, that eliminating the safe harbor could have unintended consequences, at least in the short term:

Some experts believe there is an incentive for GPOs to negotiate higher prices for products and services because GPO compensation increases as prices increase. However, other experts, as well as GPOs, stated that there is sufficient competition between them to mitigate any potential conflicts of interest. Almost 30 years after its passage, there is little empirical evidence to definitively assess the impact of the vendor-
fee-based funding structure protected under the safe harbor. While repealing the safe
harbor could eliminate misaligned incentives, most agree there would be a disruption
while hospitals and vendors transitioned to new arrangements. Over the longer term, if
the current trend of hospital consolidation continues, the concerns about these
disruptions may be diminished to the extent that large hospital systems may be in a better
position to pay GPOs directly for their services or negotiate contracts with vendors on
their own. Furthermore, given that some hospitals are already paying a subsidiary of one
GPO directly for access to vendor contracts, alternative approaches are possible.32

GPO Studies

As mentioned by the GAO, the Council finds little empirical evidence exists to definitively assess
the impact of the GPO safe harbor. Most research studies are funded by interested parties like the
Healthcare Supply Chain Association. A limited economic model with no funding ties to GPOs,
PBMs, or proponents of repeal, found that while removal of the safe harbor decreased providers’
nominal purchasing price, their total purchasing costs are the same as when the safe harbor was
present. Thus, repeal would not affect any party’s profits or costs.33 In a broader economic model, a
study found that total purchasing cost of the providers is not affected by the presence of the GPO
administration fees, although providers may experience higher unit prices.34

Legal Impact of Fitting GPOs or PBMs Within Personal Services Safe Harbor

If the GPO safe harbor were repealed, the Council believes that GPOs and PBMs simply could shift
fees into other forms, such as rebates or other fees, rather than lose their revenue stream. For
example, the current administrative fee could fit within the personal services and management
contracts safe harbor or fit within enough factors of the safe harbor that OIG would use its
enforcement discretion and not pursue criminal charges against the GPO or PBM.35 This safe
harbor covers a wide variety of conduct. The Council notes that the personal services category
covers many types of services provided in the health care industry including professional physician
services provided under an independent contractor arrangement, a physician group providing
medical services to a hospital, and medical director agreements. The management contracts
category covers all non-professional services billing and collection, accounting, marketing,
purchasing, staffing, recruiting, quality assurance, and facilities and personnel management.

In this case, the GPO Safe Harbor three percent or 4.5 - 5 percent administration fee could be
repackaged under the personal services and management contracts safe harbor as a management
contract. To fit within that safe harbor, a GPO or PBM would need to meet the following
requirements:

1. Agreement in writing and signed;
2. Covers all of the services provided;
3. Not less than one year;
4. Aggregate compensation paid to the agent (GPO) over the term of the agreement is set in
   advance, is fair market value, and does not take into the volume or value of any referrals of
   federal health care program beneficiaries;
5. Arrangement does not violate any state or federal law;
6. Contracted services do not exceed what is reasonably necessary to accomplish the
   commercially reasonable business objective; and
7. If services are on a part-time basis (e.g., part-time housekeeping), lay out schedule of
   internals, precise length, and exact charge for such intervals.
Repackaging the administrative fee into the personal services and management contracts safe harbor may not squarely meet all of the safe harbor’s requirements because a percentage may not be an aggregate compensation set in advance. OIG is silent on fixed percentages laid out in advance under this exception. OIG, in Advisory Opinions, does allow performance or other percent bonuses as compensation even if it does not fit squarely within the safe harbor. In those instances, OIG uses its enforcement discretion to decline to pursue (e.g., lack of intent). There is also a low risk that the compensation (three percent) was payment for patient referrals because the percentage does not directly vary with the number of patients treated. With determining fair market value, OIG would likely find the three percent GPO fee or the 4.5 percent PBM fee to be fair market value given the percentage of the market that uses these percentages in practice.

Moreover, specifically regarding PBMs, the Council notes that CMS Report 5-A-19, which is before the House of Delegates at this meeting, recommends supporting the active regulation of PBMs under state departments of insurance, supporting efforts to ensure that PBMs are subject to federal laws that prevent discrimination against patients, and supporting improved transparency in PBM operations including a list of disclosures.

Impact on Patient Care

The Council strongly believes that repeal of the GPO safe harbor may also have, at least in the short-term, widespread disruption of the supply chain and administrative challenges for not only hospitals (including physician-owned hospitals), but also clinics, ambulatory surgery centers, and other provider arrangements. As such, physician-owned practice settings may be adversely impacted if the viability of the GPO business model is compromised. Whatever the flaws in their funding structure, the Council finds that GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care.

Accordingly, the Council believes that adopting a policy to oppose the GPO safe harbor may not only hurt the AMA’s credibility but also will not accomplish the objectives set forth by proponents of repeal because limited economic studies show no impact on repeal, entities involve may continue to operate the same practices under a different safe harbor, and repeal would potentially cause a disruption of care and the supply chain.

Instead, the Council believes that the AMA should promote greater transparency and accountability efforts regarding the actions covered by the GPO and PBM anti-kickback safe harbor. In 2014, GAO recommended that CMS should determine whether hospitals are appropriately reporting administrative fee revenues on their Medicare cost reports and take steps to address any underreporting that may be found. In response, CMS issued a Technical Direction Letter to the Medicare Administrative Contractors (MACs) in 2015 adding steps to the desk review program. Specifically, CMS directed MACs to verify that GPO revenues have been offset where appropriate in order to mitigate any risk to the Medicare program. However, nothing has been publicly released based off of these desk reviews. Moreover, HHS has the capability to request records from GPOs the amount received from each vendor with respect to purchases made by or on behalf of the GPOs customers. Yet, the Council is unaware of any requests or public reports based off any requests since the GAO report. Given the push for greater price and cost transparency and the lack of recent data related to GPOs and PBMs, the Council recommends that the federal government renew efforts to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the GPO and PBM anti-kickback safe harbor.

Additionally, the Council believes that the AMA should focus efforts on modernizing the fraud and abuse laws to address the changing realities of the health care delivery and payment system. The
Anti-Kickback Statute was passed in 1972, Stark (physician self-referral law) in 1989. Significant changes in health care payment and delivery have occurred since the enactment of these laws. For example, PBMs did not exist, or were at least not as pervasive, when these laws were created. Numerous initiatives are attempting to align payment and coordinate care to improve the quality and value of care delivered. The delivery of care is going through a digital transformation with innovative technology. However, the fraud and abuse laws have not commensurably changed.

The fraud and abuse laws were enacted during a time when fee-for-service, which pays for services on a piecemeal basis, was blamed for rising costs. The policy reasoning behind the fraud and abuse laws is to act as a deterrent against overutilization, inappropriate patient steering, and compromised medical judgment with heavy civil and criminal penalties, such as treble damages, exclusion from participation in federal health care programs, and potential jail time.

The health care system has evolved since the creation of these laws, and the Council believes that they need to be updated to reflect changing business practices and technologies in the health care industry.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 252-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-125.986 supporting efforts to ensure that reimbursement policies established by pharmaceutical benefit managers (PBMs) are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-110.992 stating that the AMA will monitor the relationships between PBMs and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-100.956 calling for collaboration with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs (Reaffirm HOD Policy)

4. That our AMA renew efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the Group Purchasing Organization and PBMs anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages. (New HOD Policy)

5. That our AMA support efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES


5. Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)).


11. H.R. Report No. 95-393(II), at 53, reprinted in 1977 U.S.C.C.A.N. 3039, 3056. ("In fact, the committee would encourage providers to seek discounts as a good business practice which results in savings to Medicare and Medicaid program costs.").

12. 42 CFR § 1001.952(h).

13. Medicare rules generally require providers to offset purchase discounts, allowances, and refunds against expenses on their Medicare cost reports. In 2005, OIG reviewed 21 GPO members, and found that they did not fully account for net revenue distributions on their Medicare cost reports. There was considerable variation among the GPOs, with members of one GPO offsetting 92 percent of the distributions, members of another offsetting only 54 percent. In total, 22 percent of net revenue distributions were not offset. OIG, Health Care Fraud and Abuse Control Program Annual Report for FY 2005, (Aug. 2006), https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2005.pdf.


15. 42 CFR § 1001.952(d).


17. SSA § 1150A (42 U.S.C. § 1320b-23). In relevant part, the regulations requires each entity that provides PBM services to provide to the Part D sponsor and for each part D sponsor to provide to CMS the aggregate amount and type of rebates, discounts, or price concessions (excluding bona fide service fees as defined in §423.501) that the PBM negotiates that are attributable to patient utilization under the plan and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed. 42 C.F.R. § 423.514(d).

18. Based off of AMA staff interviews with trade associations and private practice attorneys who represent both sides of an arrangement.

19. 84 Fed. Reg. 2340 (Feb. 6, 2019)

20. Id.

21. Based off of AMA staff interviews with trade associations and private practice attorneys who represent both sides of an arrangement.


33 Q. Hu & L. Schwarz, Controversial Role of GPOs in Healthcare-Product Supply Chains, Production and Operations Management (2010). This study used a Hotelling model which assumes a continuum of identical providers and two manufacturers.
35 E.g., Bloomberg BNA, Health Care Program Compliance, Personal Services and Management Agreements, chap. 1415 (2012) (“If business realities preclude meeting all of the requirements, then meeting as many of the requirements as possible will increase the chances that the arrangement will be viewed as non-abusive, as long as there is no underlying purpose to induce or reward referrals of business reimbursed under federal health care programs.”).
Subject: Health Plan Payment of Patient Cost-Sharing
(Resolution 707-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 707, which was introduced by the California Delegation and assigned to the Council on Medical Service for study. Resolution 707-A-18 asked:

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

This report provides an overview of patient cost-sharing obligations including the rise of high-deductible health plans, highlights patient collection management practices by insurers, summarizes relevant AMA policy, provides a summary of relevant AMA advocacy activities, and recommends policy.

BACKGROUND

Despite coverage gains in recent years, the health care system continues to struggle with decreasing the number of uninsured patients and, even for the insured population, utilizing health care services is often unaffordable. For the insured, the trend of rising health insurance deductibles has been altering health insurance from more comprehensive coverage to insurance with higher out-of-pocket costs. Deductibles have gradually risen for decades and contribute to the changing nature of health insurance. One rationale behind high deductible health plans (HDHPs) is that they moderate the cost of health care and health insurance by shifting the rising cost of health care from insurers and employers to patients. Health plans with higher levels of cost-sharing generally have lower premiums and put a financial obligation of higher out-of-pocket costs on patients when services are used.

The prevalence of HDHPs is not limited to the Affordable Care Act (ACA) Exchanges but also widespread in employer-sponsored coverage. Notably, the growth in HDHP enrollment has been fastest among those with employer-based coverage. About 40 percent of companies that offer health insurance make HDHPs the only choice for their employees. About half of people with employer coverage have a deductible of at least $1,000. Moreover, the shift to plans with rising deductibles began before the ACA was passed. The average general annual deductible for employees has increased 49 percent over the last five years. Overall, in 2018, 29 percent of workers with employer-based coverage were enrolled in a HDHP. Although the Council believes that health insurance should balance patient responsibility and patient choice; increasingly employees do not have a choice of coverage options.
The impact of cost-sharing imposed by HDHPs is an ongoing concern for patients and physicians. HDHPs with tax-preferred savings accounts may not be a good fit for some patients, particularly low-income patients who may struggle to fund their health savings accounts (HSAs). For example, there is evidence that exposing patients to increased cost-sharing has unintended and negative consequences. Overall, HDHPs can be a good option for people who are in relatively good health, but they may expose people who have more modest incomes to out-of-pocket costs that can be a barrier to care and a risk to their financial security. HDHPs also make beneficiaries increasingly vulnerable to sharp increases in drug prices. Cost-sharing, even when tied with available information on the price of services, generally does not induce patients to shop for lower-priced services. Instead, patients more often reduce their use of health services, potentially delaying needed care and exacerbating health issues. The burden of higher cost-sharing has a disproportionate impact on patients with lower incomes whose deductible may exceed available liquid assets.

The shift in financial responsibility toward patients may contribute to physicians’ concerns about collecting cost-sharing from patients. However, if physicians do not collect these cost-sharing amounts, they sustain bad debt that adversely affects the financial sustainability of their practices. Bad debt typically is the difference between what providers billed patients and the amount those patients ultimately paid, and the phenomenon of bad debt has become an industry-wide issue for health care practitioners. Patient payments are an increasing share of expected revenues. According to the American Hospital Association, this uncompensated care reached $38.3 billion in 2016. Bad debt may affect the financial viability of practices, and collecting on bad debt takes practice time and resources, and the additional time physician offices spend on collection of bad debt is not reflected in the cost of providing care. Moreover, the significant time used to collect on such debt may cause disruptions to the patient-physician relationship.

**EXAMPLE OF INSURER PROGRAM COLLECTING COST-SHARING**

To mitigate bad debt, major national health plans, including UnitedHealthcare and Anthem, have patient payment programs through InstaMed, which allow insurers to manage patient collections for the physician practice; however, there are caveats to this model. First, practices do not have a choice of if they want to receive patient payments in this manner. Therefore, if a patient signs up for InstaMed, the practice will get paid through InstaMed. Moreover, these programs typically only issue electronic payments to the practice. If the practice does not sign up for the program and receive standard electronic fund transfers, the practice will be issued a virtual credit card for the patient’s payment. Importantly, such credit cards are associated with fees that tend to be 2-5 percent of the overall payment. Furthermore, practices may have reasons for wishing to manage patient payments themselves. For instance, the practice may have worked out a payment plan with the patient or there may be secondary or tertiary payers. The solution sought by Resolution 707-A-18 may negatively impact such business autonomy by precluding such arrangements. Advocating for patient payment programs may appear as an endorsement of such programs, which may be problematic for physicians and provider representatives of plans impacted by these patient collection methods. Accordingly, such action may adversely affect physician payment levels and processes, and could have unintended consequences within some physician practices.

**AMA POLICY**

Long-standing AMA policy and advocacy efforts acknowledge and support the business freedom of physician practices (Policies H-165.985 and H-165.838). Some physicians prefer the flexibility afforded to payment operations and do not want to cede patient collections to health plans.
Physicians currently have the ability to offer discounts or payment plans to patients to facilitate goodwill, which is an arrangement supported by long-standing Policy H-165.849. Moreover, Policy H-165.849 states that our AMA will engage in a dialogue with health plan representatives (e.g., America’s Health Insurance Plans and Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in HDHPs.

Policy D-190.974 demonstrates the AMA’s commitment to administrative simplification. Among numerous actions, it directs the AMA to continue its strong leadership role in automating, standardizing, and simplifying all administrative revenue cycle transactions between physicians in all specialties and modes of practice and all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses. Moreover, it directs the AMA to prioritize efforts to automate, standardize, and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care.

The AMA remains committed to health insurance affordability. Policy H-165.828 specifically encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Moreover, Policy H-165.828 supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.

The AMA has developed a comprehensive point-of-care pricing toolkit to help practices with patient collections (https://www.ama-assn.org/practice-management/claims-processing/managing-patient-payments). The toolkit recognizes concerns about uncollected patient financial responsibility that can result in physician practices taking on debt and contains varied resources to help mitigate the problem. This toolkit addresses point-of-care and post-visit collections and includes:

- Step-by-step guidance toward providing point-of-care pricing and collecting from patients at the time of service;
- Guidance on calculating the price of treatment at the point-of-care;
- Sample scripts to help practices collect patient payment;
- Letter templates to ask health insurers and other payers about terms and conditions of insurance contracts regarding physicians’ rights to provide point-of-care pricing and collect payments at the time of care;
- Webinars designed for practices to help patients understand their financial responsibility;
- Resource providing information on how practices can implement an effective strategy for collection of payment after a patient has left the office; and
- Guidance on the steps to take when a patient fails to pay for treatment in full.

In addition to the AMA’s point-of-care pricing toolkit, the AMA has repeatedly voiced its concern about virtual credit card payments and the fact that it may cause physicians to lose a significant amount of contractual payments to high interchange fees charged by the credit card companies. The AMA continuously advocates for transparency in virtual credit card payments including advanced disclosure of transaction fees and any rebates or incentives awarded to payers for using this payment method.
Furthermore, pursuant to Policy H-165.849, the AMA continues to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. The AMA continues to hold such meetings with insurers to address this issue as well as other issues relating to physician burden and practice sustainability.

DISCUSSION

Bad debt can affect the financial viability of practices, and collecting on this debt takes practice time and expense. Nonetheless, the Council is concerned about the unintended consequences of adopting Resolution 707-A-18. In particular, if insurance companies collect patient co-payments and deductibles, they would likely charge administrative fees to practices or lower physician payment levels. Nonetheless, the Council believes that the issues raised by Resolution 707-A-18 are compelling and warrant action, particularly for small physician practices that may be most impacted by an increase in bad debt brought about by some patients not fulfilling their cost-sharing obligations.

First, the Council recommends reaffirming long-standing policy illustrating the AMA’s commitment to the business freedom of physician practices (Policies H-165.985 and H-165.838). Additionally, because the evidence suggests that it is not the HDHP itself that is necessarily problematic but rather the inability to meaningfully fund a corresponding HSA, the Council recommends reaffirming Policy H-165.828 encouraging the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Due to the trend of increasing use of HDHPs, the Council also recommends encouraging states and other stakeholders to monitor the growth of HDHPs and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability.

The Council believes that a factor contributing to uncompensated care is the lack of patient education on their health plans. Importantly, Policy H-165.828 also supports education regarding deductibles and cost-sharing at the time of health plan enrollment, including the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. Although the Council remains steadfast in its belief that patient education will help solve the problem of uncompensated care, it notes that the Emergency Medicine Treatment and Labor Act forbids emergency care providers from discussing with the patient any potential costs of care or details of their insurance coverage until the patient is screened and stabilized. The Council agrees with and respects this prohibition. Therefore, while the Council strongly supports patient education of costs not only at the time of enrollment but also at the time of care, the Council recognizes that this discussion is precluded at the point-of-care in the case of emergencies.

To further patient education efforts, the Council recommends amending Policy D-190.974 by updating part four by addition such that our AMA will prioritize efforts to automate, standardize, and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in HDHPs. Following from this, the Council also believes that more sophisticated IT systems are critical to help enable physicians and empower patients to better understand financial obligations. Additionally, the Council recommends taking this opportunity to amend part six of Policy D-190.974 to reflect the ending of the Heal the Claims campaign and
instead recommends calling attention to the AMA’s continued efforts to ensure that physicians are aware of automating their claims cycle.

As previously noted, the prevalence of HDHPs is not isolated to the ACA Exchanges, but is also widespread in employer-sponsored coverage. The Council believes that health insurance should balance patient responsibility and patient choice; however, increasingly patients do not have a choice of coverage options. Therefore, the Council recommends reaffirming Policy H-165.849 urging the AMA to continue to engage in ongoing dialogue with health insurers and health insurance representatives about the increasingly difficulty of practices in collecting co-payments and deductibles and the underlying issue of affordability.

The Council firmly believes that there are no easy solutions to the problem of patient collections and remains unconvinced that giving insurers additional control over the process is the best solution. Instead, the Council believes that the AMA should remain committed to addressing the concerns of its members and seeking solutions to the major issue underlying Resolution 707-A-18, which is greater affordability of health insurance premiums and cost-sharing responsibilities. Accordingly, the Council suggests a set of recommendations intended to address the root of the problem.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 707-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policies H-165.985 and H-165.838 illustrating the AMA’s commitment to the business freedom of physician practices. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-165.849 stating that the AMA will continue to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.828 encouraging the development of demonstration projects to allow individuals who forego cost-sharing subsidies by enrolling in a bronze plan to have access to a partially-funded health savings account and supporting additional education regarding deductibles and cost-sharing at the time of health plan enrollment. (Reaffirm HOD Policy)

4. That our AMA amend Policy D-190.974 by addition and deletion as follows:

Administrative Simplification in the Physician Practice

1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.

2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.

3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice.
with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.

4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.

5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.

6. Our AMA will continue its efforts to expand its Heal the Claims process(TM) campaign as necessary to ensure that physicians are aware of the value of automating their claims cycle.

(Modify Current HOD Policy)

5. That our AMA support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations. (New HOD Policy)

6. That our AMA encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability. (New HOD Policy)

Fiscal Note: Less than $500

REFERENCES

1Altman, D. The Missing Debate Over Rising Health-Care Deductibles. Kaiser Family Foundation. Available at: https://www.kff.org/health-costs/perspective/the-missing-debate-over-rising-health-care-deductibles/
3https://www.pwc.com/us/touchstone2016
5 Supra note 1.
8 Supra note 1.
9 Supra note 2.
EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked: That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

Health care disparities often occur in the context of wider inequality. It has been shown that if patients’ basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. And because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, as Resolution 712 points out, value-based payment programs can disproportionately penalize physicians serving the poorest and most vulnerable populations. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council’s recommendations build upon the AMA’s current policy on value-based payment programs and social determinants of health. The Council recommends reaffirming existing AMA policies to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment. The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients, and the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations.

The Council understands and agrees with the sponsor’s concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health.
At the 2018 Annual Meeting, the House of Delegates referred Resolution 712, which was introduced by the New England Delegation and assigned to the Council on Medical Service for study. Resolution 712-A-18 asked:

That our American Medical Association (AMA): (1) study the impact of current advanced Alternative Payment Models (APMs) and risk adjustment on providers caring for vulnerable populations; and (2) advocate legislatively that advanced APMs examine the evaluation of quality performance (for bonus or incentive payment) of providers caring for vulnerable populations in reference to peer group (similarities in SES status, disability, percentage of dual eligible population).

This report provides an overview of vulnerable populations and the emergence of APMs, highlights numerous APMs and value-based care initiatives incorporating social determinants of health into their models, summarizes relevant AMA policy, provides a summary of AMA advocacy activities, and recommends policy to encourage the development of APMs that serve vulnerable populations while protecting physicians from being financially penalized.

BACKGROUND

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula and created new ways for the Medicare program to pay physicians for the care they provide to Medicare beneficiaries. Specifically, MACRA’s physician payment program is the Quality Payment Program (QPP). The QPP has two tracks of participation: APMs and the Merit-based Incentive Payment System (MIPS). As part of the QPP’s drive to value-based care, it creates incentives for physicians to participate in APMs, which aim to provide greater flexibility to manage the health of patient populations by aligning provider incentives with cost and quality goals. MACRA specifically encourages the development of Physician-Focused Payment Models (PFPMs), which are APMs wherein Medicare is the payer, physician group practices or individual physicians are APM participants, and the focus is on the quality and cost of physician services. MACRA established the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review and assess PFPM proposals submitted by stakeholders to the committee based on certain criteria defined in regulations. The PTAC is an 11-member independent federal advisory committee. Since its inception, the PTAC has received 31 proposals for consideration, a few of which have not been reviewed yet by PTAC. Of those proposals, PTAC has recommended 15 proposals to the Secretary of Health and Human Services (HHS) to test in various ways.
As the national push toward value-based payment and care delivery continues, many studies have demonstrated substantial evidence linking social circumstances to health and health outcomes. It is now understood that non-medical factors, such as social determinants of health (SDH), account for about 60 percent of a person’s health outcomes. Together, the drive toward value and recognition of SDH impacts on health are fueling interest in the ways in which addressing SDH may be incorporated into new payment and delivery models like APMs. Within an APM, physicians often are financially rewarded for keeping patients healthy and out of the hospital and emergency departments. To achieve this goal, APMs often have the flexibility to support services that can significantly improve health outcomes. Therefore, physicians can respond to APM incentives by improving care coordination and integration, which may be particularly beneficial for vulnerable populations.

However, APMs may inadvertently create incentives for physicians to avoid caring for vulnerable patients who are at increased risk for high costs and poor outcomes that are beyond the physician’s control. In order to increase health equity and to fully realize the benefits of APMs, APMs must contemplate and account for vulnerable populations.

**Impact of Vulnerable Population Status on Patient Outcomes**

Vulnerable populations in health care include the economically disadvantaged, racial and ethnic minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups; uninsured individuals; rural individuals who may have trouble accessing care; and those with stigmatized chronic conditions such as severe mental illness or human immunodeficiency virus (HIV). These populations may be more likely to suffer from hunger and access to healthy food options, lack social and economic support, have lower education levels, live in unsafe neighborhoods devoid of parks and playgrounds, and often are subjected to discrimination.

Vulnerable populations are less likely to have health coverage, struggle with health care access, and often have little interaction or trust in the health care system. They are less likely to receive preventive services and are more likely to go to the emergency department or hospital for a condition that might have been treated in a lower cost facility. As a result, their medical interventions generally come much later and at significantly higher cost than for other populations. Moreover, lower income populations are twice as likely as those with higher incomes to have behavioral health problems, three times as likely to be socially isolated, and 10 times more likely to experience food insecurity. Additionally, there is considerable overlap in vulnerable populations. For example, Black and Hispanic American minorities are significantly more likely than Whites to be uninsured, live below the poverty line, and have higher rates of HIV or AIDS diagnosis and death rates.

Though access to health care is essential for well-being, it is not the greatest health determinant. Zip Code™ now is understood to be a stronger predictor of quality of health than even genetic code. Research suggests that health-related behaviors such as smoking, diet, and exercise, are more important determinants of early death than health care itself. Furthermore, there is a growing consensus that non-medical factors shape an individual’s ability to engage in health behaviors. For example, children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health such as lack of safety, exposed garbage, and substandard housing. Such environmental factors may have multi-generational impacts.

Generally, the current health care system is not built around the poorest and most vulnerable. Exacerbating the ability to effectively care for these populations is the fact that many physicians are not able to identify high-risk patients. Some of the current risk algorithms used by payers were
originally developed without access to electronic medical record (EMR) data, so many current predictive risk tools have limited utility. The link between non-medical factors and poor health outcomes is well-documented, but few traditional payment and delivery models are equipped to address these non-medical factors that drive high health care costs and poor outcomes.

Addressing the Unique Needs of Vulnerable Populations in Payment and Delivery

There are a growing number of initiatives to address SDHs and challenges unique to vulnerable populations within and outside of the health care system. These include multi-payer federal and state initiatives, Medicaid initiatives led by states or health plans, and physician-level activities focused on identifying and addressing the social needs of their patients. APMs can provide opportunities to cover services that can help provide care and support that vulnerable or high-risk populations need but that are generally not available under traditional payment models. Examples of such initiatives are highlighted below and include: Accountable Health Communities, the Chinese Community Accountable Care Organization (ACO), the Acute Unscheduled Care Model, and the Patient-Centered Opioid Addiction Treatment (P-COAT) APM.

Accountable Health Communities

In 2016, the Center for Medicare and Medicaid Innovation (CMMI), which was established by the Affordable Care Act, announced the Accountable Health Communities model, which is focused on connecting Medicare and Medicaid beneficiaries with community services to address health-related social needs. The model provides funding to examine whether systematically identifying and addressing social needs of beneficiaries through screening, referral, and community navigation services affects health costs and reduces health care utilization. In 2017, CMMI awarded grants to organizations to participate in the model over a five-year period.

Twenty awardees will encourage partner alignment to ensure that community services are available and open to the needs of beneficiaries. To implement the alignment approach, bridge organizations will serve as “hubs” in their communities that will identify and partner with clinical delivery sites to conduct systematic screenings of beneficiary health-related social needs and make referrals to community services that may be able to address the recognized social needs; coordinate and connect beneficiaries to community service providers through community service navigation; and align model partners to optimize community capacity to address these social needs.

The Chinese Community ACO

The Chinese Community ACO (CCACO) is a community-based physician-owned ACO that serves about 12,000 Medicare fee-for-service (FFS) beneficiaries in the Chinese communities in New York City. The aim of the model is to reduce overall health care costs and disparities by identifying high-risk individuals and undertaking proactive disease management. The CCACO establishes a network of organizations by partnering with hospitals, nursing homes, home health agencies, senior centers, and others to facilitate coordinated care. The model anticipates that, due to care coordination efforts, it will prevent emergency room visits and hospital readmissions in this population.

Acute Unscheduled Care Model (AUCM) Enhancing Appropriate Admissions from the American College of Emergency Physicians (ACEP)

The AUCM was developed by the ACEP. The particular payment model was submitted to the PTAC, and the PTAC subsequently recommended to the Secretary of HHS that the model be
implemented. It centers on incentivizing improved quality and decreased costs associated with the
discharge decisions made by emergency department (ED) physicians.\textsuperscript{14} The model proposes that it
may reduce Medicare spending and improve quality care by reducing avoidable hospital inpatient
admissions and observation days by giving ED physicians the ability to coordinate and manage
post-discharge home services. The model is a bundled payment, and the episode of care begins
with a qualifying ED visit and ends after 30 days or with the patient’s death.\textsuperscript{15} All of the Medicare
services received within that 30-day window are included in the bundle. To assist in care
transformation efforts, the model also uses several waivers in order to allow ED physicians to offer
telehealth services, bill for transitional management codes, and permit clinical staff to offer home
visits.

Patient-Centered Opioid Addiction Treatment (P-COAT) APM

The P-COAT model is a payment model created jointly by the American Society of Addiction
Medicine (ASAM) and the AMA. The model proposes to manage opioid use disorder, a highly
stigmatized condition, by increasing utilization of and access to medications for the treatment of
opioid use disorder by providing the appropriate financial support to successfully treat patients and
broaden the coordinated delivery of medical, psychological, and social supports.\textsuperscript{16} The current
payment system offers little support for the coordination of behavioral and social supports that
patients being treated for opioid use disorder need. Therefore, under P-COAT, treatment teams are
eligible to receive two new types of payments that would be expected to provide the necessary
financial support to enable providers to deliver the appropriate opioid addiction treatment.\textsuperscript{17}

AMA POLICY

The AMA has a wealth of policy on both APMs and SDH. Regarding APMs, Policy H-385.913
promulgates goals for physician-focused APMs, develops guidelines for medical societies and
physicians to begin identifying and developing APMs, encourages the Centers for Medicare &
Medicaid Services (CMS) and private payers to support assistance to physician practices working
implement APMs, and states that APMs should account for the patient populations, including
non-clinical factors. Policy H-385.908 states that the AMA will continue to urge CMS to limit
financial risk requirements to costs that physicians participating in an APM have the ability to
control or influence, will work with stakeholders to design risk adjustment systems that identify
new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a
patient’s health and success of treatment, such as disease stage, access to health care services, and
socio-demographic factors.

Moreover, AMA policy is committed to promoting physician-led payment reform programs that
serve as models for others working to improve patient care and lower costs. Policy D-390.953
directs the AMA to advocate with CMS and Congress for alternative payment models developed in
concert with specialty and state medical organizations. Policy H-390.844 emphasizes the
importance of physician leadership and accountability to deliver high quality and value to patients
and directs the AMA to advocate for providing opportunities for physicians to determine payment
models that work best for their patients, their practices, and their regions. Policy H-450.961 states
that incentives should be intended to promote health care quality and patient safety and not
primarily be intended to contain costs, provide program flexibility that allows physicians to
accommodate the varying needs of individual patients, adjust performance measures by risk and
case-mix to avoid discouraging the treatment of high-risk individuals and populations, and support
access to care for all people and avoid selectively treating healthier patients. Additionally, Policy
D-35.935 supports physician-led, team-based care delivery recognizing that the interdisciplinary
care team is well equipped to provide a whole-person health care experience.
The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to exercise leadership aimed at addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency.

Policy H-280.945 calls for better integration of health care and social services and supports while Policy H-160.896 calls to expand payment reform proposals that incentivize screening for social determinants of health and referral to community support systems. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

Recognizing that current risk adjustment and performance measure systems may disincentivize caring for the most vulnerable, Policy H-450.924 supports that hospital program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing hospitals, including safety net hospitals, and physicians that may exacerbate health care disparities.

AMA ACTIVITY

The AMA continues to work to aid physicians in the implementation of MACRA and by encouraging and enabling physician participation in APMs. 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. Such areas for improvement in methodology include performance targets, risk adjustment, and attribution. The AMA recognizes that proper methodologies enable more physicians to participate in APMs and promotes design of APMs in such a way that prioritizes the patient’s need.

The AMA continues to strive to ensure that all communities of Americans receive equal access to quality health care. The AMA is committed to working toward the goal of all Americans having access to affordable and meaningful health care. It is addressing this issue systemically by striving for health equity by mitigating disparity factors. For example, the AMA has developed numerous resources including a Health Disparities Toolkit that helps connect physicians and care teams to chronic disease prevention programs in the community. The AMA STEPSForward™ module entitled Addressing Social Determinants of Health describes how a practice can select and define a plan to address SDH issues. Additionally, steps toward health equality are being taken in the AMA’s effort toward creating the medical school of the future. Within the AMA’s Accelerating Change in Medical Education (ACE) initiative, some medical schools are incorporating education on disparities within their curricula while others are addressing diversity in the health care workforce by changing admissions and pipeline programs to ensure that our nation has the diverse workforce that it needs.

Additionally, the AMA is integrating SDH into its Integrated Health Model Initiative (IHMI), a collaborative effort that supports a continuous learning environment to enable interoperative technology solutions and care models that evolve with real world use and feedback. IHMI’s
collaborative platform is discussing SDH with the goal of identifying those factors that should be incorporated into the IHMI data model. Moreover, the IHMI team has delivered a module that incorporates two of the widely accepted SDH: the nine-digit Zip Code™ where one lives and those who are dually-eligible for Medicaid and Medicare.

Importantly, the AMA recognizes that health quality can only happen in concert with efforts to improve physician satisfaction and wellbeing. Therefore, the AMA is helping create an engaged workforce and mitigating burnout. To that end, the AMA has developed STEPSForward™ resources and Burnout Assessment Tools to allow physicians to assess their practices and find ways to leverage their entire care team to improve physician and patient experience and care. The AMA knows that advocating for physicians and patients is critical to achieve health equity. Patients and the public are partners in the quest for equitable access to quality health and health care.

Moreover, the AMA is establishing a new Health Equity Center with the goal of enabling optimal health for all with an eye on social justice. The Center will serve as a demonstration of the AMA’s long-term and enduring commitment to health equity.

DISCUSSION

Health care disparities often occur in the context of wider inequality. It has been shown that if patients’ basic needs are not met, they are not likely to stay healthy regardless of the quality of health care received. Because APMs are typically designed to be flexible to compensate for care that is not traditionally reimbursed, they present an opportunity to better care for and serve vulnerable populations. However, several studies have demonstrated that value-based payment programs disproportionately penalize physicians serving the poorest and most vulnerable populations, possibly disincentivizing physicians from caring for them. Therefore, the Council offers a set of recommendations that it hopes mitigates these negative outcomes, penalties, and events. In doing so, the Council recommends ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Council’s recommendations build upon the AMA’s current policy on value-based payment programs and social determinants of health. The Council notes that reaffirming existing AMA policies helps to highlight the need for health equity across populations and the corresponding need for APMs and risk adjustment methodologies to protect against financially penalizing the physicians who care for and serve populations who are overwhelmingly sicker and poorer. The Council is sensitive to concerns that APMs may have the impact of not only financially penalizing physicians caring for at-risk populations, but also causing adverse selection in patient treatment.

The Council believes that it is critical that social determinants of health be meaningfully incorporated into APM quality measures to encourage and support physicians to care for these patients. The current health care system was not built for vulnerable populations, and they remain woefully underserved. Therefore, the Council recommends that APMs be designed with the flexibility needed to address the unique challenges of vulnerable populations and believes that PFPMs provide an excellent opportunity to transform care delivery to better meet the needs of underserved populations.

The Council understands and agrees with the sponsor’s concern that APMs may have adverse effects on vulnerable populations because current risk adjustment methodologies are not accurate enough to distinguish between suboptimal care and high-quality care provided to high-risk individuals. Accordingly, the Council believes that it is critical that the AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of
health. The Council is steadfast in its belief that the structure and quality reporting of APMs must protect against penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician’s control. Furthermore, because of the Council’s commitment to this principle, the Council believes that the topic of risk adjustment warrants revisiting and notes that at the 2019 Interim Meeting, it will present a report specifically addressing ways in which risk adjustment methodology and implementation can be improved.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 712-A-18 and the remainder of the report be filed:

1. That our American Medical Association (AMA) support alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities. (New HOD Policy)

2. That our AMA continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations. (New HOD Policy)

3. That our AMA continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician’s control. (New HOD Policy)

4. That our AMA reaffirm Policy H-385.913 stating that APMs should limit physician accountability to aspects of spending and quality that they can reasonably influence; APMs should understand their patient populations, including non-clinical factors; and support new data sources that enable adequate analyses of clinical and non-clinical factors that contribute to a patient’s health and success of treatment. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-385.908 stating that the AMA should continue advocating for APMs limiting the financial risk requirements to costs that physicians participating in an APM have the ability to control or influence and work with stakeholders to design risk adjustment systems that identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient’s health and success of treatment, such as severity of illness, access to health care services, and socio-demographic factors. Moreover, Policy H-385.908 recognizes that technology should enable the care team and states that the AMA should work with stakeholders to develop information technology (IT) systems that support and streamline clinical participation and enable IT systems to support bi-directional data exchange. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-350.974 recognizing that racial and ethnic health disparities is a major public health problem, stating that the elimination of racial and ethnic disparities in health care is an issue of highest priority for the AMA, and supporting education and training on implicit bias, diversity, and inclusion. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-35.985 supporting physician-led, team-based care recognizing that interdisciplinary physician-led care teams are well equipped to provide a whole-person health care experience. (Reaffirm HOD Policy)
8. That our AMA reaffirm Policy D-350.995 promoting diversity within the workforce as one 
   means to reduce disparities in health care. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-440.828 on community health workers (CHWs) recognizing 
   that they play a critical role as bridgebuilders between underserved communities and the health 
   care system and calling for sustainable funding mechanisms to financial CHW services. 
   (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-450.924 supporting that hospital program assessments should 
    account for social risk factors so that they do not have the unintended effect of financially 
    penalizing safety net hospitals and physicians that exacerbate health care disparities. (Reaffirm 
    HOD Policy)

11. That our AMA reaffirm Policy H-280.945 supporting better integration of health care and 
    social services and supports. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policy H-160.896 calling to expand payment reform proposals that 
    incentivize screening for social determinants of health and referral to community support 
    systems. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


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EXECUTIVE SUMMARY

While the extent of corporate investment in physician practices is not precisely known, growing numbers of physicians are employed by corporations including hospitals, health systems and insurers. Increasingly, private equity firms have also acquired majority and/or controlling interests in entities that manage physician practices. However, there is little peer-reviewed evidence regarding the impact of these arrangements on physicians, patients or health care prices, and physician experiences and opinions vary.

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues; loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians’ financial pressures; potentially fewer administrative and regulatory burdens on physicians; and centralized resources for certain functions such as IT, marketing or human resources. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician providers.

Longstanding AMA policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit. This report recommends a series of guidelines that should be considered by physicians who are contemplating corporate investor partnerships; supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices; and encourages further study by affected national medical specialty societies.
REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 11-A-19

Subject: Corporate Investors

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee G
(Rodney Trytko, MD, Chair)

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-383.979, “Corporate Investors.” This policy states that our American Medical Association (AMA) will study, with report back at the 2019 Annual Meeting, the effects on the health care marketplace of corporate investors (e.g., public companies, venture capital/private equity firms, insurance companies and health systems) acquiring a majority and/or controlling interest in entities that manage physician practices, such as the degree of corporate investor penetration and investment in the health care marketplace; the impact on physician practice and independence; patient access; resultant trends in the use of non-physician extenders; long term financial viability of practices; effects of ownership turnovers and bankruptcies on patients and practice patterns; effectiveness of methodologies employed by unpurchased private independent, small group and large group practices to compete for insurance contracts in consolidated marketplaces; and the relative impact corporate investor transactions have on the paths and durations of junior, mid-career and senior physicians.

This report describes physician practice consolidation with corporate investors, including private equity investment in physician practices; discusses the corporate practice of medicine; summarizes relevant AMA policy; and makes policy recommendations.

BACKGROUND

Consolidation among health care entities, including consolidation involving physician practices, is closely monitored by the AMA. An array of factors—including changes in payment and delivery models, physician payment challenges, high costs of new technology and equipment, and increased administrative and regulatory burdens—have driven some physicians to be employed by, merge with or join hospitals, health systems and insurers. Increasingly, private equity partnerships/firms, which pool funds to invest in companies with the goal of running them more efficiently and selling them at a profit, have also acquired majority and/or controlling interests in entities that manage physician practices.

While the extent of corporate investment in health care is not precisely known, increasing numbers of physicians are employed by corporations, including hospitals, health systems and health insurers.1 Data from the 2018 Health Care Services Acquisition Report demonstrates corporate investor interest in physician practices. The report documented that 2017 saw the highest annual number of transactions (166 deals) involving physician medical groups since 1998 (264 deals). Of the 10 largest physician medical group transactions completed between 2013 and 2017, two were acquisitions of large physician groups by UnitedHealth’s Optum unit, and another two involved private equity firms. Many of the largest transactions involved public companies.2
The long-term trend away from physicians being practice owners and toward physicians being employees has been documented via the AMA’s Physician Practice Benchmark Surveys, which yield nationally representative samples of non-federal physicians providing at least 20 hours of patient care. These surveys, conducted biennially, have found that physician ownership dropped by seven percentage points (from 53.2 percent to 45.9 percent) between 2012 and 2018. Notably, the year 2018 was the first time that the percentage of physician owners was less than the percentage of physician employees (47.4 percent).

Private Equity Investment in Physician Practices

Private equity firms, which acquire equity in businesses with funds from private investors, vary in terms of size, structure, business model and investment thesis. Venture capital is typically used to invest in emerging or early stage businesses such as start-ups. Buyout or leveraged buyout firms typically invest in mature or later-stage businesses, often taking a controlling interest.

Private equity investment in dermatology, radiology, anesthesiology, urology, gastroenterology, cardiology, orthopedic, radiology and ophthalmology practices, among other specialties, has garnered substantial publicity and attention from the physician community. Growth in the demand for health care services, coupled with an aging population and the development of innovative treatments, have made the health care sector attractive to private equity investors. Globally, total disclosed value of deals in the sector exceeded $63 billion in 2018, the most since 2006, with much of this activity concentrated in North America and the US in particular. Providers and related services, including physician practice management, accounted for the most deals in 2018, with increased activity observed in anesthesia, radiology and behavioral health. A reported 84 private equity deals involving providers (including but not limited to physician practices) were consummated in 2018, totaling $23 billion. Private equity firms have also invested in hospitals, ambulatory surgical centers, retail health, health information technology (IT), home care and hospice, among many other services.

Hospitals, health systems, academic medical centers, large multispecialty groups, and corporate buyers frequently compete with private equity firms for the same physician practice targets. Corporate buyers may also partner with private equity investors or form consortia of buyers to acquire highly sought-after practices. Increased competition for physician groups in some specialties has led price valuations of these practices to rise.

Because many private equity transactions are not disclosed (nondisclosure agreements are commonly used during negotiations), the degree of investment in physician practices, while believed to be relatively small overall, cannot be precisely determined. Incomplete data on corporate transactions involving physician practices is in fact a significant impediment to determining the impact of corporate investors on physicians, patients, and the health care marketplace. That said, there is evidence that physician practices are being acquired, not only by private equity firms but also by hospitals, health systems, academic medical centers, insurers, and large physician groups. Transactions involving private equity investors are occurring with some regularity. Consequently, affected physician specialties are attempting to understand these practice shifts as well as the risks and benefits of this practice model.

Dermatology is one such specialty, having experienced a surge in private equity deals involving dermatology-related practices in the last three to five years. Fifteen percent of recent private equity/physician practice transactions have been “dermatology-related,” although dermatologists make up only one percent of US physicians. As noted in a recent commentary in JAMA Dermatology:
Consolidation of practices fueled by private equity investments has begun to transform dermatology … Existing dermatologists are encouraged to stay after the sale through equity stakes or deferred payouts, but in some cases, the investors may accept departures because the buyout recipients can sometimes be replaced by younger dermatologists or physician assistants who are paid at a lower level.\(^{11}\)

Private equity firms have also shown interest in ophthalmology practices, as described in *Review of Ophthalmology*:

The basic premise is that a private equity firm offers to form a partnership with an ophthalmology practice that it believes has the potential to grow. It provides funding to the practice owners, including an upfront payment in cash and/or stock, in exchange for a percentage of future profits. Ultimately, the goal is to increase the value of the practice by investing in its growth—often partly by consolidating it with other practices—so that in a few years it can be resold to another private equity firm for a significant profit.\(^{12}\)

Noted researcher Lawrence Casalino, MD, et al. described the phenomenon as follows:

These investors anticipate average annual returns of 20 percent or more. To achieve such returns, private equity firms focus on acquiring “platform practices” that are large, well managed, and reputable in their community. The firms sell these practices after augmenting their value by recruiting additional physicians, acquiring smaller practices to merge with the larger practice, increasing revenue (for example, by bringing pathology services into a dermatology practice), and decreasing costs (for example, by substituting physician assistants for physicians). Growth makes it possible to spread fixed costs, exploit synergies across merged practices, expand ancillary revenues, and increase negotiating leverage with health insurers.\(^{13}\)

A recent *JAMA Viewpoint* concluded:

Even though consolidation may create economies of scale and layoffs and other cost-cutting measures may reduce operating costs, increased market power over price negotiations with insurers and boosting volume for ancillary revenue streams may increase spending. Empirical analysis is needed to understand the net consequences and to compare spending among private equity-owned, hospital-owned, and independent practices.\(^{14}\)

**Risks and Benefits of Partnering with Corporate Investors**

There is little peer-reviewed evidence regarding the impact of corporate investors on physicians, physician autonomy, patients or health care prices. Anecdotal information suggests an increase in the use of non-physician extenders by some private equity firms and other challenges facing physicians working for practices affiliated with private equity firms. The experiences of practices entering employment arrangements with hospitals, health systems, academic medical centers and insurers may differ from private equity investors because these entities function in the health care marketplace and frequently have existing physician leadership in place. Additionally, in contrast to private-equity backed practices, hospitals, health systems and academic medical centers may use some of their revenues to provide uncompensated care and/or contribute to medical education and training.\(^{15}\)

There are risks and benefits of partnering with any corporate investor, including a private equity firm. Risks include loss of control over the physician practice and its future and future revenues;
loss of some autonomy in decision-making; an emphasis on profit or meeting financial goals; potential conflicts of interest; and potential uncertainties for non-owner early and mid-career physicians. Benefits include financially lucrative deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions, which may relieve physicians’ financial pressures; potentially fewer administrative and regulatory burdens on physicians; and centralized resources for certain functions such as IT, marketing or human resources. Concerns regarding these partnerships have primarily centered on the potential for subsequent increases in prices, service volume, and internal referrals, as well as the use of unsupervised non-physician providers. Importantly, corporate investors are obviously not all the same and may differ significantly in terms of their business models and culture. Some are centralized and physician-led, while others are centralized but not physician-led; the degree of physician autonomy in decision making also varies.

AMA ACTIVITY

In monitoring mergers and acquisitions, the AMA’s position is that each health care entity consolidation must be examined individually, taking into account case-specific variables related to market power and patient needs. AMA policy strongly supports and encourages competition in all health care markets to provide patients with more choices while improving care and lowering the costs of that care. Markets should be sufficiently competitive to allow physicians to have adequate practice options. The AMA also recognizes that employment preferences vary greatly among physicians, and that employment by large systems can be an attractive practice option for some physicians. A 2013 AMA-RAND study on professional satisfaction found that physicians in physician-owned practices were more satisfied than physicians in other ownership models (e.g., hospital or corporate ownership), but that work controls and opportunities to participate in strategic decisions mediate the effect of practice ownership on overall professional satisfaction.

The AMA promotes physician leadership in integrated structures and has developed policies and resources intended to help safeguard physicians employed by large systems. The AMA has also developed several resources intended to help physicians understand employment contracts. These include the Annotated Model Co-Management Service Line Agreement, Annotated Model Physician-Group Practice Employment Agreement, and the Annotated Model Physician-Hospital Employment Agreement as well as a Making the Rounds podcast on contracts. For physicians considering a practice setting change or looking for an alignment strategy with an integrated health system, the AMA developed the guide Joining or Aligning with a Physician-led Integrated Health System. The AMA has also made available a set of resources called “Unwinding Existing Arrangements” that guides employed physicians on how to “unwind” from their organization, factoring in operational, financial, and strategic considerations.

At the time that this report was written, the AMA was planning to release, mid-year in 2019, resources related to venture capital and private equity investments that highlight the main issues physicians may encounter when engaging with such firms, including modifications to compensation, investment in infrastructure, how to evaluate contractual agreements, and hands-on management. A related checklist was also planned that will offer specific considerations such as terms-of-sale for the practice, standardization techniques and economies of scale, and unwinding terms.

Corporate Practice of Medicine

The term “corporate practice of medicine” encompasses complex legal issues that may mean different things to different people and vary widely by state. The corporate practice of medicine
can, for example, prohibit a lay corporation from practicing medicine or employing physicians, or prohibit non-physicians or lay organizations from having an ownership interest in a physician practice. The doctrine is based on concerns that: (1) allowing corporations to practice medicine or employ physicians will result in the commercialization of the practice of medicine; (2) a corporation’s obligation to its shareholders may not align with a physician’s obligations to his or her patients; and (3) employment of a physician by a corporation may interfere with the physician’s independent medical judgement.18

As delivery systems and physician employment arrangements have evolved over the years, so too has the corporate practice of medicine doctrine. The health care environment is shifting toward increased integration of care, with growth in both the number of employed physicians and acquisitions of physician practices. These trends have led to formalized employment relationships between physicians and non-physician entities, arrangements that in certain states may run afoul of corporate practice of medicine policies. Council on Medical Service Report 6-I-13 addressed the corporate practice of medicine.

RELEVANT AMA POLICY

Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. Under Policy D-225.977, the AMA continues to assess the needs of employed physicians, ensuring physician clinical autonomy and self-governance. Policy H-285.951 states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of care. Policy H-215.968 supports and encourages competition between and among health facilities as a means of promoting the delivery of high-quality, cost-effective care. Antitrust relief is a top AMA priority under Policy H-380.987.

AMA Principles for Physician Employment are outlined in Policy H-225.950. Policy H-225.997 addresses physician-hospital relationships, and Policy H-225.942 outlines physician and medical staff rights and responsibilities. Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with a series of principles, including that: (a) physician clinical autonomy is preserved; (b) physicians are included and actively involved in integrated leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure; (d) physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care; (e) a mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care; and (f) a clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures. Policy H-160.960 states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. Truth in advertising is addressed by Policies H-410.951 and H-405.969.

AMA policy does not prohibit the application of restrictive covenants in the physician employment context generally, although Policy H-225.950, “Principles for Physician Employment,” discourage
physicians from entering into agreements that restrict the physician’s right to practice medicine for
a specified period of time or in a specified area upon termination of employment. AMA Code of
Medical Ethics Opinion 11.2.3.1 states that covenants-not-to-compete restrict competition, can
disrupt continuity of care, and may limit access to care. Accordingly, physicians should not enter
into covenants that: (a) unreasonably restrict the right of a physician to practice medicine for a
specified period of time or in a specified geographic area on termination of a contractual
relationship; and (b) do not make reasonable accommodation for patients’ choice of physician. This
opinion also states that physicians in training should not be asked to sign covenants not to compete
as a condition of entry into any residency or fellowship program.

Policy H-140.984 opposes an across-the-board ban on self-referrals because of benefits to patients
including increased access to competition, and includes standards to ensure ethical and acceptable
financial arrangements. This policy states that the opportunity to invest in the medical or health
care facility established by a health care services financial arrangement should be open to all
individuals who are financially able and interested in an investment.

DISCUSSION

The Council’s study of corporate investors acquiring majority and/or controlling interest in entities
that manage physician practices was hindered by the lack of empirical evidence regarding the
impact of these practice models on physicians, patients, medical practice, and the costs and quality
of care. Although anecdotal information is available from affected specialties, there is not sufficient
data to draw meaningful or actionable conclusions. Nonetheless, the Council underscores the
paramount importance to this discussion of safeguarding patient-centered care, clinical governance
and physician autonomy in all physician practice arrangements, including those involving
corporate investors.

The Council also believes it is worth noting that physician opinions vary regarding corporate
involvement in physician practices. Although there has been a great deal of angst among
many physicians regarding private equity investments in practices, other physicians and physician
groups have readily partnered with these firms. Long-standing policy states that physicians are free
to choose their mode of practice and enter into contractual arrangements as they see fit, and it is
essential that the AMA maintain a leadership role that is uniting and supportive of all physicians
and care delivery models.

The Council recommends, therefore, reaffirmation of four existing AMA policies—on the
corporate practice of medicine, financial incentives, physician employment, and corporate
ownership of private medical practices—that are relevant to corporate investor relationships with
physician practices. Because physicians appear to be looking for guidance and solutions, the
Council also recommends a series of guidelines that it believes should be considered by physicians
who are contemplating corporate investor partnerships.

As previously noted, nondisclosure agreements are commonly used in private equity and corporate
investor transactions, and the Council believes that more information is needed regarding the
degree of corporate investment in physician practices and what this means for health care prices.
The lack of complete and accurate information may prevent health care markets from operating
efficiently and preclude patients from making informed decisions regarding low-cost, high-value
care. Accordingly, the Council recommends supporting improved transparency regarding corporate
investment in physician practices and subsequent changes in health care prices.
The Council recognizes that further study is needed on the impact of corporate investors, and recommends encouraging national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and physicians.

Finally, the Council recommends rescinding Policy D-383.979, which led to the development of this report.

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) reaffirm Policy H-215.981, which opposes federal legislation preempting state laws prohibiting the corporate practice of medicine; states that the AMA will continue monitoring the corporate practice of medicine and its effect on the patient-physician relationship, financial conflicts of interest, and patient-centered care; and directs the AMA to provide guidance, consultation and model legislation regarding the corporate practice of medicine, at the request of state medical associations, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-225.950, which affirms that a physician’s paramount responsibility is to his or her patients, and which outlines principles related to conflicts of interest and contracting. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-285.951, which states that physicians should have the right to enter into whatever contractual arrangements they deem desirable and necessary but should be aware of potential conflicts of interest due to the use of financial incentives in the management of medical care. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-160.960, which states that when a private medical practice is purchased by corporate entities, patients shall be informed of the ownership arrangement by the corporate entities and/or the physician. (Reaffirm HOD Policy)

5. That our AMA encourage physicians who are contemplating corporate investor partnerships to consider the following guidelines:
   a. Physicians should consider how the practice’s current mission, vision, and long-term goals align with those of the corporate investor.
   b. Due diligence should be conducted that includes, at minimum, review of the corporate investor’s business model, strategic plan, leadership and governance, and culture.
   c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
   d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
   e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
   f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.

h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.

i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships. (New HOD Policy)

6. That our AMA support improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices. (New HOD Policy)

7. That our AMA encourage national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty. (New HOD Policy)

8. That our AMA rescind Policy D-383.979, which requested this report. (Rescind HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

3 Kane C. Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees. AMA: Physician Practice Benchmark, 2019.
4 Ibid.
6 Ibid.
7 Ibid.
8 Ibid.
10 Ibid.
11 Ibid.
14 Gondi, S and Song Z. Potential Implications of Private Equity Investments in Health Care Delivery. JAMA. Published online February 28, 2019. Available at: https://jamanetwork.com/journals/jama/fullarticle/2727259.
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APPENDIX

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

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
   a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address. b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority. d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients. (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions. e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience. Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
   a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
   a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession. b) Physicians should never be coerced into employment with hospitals, health care systems,
medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts. c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based. d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures. (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff. (g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment. (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved. Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations
a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs. b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes. c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of
their employment agreements, nor be retaliated against by their employers, for asserting these
interests. d) Employers should seek the input of the medical staff prior to the initiation, renewal, or
termination of exclusive employment contracts.
Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further
guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations
a) All physicians should promote and be subject to an effective program of peer review to monitor
and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care
services provided within their practice settings. b) Peer review should follow established
procedures that are identical for all physicians practicing within a given health care organization,
regardless of their employment status. c) Peer review of employed physicians should be conducted
independently of and without interference from any human resources activities of the employer.
Physicians--not lay administrators--should be ultimately responsible for all peer review of medical
services provided by employed physicians. d) Employed physicians should be accorded due
process protections, including a fair and objective hearing, in all peer review proceedings. The
fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right
to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a
defense. Due process protections should extend to any disciplinary action sought by the employer
that relates to the employed physician's independent exercise of medical judgment. e) Employers
should provide employed physicians with regular performance evaluations, which should be
presented in writing and accompanied by an oral discussion with the employed physician.
Physicians should be informed before the beginning of the evaluation period of the general criteria
to be considered in their performance evaluations, for example: quality of medical services
provided, nature and frequency of patient complaints, employee productivity, employee
contribution to the administrative/operational activities of the employer, etc. f) Upon termination
of employment with or without cause, an employed physician generally should not be required to
resign his or her hospital medical staff membership or any of the clinical privileges held during the
term of employment, unless an independent action of the medical staff calls for such action, and the
physician has been afforded full due process under the medical staff bylaws. Automatic rescission
of medical staff membership and/or clinical privileges following termination of an employment
agreement is tolerable only if each of the following conditions is met: i. The agreement is for the
provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive
contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit
interested parties to express their views on the matter, with the medical staff subsequently making a
recommendation to the governing body as to whether the contract should be terminated, as outlined
in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership
and/or clinical privileges must be resigned upon termination of the agreement.
Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care
Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements
a) Although they typically assign their billing privileges to their employers, employed physicians
or their chosen representatives should be prospectively involved if the employer negotiates
agreements for them for professional fees, capitation or global billing, or shared savings.
Additionally, employed physicians should be informed about the actual payment amount allocated
to the professional fee component of the total payment received by the contractual arrangement. b)
Employed physicians have a responsibility to assure that bills issued for services they provide are
accurate and should therefore retain the right to review billing claims as may be necessary to verify
that such bills are correct. Employers should indemnify and defend, and save harmless, employed
physicians with respect to any violation of law or regulation or breach of contract in connection
with the employer's billing for physician services, which violation is not the fault of the employee.
Financial Incentives Utilized in the Management of Medical Care H-285.951

Our AMA believes that the use of financial incentives in the management of medical care should be guided by the following principles: (1) Patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated. (2) Physicians should have the right to enter into whatever contractual arrangements with health care systems, plans, groups or hospital departments they deem desirable and necessary, but they should be aware of the potential for some types of systems, plans, group and hospital departments to create conflicts of interest, due to the use of financial incentives in the management of medical care. (3) Financial incentives should enhance the provision of high quality, cost-effective medical care. (4) Financial incentives should not result in the withholding of appropriate medical services or in the denial of patient access to such services. (5) Any financial incentives that may induce a limitation of the medical services offered to patients, as well as treatment or referral options, should be fully disclosed by health plans to enrollees and prospective enrollees, and by health care groups, systems or closed hospital departments to patients and prospective patients. (6) Physicians should disclose any financial incentives that may induce a limitation of the diagnostic and therapeutic alternatives that are offered to patients, or restrict treatment or referral options. Physicians may satisfy their disclosure obligations by assuring that the health plans with which they contract provide such disclosure to enrollees and prospective enrollees. Physicians may also satisfy their disclosure obligations by assuring that the health care group, system or hospital department with which they are affiliated provide such disclosure to patients seeking treatment. (7) Financial incentives should not be based on the performance of physicians over short periods of time, nor should they be linked with individual treatment decisions over periods of time insufficient to identify patterns of care. (8) Financial incentives generally should be based on the performance of groups of physicians rather than individual physicians. However, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group. (9) The appropriateness and structure of a specific financial incentive should take into account a variety of factors such as the use and level of "stop-loss" insurance, and the adequacy of the base payments (not at-risk payments) to physicians and physician groups. The purpose of assessing the appropriateness of financial incentives is to avoid placing a physician or physician group at excessive risk which may induce the rationing of care. (10) Physicians should consult with legal counsel prior to agreeing to any health plan contract or agreeing to join a group, delivery system or hospital department that uses financial incentives in a manner that could inappropriately influence their clinical judgment. (11) Physicians agreeing to health plan contracts that contain financial incentives should seek the inclusion of provisions allowing for an independent annual audit to assure that the distribution of incentive payments is in keeping with the terms of the contract. (12) Physicians should consider obtaining their own accountants when financial incentives are included in health plan contracts, to assure proper auditing and distribution of incentive payments. (13) Physicians, other health care professionals, third party payers and health care delivery settings through their payment policies, should continue to encourage use of the most cost-effective care setting in which medical services can be provided safely with no detriment to quality.

Corporate Ownership of Established Private Medical Practices H-160.960

When a private medical practice is purchased by corporate entities, patients going to that practice shall be informed of this ownership arrangement by the corporate entities and/or by the physician.
Whereas, Many patients are insured by third-party payers which require prior authorization before testing and therapies can be performed by a medical professional; and

Whereas, The prior authorization process may become arduous and time consuming causing delay in the performance of testing and therapies; and

Whereas, Many times the prior authorization process cannot be completed in a timely manner causing or contributing to the morbidity or mortality of the patient; and

Whereas, The physician is required to identify processes which primarily caused and secondarily contributed to the demise of a patient; therefore be it

RESOLVED, That our American Medical Association support the establishment of ICD codes that cover and fully describe prior authorization processes and any and all other administrative and bureaucratic obstacles that may cause or in part contribute to a patient’s morbidity or mortality by both delay, as well as denial, of services. (New HOD Policy)

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

Received: 03/18/19
Whereas, Our AMA has extensive policy on medical student, resident, and physician stress and burnout and suicide; and

Whereas, In medical malpractice cases, dealing with the plaintiff’s attorneys can make it difficult for health care workers to know what to do, and who they can talk to, professionally or legally; and

Whereas, When there is an adverse event in health care, there is often a “culture of silence,” in which defense lawyers ask healthcare workers not to discuss the case outside of work because of various legal implications (including potential HIPAA violations); and

Whereas, Second victims are defined as “a health care provider involved in an unanticipated patient event, a medical error, and/or a patient-related injury and become victimized in the sense that they are traumatized by the event”1; and

Whereas, Commonly-reported symptoms of second victim phenomenon include fatigue, sleep disturbances, frustration, difficulty concentration, flashbacks, decreased job satisfaction, grief/remorse, and loss of confidence; and

Whereas, High-risk scenarios for second victim phenomenon include medical errors, death experiences, unexpected patient demises, and unexpected connections between patients and one’s family members; and

Whereas, There is some evidence that peer support groups for second victim phenomenon may be helpful for healthcare workers; and

Whereas, The issues of stress, burnout, and second victim phenomenon are likely to impact our physician workforce in the near and distant future; therefore be it

RESOLVED, That our American Medical Association encourage institutional, local, and state physician wellness programs to consider developing peer support groups to address the “second victim phenomenon” (Directive to Take Action); and be it further

RESOLVED, That our AMA work with other interested organizations to develop a survey of all physicians in the United States to quantitate the effects of stress and burnout on them, and its potential impact on our physician workforce. (Directive to Take Action)

Fiscal Note: Estimated cost of $465,000 to implement resolution.

Received: 04/04/19
References:

RELEVANT AMA POLICY

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

Programs on Managing Physician Stress and Burnout H-405.957
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.

Study of Medical Student, Resident, and Physician Suicide D-345.984
Our AMA will: (1) determine the most efficient and accurate mechanism to study the actual incidence of medical student, resident, and physician suicide, and report back at the 2018 Interim Meeting of the House of Delegates with recommendations for action; and (2) request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are
outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
   A. be available to all medical students on an opt-out basis;
   B. ensure anonymity, confidentiality, and protection from administrative action;
   C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
   D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

Citation: CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18

Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs H-295.993

Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.

Citation: Sub. Res. 84, I-82; Reaffirmed: CME Rep. 4, I-98; Reaffirmed and appended: CME Rep. 01, A-18
Whereas, The patient-physician relationship is among the most important elements of our medical profession; and

Whereas, The quality of the patient-physician relationship is crucial to the care of the patient, improving the value of the patient-physician encounter to both parties and greatly enhancing the chances that the patient’s concern can be met; and

Whereas, Dr. Bernard Lown, in his book “The Lost Art of Healing: Practicing Compassion in Medicine” states that “the three thousand year tradition which bonded doctor and patient in a special affinity of trust is being traded for a new type of relationship; healing is replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technology;” and

Whereas, Dr. Lown’s observations are more relevant now than ever before as a result of: (1) increasing time constraints on physicians due to scheduling issues; (2) the intrusion of electronic devices in the consultation room, which can make sustained eye contact between the patient and his/her physician more challenging; and (3) curriculum changes in some medical schools such that history-taking and examination skills are not emphasized as they once were; and

Whereas, As physicians, we owe it to our patients and ourselves to do everything we can to preserve the patient-physician relationship; therefore be it

RESOLVED, That our American Medical Association, in an effort to improve professional satisfaction among physicians while also enhancing patient care, conduct a study to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, as well as identify healthcare work environment factors that impact a physician’s ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter, and report back at the 2020 Interim Meeting. (Directive to Take Action)

Fiscal note: Modest: Between $1,000 - $5,000.

Received: 04/12/19
Whereas, In February 2019 the AMA released results of its 2018 Prior Authorization Physician Survey showing that 28 percent of physicians indicated the prior authorization process required by health insurers has led to serious or life-threatening events for their patients; and

Whereas, 91 percent of the physicians responding to the AMA prior authorization survey indicated the prior authorization process delays patient access to necessary care; and

Whereas, 88 percent of the respondents to the AMA prior authorization survey believe burdens associated with prior authorization have increased during the past five years; and

Whereas, The AMA prior authorization survey illustrates that prior authorization programs and processes are costly, inefficient, and pose obstacles to patient-centered care; and

Whereas, The current prior authorization process is in need of reform so patients receive timely access to evidence-based care; and

Whereas, The prior authorization process in Delaware mirrors the challenges reflected in the 2018 AMA Prior Authorization Physician Survey; and

Whereas, The Medical Society of Delaware (MSD) is leading a groundbreaking initiative to utilize emerging technology to reduce the arduous process of prior authorization, improve access to care for patients, and reduce unnecessary health care spending; and

Whereas, MSD is now prepared to launch a pilot program in the State of Delaware designed to test and validate such new technology; and

Whereas, Our American Medical Association, a national medical association, is best positioned to drive reform and improvement of the prior authorization process; therefore be it

RESOLVED, That our American Medical Association explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. (Directive to Take Action)

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

Received: 04/24/19

Whereas, The government is moving to credential hospitals as different level stroke centers and would then direct ambulances to divert patients to these hospitals; and

Whereas, Much of the focus for such diversion would be a hospital’s ability to provide mechanical thrombectomy service; and

Whereas, Mechanical thrombectomy is a relatively straightforward endovascular procedure that is infrequently performed as part of successful stroke management—for example a hospital that sees 1000 patients per year as a “rule out stroke” might actually only have 500 stroke patients, and only 20 patients who qualify for mechanical thrombectomy, of which only 10 will potentially do well after the thrombectomy; and

Whereas, Some of the planned requirements for these stroke center designations, such as from The Joint Commission, are arbitrary, and unduly burdensome, and not based on sound scientific evidence such as:

(a) Doctors who perform fewer than 15 thrombectomies per year would no longer be eligible to cover call

(b) Doctors covering endovascular services could only cover one hospital at a given time; and

Whereas, There are no studies available that establish a distinct threshold for a volume – outcome relationship in regards to mechanical thrombectomy; and

Whereas, These stringent requirements will unnecessarily disqualify most endovascular proceduralists – endovascular neurosurgeons, endovascular neurologists, and endovascular neuro-radiologists -- from continuing to work, as they will not be able to perform 15 thrombectomies per year; and

Whereas, The Society for Interventional Radiology sponsored an independent analysis of the Centers for Medicare and Medicaid Services’ thrombectomy data from 2016 that showed that 85% of physicians who billed this code, billed it 10 times or fewer, and of the 15% of physicians who performed the procedure more than 10 times that year, the median number was 15; that is to say, most physicians who were performing the procedure, would not meet the stringent volume requirement; and
Whereas, There is no reason that a doctor could not cover more than one hospital at a time for a procedure that is straightforward, brief, and will likely be performed at even a busy hospital no more than once per week; and

Whereas, These unusually stringent requirements will actually prevent most hospitals from achieving appropriate stroke center designations, and will thus lead to having all neurological volume diverted away from their ER’s, leading paradoxically to potential stroke patients being diverted long distances for care when such care was readily available nearby; therefore be it

RESOLVED, That our American Medical Association advocate for changing the following two provisions from The Joint Commission Stroke Center Requirements:

1) Stroke procedurists should not be required to perform 15 mechanical thrombectomies per year to qualify for taking endovascular call at designated stroke hospitals; and

2) Stroke procedurists should be able to take call at more than one hospital at a time.

(Directive to Take Action)

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

Received: 04/25/19
Whereas, Concerns regarding gaps in medical quality and patient safety led The Joint Commission in 1996 to identify serious patient safety events (such as patient death, permanent harm to a patient, or temporary harm to a patient requiring immediate intervention to sustain the patient’s life) as “Sentinel Events” that warrant immediate investigation and remediation to prevent their recurrence; and

Whereas, The National Quality Forum (NQF) expanded such analysis of serious patient safety events to develop its list of “Never Events,” events that could occur during the process of offering medical care that should be expected to never happen, such as wrong-sited surgery; and

Whereas, Payors of health care services, including the Center for Medicare and Medicaid Services (CMS) and major commercial payors, have determined that insurance claims for entire episodes of care should be denied if, in the course of that care episode, a “never event” occurred; and

Whereas, The 2016 list of “Never Events” (referred to formally as “Serious Reportable Events”) compiled by the NQF, includes “Patient death or serious injury associated with a fall while being cared for in a health care setting;” and

Whereas, Out of sincere concern for the safety of patients, and out of concern regarding adverse publicity should a “never event” occur, and out of concern that reimbursement could be significantly impacted adversely were a “never event” to occur, hospitals are diligent about educating their staff about “never events” on the NQF list and how to avoid them; and

Whereas, Our current system of “keeping score” of falls has created a disincentive for mobilizing patients and consequently increases patients’ risk for falls due to deconditioning effects of bed rest;¹ and

Whereas, Nursing staff in hospitals are understandably afraid for what may happen to patients or to themselves as licensed health professionals and as employees were there to be a patient fall resulting in serious injury or patient death, and have become hypervigilant, to assure that patients do not experience falls in the healthcare setting;²,³ and

Whereas, “Driving in fear” has been shown to be counterproductive to the generation of improved overall results in patient safety and health care outcomes; and

Whereas, A result of nursing staff fear has been demonstrated to be an increase in efforts of nursing staff to keep patients in bed and to not get up and move about, lest a fall occur,
including the use of bed and chair alarms, which further restrict mobility, to notify staff should a
patient get up;3-7 and

Whereas, Restricting mobility has been shown to directly cause loss of muscle mass and
strength8 and increase fall risk in older adult patients9, and is associated with Hospital-Acquired
Disability10 and are counterproductive to patients restoring their functional abilities after an
illness or injury leads to a hospitalization; and

Whereas, Limiting older adult patient mobility during a hospital stay results in post-hospital
syndrome11 and trauma of hospitalization12, increasing risk for adverse health events such as
falls post discharge,13 new nursing home placement,14 mortality,14 decrease quality of life and
readmission within 30 days;15 and

Whereas, The Wisconsin State Journal, the daily newspaper in the state’s second largest city,
published a three-part Special Report in March 2019, supported by a journalism fellowship from
the Gerontological Society of America, Journalists Network on Generations and the
John A. Hartford Foundation, reporting that Wisconsin leads the nations in falls, in fatal falls,
and falls in health care institutions, and highlighting research in the nursing professional
literature that accreditation standards intended to prevent falls can have counterproductive
effects; and

Whereas, It has been demonstrated through research by the University of Wisconsin’s
Barbara King, RN, PhD, and others that patients’ functional abilities during a hospitalization and
in the weeks or months after hospital discharge are diminished quantitatively and over longer
spans of time when patients have been kept in bed longer rather than assisted to get up and
reestablish mobility sooner;16-19 and

Whereas, It has been demonstrated through an impact assessment of CMS “never events” that
the CMS policy on falls has actually had no salutary effect on the rates of injurious falls;20
therefore be it

RESOLVED, That our American Medical Association study the merits of recommending that
“Patient death or serious injury associated with a fall while being cared for in a health care
setting” be removed from the list of “Never Events” for which a hospital may face an adverse
payment decision by third-party payors or an adverse accreditation decision by The Joint
Commission (Directive to Take Action); and be it further

RESOLVED, That our AMA study the merits of recommending that a pay-for-performance
measure be added which would reward health care organizations for taking steps resulting in
patients’ improved ability to participate in self-care, improved functional status, and improved
mobility for seniors who have been admitted to a facility for a condition resulting in a temporary
need for bed rest. (Directive to Take Action)

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

Received: 05/01/19
References:
10. Covinsky KE, Pierluissi E, Johnston CB. (2011). Hospitalization-associated disability: “She was probably able to ambulate, but I’m not sure”. *JAMA*, 306; 1782-1793.
Whereas, Physicians in the U.S. are faced with increased administrative burdens and burnout related to new payment models from insurance companies and regulations from the federal government that already lead to less time with their patients; and

Whereas, These new models also put more burdens on patients in the form of higher out-of-pocket costs as employers, health insurance companies and government health programs move to higher deductible health plans; and

Whereas, These high deductibles woven into insurance contracts with providers are creating a new and growing administrative burden for physicians when the doctor is forced to track down the unpaid portion of the care not covered by the health plan; and

Whereas, Because the size and scope of the deductible is created by the insurance company in their contract, the physician shouldn’t be forced to spend physician and practice staff time tracking down a portion of a payment created by the health plan’s reimbursement formula. That should be the responsibility of the insurance company; and

Whereas, The percentage of large employers offering a high deductible health plan is projected to increase from 80% in 2018 to 92% in 2019, according to a survey of 170 large employers by the National Business Group on Health; and

Whereas, Four in ten, or 39%, of employers offer a high-deductible plan as the only option for their workers, the same National Business Group on Health survey shows; and

Whereas, The American Hospital Association reports uncompensated care costs are rising in part due to patients paying higher out-of-pocket costs from high deductibles. In 2016, the AHA’s most recent report, shows uncompensated care costs rose to $38.3 billion in 2016 from $35.7 billion in 2015; therefore be it

RESOLVED, That our American Medical Association advocate for legislation that brings an end to insurance company practices that make it the physician’s responsibility to recoup patient out-of-pocket costs and deductibles created by health plans. (Directive to Take Action)

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