DISCLAIMER

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee G

Rodney Trytko, MD, MPH, MBA, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 31 – Non-Payment and Audit Takebacks by CMS
2. Board of Trustees Report 32 – Impact of High Capital Costs of Hospital EHRs on the Medical Staff
3. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2009 AMA House Policies
4. Council on Medical Service Report 8 – Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor
5. Council on Medical Service Report 10 – Alternative Payment Models and Vulnerable Populations
6. Resolution 704 – Prior Authorization Reform
7. Resolution 710 – Council for Affordable Quality Healthcare Attestation

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

8. Board of Trustees Report 13 – Employed Physician Bill of Rights and Basic Practice Professional Standards
9. Board of Trustees Report 15 – Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization
10. Council on Medical Service Report 7 – Hospital Consolidation
11. Council on Medical Service Report 9 – Health Plan Payment of Patient Cost-Sharing
12. Council on Medical Service Report 11 – Corporate Investors
13. Resolution 702 – Peer Support Groups for Second Victims
14. Resolution 706 – Hospital Falls and “Never Events” – A Need for More in Depth Study
15. Resolution 708 – Access to Psychiatric Treatment in Long-Term Care
16. Resolution 711 – Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs
17. Resolution 712 – Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives
18. Resolution 714 – Medicare Advantage Step Therapy

19. Resolution 717 – Military Physician Reintegration into Civilian Practice

RECOMMENDED FOR REFERRAL

20. Resolution 703 – Preservation of the Patient-Physician Relationship

RECOMMENDED FOR REFERRAL FOR DECISION

21. Resolution 719 – Interference with Practice of Medicine by the Nuclear Regulatory Commission

RECOMMENDED FOR NOT ADOPTION

22. Resolution 705 – Physician Requirements for Comprehensive Stroke Center Designation

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

23. Resolution 709 – Promoting Accountability in Prior Authorization
24. Resolution 713 – Selective Application of Prior Authorization
25. Resolution 718 – Economic Discrimination in the Hospital Practice Setting

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 701 – Coding for Prior Authorization Obstacles
- Resolution 707 – Cost of Unpaid Patient Deductibles on Physician Staff Time
- Resolution 715 – Managing Patient-Physician Relations Within Medicare Advantage Plans
- Resolution 716 – Health Plan Claim Auditing Programs

(1) BOARD OF TRUSTEES REPORT 31 - NON-PAYMENT AND AUDIT TAKEBACKS BY CMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that recommendations in Board of Trustees Report 31 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 31 adopted and the remainder of the report filed.

Board of Trustees Report 31 recommends that our AMA advocate to oppose claim nonpayment, extrapolation of overpayments, and bundled payment denials based on minor wording or clinically insignificant documentation inconsistencies.

Testimony was limited but supportive of Board of Trustees Report 31. A member of the Board of Trustees introduced the report, explaining that although the AMA has extensive policy opposing claim nonpayment for inadvertent, unintentional, or clerical documentation errors, the Board believes that AMA policy could be more specific in addressing minor wording errors or clinically insignificant inconsistencies. Because testimony was supportive, your Reference Committee recommends that the recommendations in Board of Trustees Report 31 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 32 - IMPACT OF HIGH CAPITAL COSTS OF HOSPITAL EHRS ON THE MEDICAL STAFF

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that recommendations in Board of Trustees Report 32 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 32 adopted and the remainder of the report filed.

Board of Trustees Report 32 recommends that our AMA rescind Policy D-225.974.

A member of the Board of Trustees introduced the report. Testimony overall was supportive of the report. Your Reference Committee thanks the Board of Trustees for its thoughtful and thorough report. Moreover, your Reference Committee highlights that the Board’s report was well-researched and based on all available evidence. Accordingly, your Reference Committee recommends that Board of Trustees Report 32 be adopted.

(3) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2009 AMA HOUSE POLICIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 1 adopted and the remainder of the report filed.

Council on Medical Service Report 1 contains recommendations to retain or rescind 2009 AMA socioeconomic policies.

Testimony on Council on Medical Service 1 was provided by a member of the Council on Medical Service who introduced the report which is the result of the Council's review of 81 assigned socioeconomic policies. Because there was no additional testimony, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 8 - GROUP PURCHASING ORGANIZATIONS AND PHARMACY BENEFIT MANAGER SAFE HARBOR

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 8 adopted as amended with the addition of a new Recommendation and the remainder of the report filed.

6. That the AMA, via a letter, immediately ask the Secretary of HHS and other appropriate stakeholders to request the HHS OIG to examine the supply chain of pharmaceuticals, pharmacy benefit managers, Safe Harbor laws and regulations, and expeditiously make recommendations to make prescription drugs more accessible and affordable to patients with an emphasis on examining the governing contracts for drugs in short supply and/or that are exceedingly

<u>expensive to ensure compliance with all the safe harbor provisions.</u>

Council on Medical Service Report 8 recommends that our AMA reaffirm Policies H-125.986, H-110.992, and H-100.956; 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; and 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.

Testimony on Council on Medical Service Report 8 was unanimously supportive. A member of the Council on Medical Service introduced the report. The Council stated that, 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. Moreover, a limited economic model found that, while removal of the safe harbor decreased providers' nominal purchasing price, their total purchasing costs are the same when the safe harbor was present. This means that repeal of the safe harbor would not affect any party's profits or costs.

Additionally, the Council member testified that the Council has numerous concerns should the safe harbor be repealed including that GPOs and PBMs could simply shift fees into other forms, such as rebates or other fees, rather than lose their revenue streams. 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 could be adversely impacted if the viability of the GPO business model is compromised. Overall, the Council found that, whatever the defects in their funding structure, GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care. Testimony echoed this statement saying that GPOs can help level the field among smaller sites and practices.

An amendment was offered to state that the GPO safe harbor should not apply to PBMs. However, as the Council on Legislation highlighted, our AMA is already advocating that the Office of the Inspector General (OIG) needs to either 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. Our AMA's comments stated 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. Our AMA requested that OIG clarify what PBM fees and services apply to both the proposed and existing safe harbors. Otherwise, our AMA is concerned that the lack of clarity may provide further opportunity for exploitation. Taking into account this recent comment letter and advocacy, the Reference Committee does not recognize the need for the proposed amendment.

Moreover, specifically regarding PBMs, testimony highlighted CMS Report 5-A-19, which is before the House of Delegates at this meeting in Reference Committee A. CMS Report 5-A-19 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.

Your Reference Committee thanks the Council on Medical Service for its thorough report of a complex and nuanced issue. Accordingly, your Reference Committee recommends that the report be adopted and the remainder of the report be filed.

(5) COUNCIL ON MEDICAL SERVICE REPORT 10 - ALTERNATIVE PAYMENT MODELS AND VULNERABLE POPULATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 10 adopted and the remainder of the report filed.

Council on Medical Service Report 10 recommends that our AMA reaffirm Policies H-385.913, H-385.908, H-350.974, D-35.985, D-350.995, H-440.828, H-450.924, H-280.945, and H-160.896; support APMs that link quality measures and payments to outcomes specific to vulnerable and high-risk populations; encourage the development and implementation of APMs that provide services to improve the health of vulnerable and high-risk populations; and continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health.

Testimony on Council on Medical Service Report 10 was mixed. A member of the Council introduced the report stating that the report builds upon the AMA's current policy on value-based payment and social determinants of health. In its report, the Council offers a set of recommendations that it hopes mitigates negative outcomes, penalties, and events for both vulnerable populations and the physicians serving them. In doing so, the Council recommended 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 Reference Committee believes that the Council produced a strong report that furthers the health of vulnerable populations and incentivizes physicians to care for them. There was testimony that the report should have included practice costs. However, your Reference Committee believes that this mention is outside of the scope of this report and represents an area of significant and ongoing AMA study and advocacy efforts. Additionally, while there were concerns that the report did not specifically address what risk adjustment methods may be most appropriate to care for

vulnerable populations, your Reference Committee highlights that the Council on Medical Service is producing a report specifically on risk adjustment improvements for Interim 2019. Your Reference Committee believes it is imperative to start advocating for the recommendations in Council on Medical Service Report 10 immediately and continue to build upon this work following the Council's upcoming report at Interim and beyond. Your Reference Committee believes the intersection of APMs and vulnerable populations deserves significant attention and believes that the Council's report represents a first step in the right direction. Accordingly, your Reference Committee recommends that Council on Medical Service Report 10 be adopted.

(6) RESOLUTION 704 - PRIOR AUTHORIZATION REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 704 be adopted.

HOD ACTION: Resolution 704 adopted.

Resolution 704 asks that our AMA 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.

Your Reference Committee agrees with the uniformly supportive testimony for Resolution 704. Of note, the Council on Medical Services testified on the importance of the evaluation of the efficacy and appropriateness of emerging technological resources designed to automate the prior authorization process, while also maintaining the AMA's efforts to reduce the overall volume of prior authorizations. Your Reference Committee notes that the AMA's Prior Authorization and Utilization Management Reform Principles, released in 2017, specifically call for the utilization of technology to standardize prior authorization and reduce its patient and physician burdens. Your Reference Committee believes that this resolution represents an appropriate extension of existing AMA efforts and policy and recommends that Resolution 704 be adopted.

(7) RESOLUTION 710 - COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE ATTESTATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 710 be adopted.

HOD ACTION: Resolution 710 adopted.

Resolution 710 asks that our AMA work with the Council for Affordable Quality Healthcare (CAQH) and any other relevant organizations to reduce the frequency of required CAQH reporting to twelve months or longer unless the physician has a change in relevant information to be updated.

Testimony was limited but supportive of Resolution 710. Your Reference Committee concurs with testimony describing CAQH attestation requirements as an administrative burden for physicians. Accordingly, your Reference Committee recommends that Resolution 710 be adopted.

(8) BOARD OF TRUSTEES REPORT 13 - EMPLOYED PHYSICIAN BILL OF RIGHTS AND BASIC PRACTICE PROFESSIONAL STANDARDS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 of Board of Trustees Report 13 be amended by addition to read as follows:

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 relevant 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)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 13 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 13 adopted as amended and the remainder of the report filed.

Board of Trustees Report 13 recommends that our AMA reaffirm Policies H-225.950, H-225.997, H-225.942, H-225.955, H-300.982, and H-383.998; amend Policies H-225.955 and H-225.950; and advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

A member of the Board of Trustees introduced the report stating that the Board's analysis found that most of the concepts set forth in the referred resolutions are already addressed in AMA policy, and the Board recommends reaffirmation of these policies. In some cases, the proposed policies in the resolutions were 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.

Testimony on the report was unanimously supportive. There was one amendment presented asking that physicians only need to disclose *relevant* financial information. Your Reference Committee agrees and accepts this amendment. Accordingly, your Reference Committee recommends that Board of Trustees Report 13 be adopted as amended.

(9) BOARD OF TRUSTEES REPORT 15 - PHYSICIAN BURNOUT AND WELLNESS CHALLENGES; PHYSICIAN AND PHYSICIAN ASSISTANT SAFETY NET; IDENTIFICATION AND REDUCTION OF PHYSICIAN DEMORALIZATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 15 be amended by addition to read as follows:

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 local 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.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations on Board of Trustees Report 15 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 15 adopted as amended and the remainder of the report filed.

Board of Trustees Report 15 recommends that our AMA reaffirm Policies H-170.986, H-405.957, H-405.961, D-405.990, H-95.955, and H-295.858; amend policy H-405.961 to encourage state medical societies to collaborate with state medical boards to develop strategies to destigmatize physician burnout and encourage physicians to participate in the state's physician health program without fear of loss of license or employment; and amend Policy D-310.968 to encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify factors that may lead to physician demoralization; 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; and continue to address the institutional causes of physician demoralization and burnout, and develop and promote mechanisms by which physicians in all practice 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.

Testimony strongly supported Board of Trustees Report 15. A member of the Board of Trustees introduced the report, affirming that the AMA fully supports programs to assist physicians in early identification and management of stress and prevention of burnout and demoralization, which is evidenced by the AMA's ongoing development of targeted policies and tools and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars. Additional testimony was appreciative of the AMA's ongoing work to address physician burnout and demoralization. Your Reference Committee agrees with a minor amendment to Recommendation 3.7, and

recommends that the recommendations in Board of Trustees Report 15 be adopted as amended and the remainder of the report be filed.

(10) COUNCIL ON MEDICAL SERVICE REPORT 7 - HOSPITAL CONSOLIDATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 7 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 7 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 7 recommends that our AMA affirm that: (a) health care entity mergers should be examined individually, considering case-specific variables of market power and patient needs; (b) our AMA strongly supports and encourages competition in all health care markets; (c) our 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 report also recommends that our 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.

There was supportive testimony on Council on Medical Service Report 7. A member of the Council on Medical Service introduced the report, noting that our AMA's own research has found that most hospital markets are highly concentrated, and that this concentration is largely due to consolidation. The Council member explained that addressing hospital mergers with the same vigor that our AMA has addressed major health insurance mergers would place an undue burden on the association's resources and could alienate some AMA members. Additional testimony affirmed that the consolidation trend is worrisome but that it would be difficult for our AMA to address these mergers. Your Reference Committee agrees with an amendment to

Recommendation 3 asking our AMA to work with interested state medical associations to monitor hospital markets and review the impact of health system integration. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 9 - HEALTH PLAN PAYMENT OF PATIENT COST-SHARING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be amended by addition of a new Recommendation to read as follows:

7. That our AMA advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be amended by addition of a new Recommendation to read as follows:

~~8. That our AMA support health plan and insurer programs that collect patient co-payments and deductibles only if such programs allow physicians to opt out, are transparent about all program specifics, and do not penalize physicians who elect not to participate. (New HOD Policy)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be amended by addition of a new Recommendation to read as follows:

9. That our AMA monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 9 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 9 recommends that our AMA reaffirm Policies H-165.985, H-165.838, H-165.849, and H-165.828; amend Policy D-190.974 to prioritize efforts to determine patient financial responsibility at the point of care, especially for patients in high-deductibles plans; and support the development of IT systems to enable physicians and patients to better understand financial obligations and to encourage states and others to monitor the growth of high deductible health plans and other forms of cost-sharing to assess their impacts on access to care, health outcomes, medical debt, and physician practice sustainability.

Testimony on Council on Medical Service Report 9 was generally supportive. A member of the Council introduced the report. The Council noted that it has concerns over asking insurance companies to get further entrenched in the health care system and patient care by taking over collection of co-payments and deductibles. Additionally, the Council does not believe that it is feasible that insurers will agree to assume the financial risk of taking over patient payments for physicians, which could end up as insurer bad debt. And, if insurers do assume this risk, the Council doubts the insurer's motives. Inevitably, the Council believes that the insurer will profit off of this arrangement, and, when a patient does not pay the insurer, the Council doubts that insurers will pay physicians their contracted rate. Moreover, the Council is concerned that, if patients do not pay the insurer, they may lose coverage, which is neither helpful for physician practices nor is it in the best interest of the patient.

Your Reference Committee offers several new recommendations to address testimony that stated that the Council did not call for sufficient action in its report. First, your Reference Committee recommends advocating for the inclusion of health insurance contract provisions that permit physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service. Your Reference Committee believes that it is imperative that all physicians, other than those prohibited by EMTALA, should be legally permitted to collect patient financial obligations at the point of care. Your Reference Committee highlights that report recommendations 4 and 5 are also directly aimed at simplifying and expediting patient collections at the point of care.

Moreover, your Reference Committee offers a new recommendation consistent with our AMA's long-standing policy on freedom of choice to support health plan and insurer programs that collect patient co-payments and deductibles only if the program allows physicians to opt-out, is transparent about all program specifics, and does not penalize physicians who elect not to participate. Your Reference Committee believes that our AMA must support physicians who choose to utilize insurer programs and subsequently

be paid directly by the insurer rather than the patient. However, your Reference Committee recognizes the need for safe-guarding such insurer policies, particularly to protect physicians who wish not to participate in such arrangements and to ensure that they are not penalized for their non-participation.

Finally, your Reference Committee recommends a new recommendation calling on our AMA to monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles. Your committee recognizes the benefits and downsides of participating in such arrangements and calls on the AMA to monitor these programs and how they affect physician practices, including practice sustainability.

Your Reference Committee believes its recommended amendments represent a politically viable solution to the issue of insurers collecting co-payments and deductibles and also offers a balanced approach recognizing varying physician preferences on how to collect, or be paid, patient financial obligations. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

(12) COUNCIL ON MEDICAL SERVICE REPORT 11 - CORPORATE INVESTORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 11 be amended by addition of a new recommendation to read as follows:

9. That our AMA support consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 11 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 11 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 11 recommends that our AMA adopt a series of guidelines that should be considered by physicians contemplating corporate investor partnerships. Additionally, the report recommends supporting improved transparency regarding corporate investment in physician practices, and encourages further study by affected national medical specialty societies.

Testimony was supportive of Council on Medical Service 11. A member of the Council on Medical Service introduced the report, explaining that growing numbers of physicians

are employed by corporations, although the extent of corporate investment in physician practices is not known. The Council member highlighted longstanding AMA policy on the corporate practice of medicine and also policy affirming that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit. Additional testimony described the challenges of obtaining data on corporate investment in physician practices which is frequently not disclosed. Your Reference Committee heard testimony asking our AMA to solicit feedback on corporate investors, and supports the addition of a new recommendation asking our AMA to support consideration of options for gathering information on this important and rapidly evolving issue. Your Reference Committee also notes that our AMA will continue to monitor corporate investment in physician practices and its impact on patients and physicians. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 11 be adopted as amended and the remainder of the report be filed.

(13) RESOLUTION 702 - PEER SUPPORT GROUPS FOR SECOND VICTIMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 702 be amended by addition to read as follows:

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

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 702 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with other interested organizations to encourage that any future surveys of physician burnout should incorporate questions about the prevalence and potential impact of the "second victim phenomenon" ~~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)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

Resolution 702 asks that our AMA encourage institutional, local, and state physician wellness programs to consider developing peer support groups to address the "second victim phenomenon"; and 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.

Testimony was generally supportive of Resolution 702. Several speakers noted the value of peer support groups centered around "second victim" experiences. One speaker expressed concerns regarding legal issues that could impact peer support groups, although others stated that these legal issues, such as discoverability, had not been problematic. Testimony on the second Resolve clause questioned whether physician surveys on this issue are needed, and an amended version was offered. Your Reference Committee incorporated amendments to the first and second Resolve clauses and recommends that Resolution 702 be adopted as amended.

(14) RESOLUTION 706 - HOSPITAL FALLS AND "NEVER EVENTS" - A NEED FOR MORE IN DEPTH STUDY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 706:

RESOLVED, That our American Medical Association work with interested state medical associations and national medical specialty societies to support research regarding the feasibility and impact of removing patient falls with injury from Medicare's list of "never events." (New HOD Policy)

HOD ACTION: Alternate resolution adopted in lieu of Resolution 706.

Resolution 706 asks that our AMA 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; and 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.

Testimony was generally supportive of Resolution 706. Testimony was also supportive of alternate language offered by a member of the Council on Medical Service that asks

the AMA to work with interested state medical associations and national medical specialty societies to support research regarding the feasibility and impact of removing patient falls with injury from Medicare's list of "never events." Your Reference Committee supports this language and recommends that the alternate resolution be adopted in lieu of Resolution 706.

(15) RESOLUTION 708 - ACCESS TO PSYCHIATRIC TREATMENT IN LONG-TERM CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve in Resolution 708 be amended by deletion to read as follows:

~~RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services (CMS) to acknowledge that psychotropic medications can be an appropriate long-term care treatment for patients with chronic mental illness (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve in Resolution 708 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ask CMS to discontinue the use of antipsychotic ~~psychotropic~~ medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve in Resolution 708 be amended by deletion to read as follows:

~~RESOLVED, That our AMA ask the CMS to acknowledge that antipsychotic medication can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve in Resolution 708 be amended by deletion to read as follows:

~~RESOLVED, That our AMA ask CMS to refrain from issuing citations or imposing financial penalties for the medically necessary and appropriate use of antipsychotic medication for the treatment of dementia-related psychosis. (Directive to Take Action)~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 708 be adopted as amended and Policy D-120.951 be reaffirmed.

HOD ACTION: Resolution 708 adopted as amended and Policy D-120.951 reaffirmed.

Resolution 708 asks that our AMA ask the Centers for Medicare and Medicaid Services (CMS) to acknowledge that psychotropic medications can be an appropriate long-term care treatment for patients with chronic mental illness; ask CMS to discontinue the use of psychotropic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications; ask the CMS to acknowledge that antipsychotic medication can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed; and ask CMS to refrain from issuing citations or imposing financial penalties for the medically necessary and appropriate use of antipsychotic medication for the treatment of dementia-related psychosis.

Testimony on Resolution 708 was unanimously supportive. A member of the Council on Medical Service called for an amendment to adopt the second Resolve and reaffirm Policy D-120.951 in lieu of the other Resolve clauses. In its testimony, the Council noted that Policy D-120.951 not only addresses the first, third, and fourth Resolve clauses but also is nearly identical language. However, the Council supports adoption of the second Resolve and recognizes our AMA's lack of policy on the use of antipsychotic medication as a factor in Nursing Home Compare rankings. Testimony noted that current CMS policies on the use of antipsychotic medications may cause patient harm and urged AMA action on this issue. Your Reference Committee agrees and therefore recommends that Resolution 708 be adopted as amended and Policy D-120.951 be reaffirmed.

Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951
Our AMA will meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial

penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis. (Res. 523, A-12)

(16) RESOLUTION 711 - IMPACT ON THE MEDICAL STAFF OF THE SUCCESS OR FAILURE IN GENERATING SAVINGS OF HOSPITAL INTEGRATED SYSTEM ACOS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate Resolution be adopted in lieu of Resolution 711:

EFFECTS OF HOSPITAL INTEGRATED SYSTEM ACCOUNTABLE CARE ORGANIZATIONS

RESOLVED, That our American Medical Association encourage studies into the effect of hospital integrated system Accountable Care Organizations' (ACOs) ability to generate savings and the effect of these ACOs on medical staffs and potential consolidation of medical practices. (New HOD Policy)

HOD ACTION: Alternate Resolution adopted in lieu of Resolution 711.

Resolution 711 asks that our AMA study the effect of hospital integrated system ACOs' failure to generate savings on downsizing of the medical staff and further consolidation of medical practices and the root causes for failure to generate savings in hospital integrated ACOs, as compared to physician-owned ACOs, and report back at the 2019 Interim Meeting.

There was generally supportive testimony on Resolution 711. The Council on Medical Service called for adoption of an alternate resolution to support studies into how to improve ACO performance and physician satisfaction with ACOs. In its testimony, the Council stated that it believes that the request of Resolution 711 is not best directed at our AMA but rather that the request is more appropriate for ACO organizations or the American Hospital Association. In particular, the Council noted that, though well-intentioned, our AMA simply does not have the necessary data to complete this study. Your Reference Committee agrees and therefore recommends an alternate resolution encouraging other organizations to study hospital integrated system ACOs.

(17) RESOLUTION 712 - PROMOTION OF EARLY RECOGNITION AND TREATMENT OF SEPSIS BY OUT-OF-HOSPITAL HEALTHCARE PROVIDERS TO SAVE LIVES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 712:

RESOLVED, That our American Medical Association work with interested national medical specialty societies to promote the importance of early detection and treatment of sepsis by physicians. (New AMA Policy)

HOD ACTION: Alternate resolution adopted in lieu of Resolution 712.

Resolution 712 asks that our AMA collaborate with interested medical organizations such as the Centers for Disease Control and Prevention and the Society of Critical Care Medicine to promote the importance of early detection and expedited intervention of sepsis by healthcare providers who work in out-of-hospital settings to improve patient outcomes and save lives.

There was limited but supportive testimony on Resolution 712. An amended version of Resolution 712 was offered by the resolution's sponsor to address concerns regarding early antibiotic use among emergency medical technicians. Your Reference Committee crafted an simpler alternate resolution which achieves the intent of Resolution 712 and is inclusive of physicians in all settings. Accordingly, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolution 712.

(18) RESOLUTION 714 - MEDICARE ADVANTAGE STEP THERAPY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 714.

HOD ACTION: Alternate resolution adopted in lieu of Resolution 714.

RESOLVED, That our AMA believes that step therapy programs create barriers to patient care and encourages health plans to instead focus utilization management protocol on review of statistical outliers; and be it further

RESOLVED, That our AMA advocate that the Medicare Advantage step therapy protocol, if not repealed, should feature the following patient protections:

1. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient "fails" a treatment;
2. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients' best interests;
3. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
4. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;
5. Include an exemption from step therapy for emergency care;
6. Require health insurance plans to process step therapy approval and override request processes electronically;
7. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and
8. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition.

Resolution 714 asks that our AMA our AMA work with the Centers for Medicare and Medicaid Services (CMS) to immediately publish guidance to plans that lays out, at minimum, the patient safeguards proposed/finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses proposed rule so that beneficiaries have some protections in 2019, and asks that CMS does not respond to stakeholder input and publish guidance according to these and other principles, our AMA support and actively work to advance Congressional action to provide patients safeguards in the 2019 plan year.

Your Reference Committee agreed with the significant testimony in support of Resolution 714. In order to adequately protect patients from the problematic aspects of step therapy, your Reference Committee believes that the AMA needs to further weigh in on this issue. As highlighted in testimony from the Council on Legislation, the AMA has

been extremely active in attempting to prevent the expansion of step therapy to Medicare Part B drugs. Unfortunately, as noted by several commenters, these efforts have failed to prevent implementation of this problematic program, making further action at this time appropriate. The Committee notes that it received an alternate resolution submitted by the Council on Legislation, which called for the AMA to adopt policy consistent with both the current AMA compendium and ongoing federal and state legislative bills and regulatory developments. Although the Council's language was useful, we believe it fell short of adequately calling for direct action while also failing to adequately address the recurrence of a systematic disease event. As a result, the Committee crafted and recommends adoption of the alternate resolution in lieu of Resolution 714.

(19) RESOLUTION 717 - MILITARY PHYSICIAN REINTEGRATION INTO CIVILIAN PRACTICE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 717:

REENTRY INTO PHYSICIAN PRACTICE

HOD ACTION: Alternate resolution adopted in lieu of Resolution 717:

RESOLVED, That our American Medical Association encourage hospitals to establish alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges; and be it further

RESOLVED, That our AMA encourage The Joint Commission and other accrediting organizations to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges.

Resolution 717 asks that our AMA develop recommendations to inform local credentialing bodies of pathways to facilitate the process of military veteran physicians and surgeons to return to civilian practice without compromising patient care.

Testimony on Resolution 717 was mixed. An alternate resolution was offered to broaden the resolution to include all physicians attempting to reenter the physician workforce. This alternate received overwhelming supportive testimony and highlights that all physicians who, for whatever reason, stepped away from medicine for a period of time

need assistance transitioning back to practice. Your Reference Committee wholeheartedly agrees and therefore recommends adoption of the alternate resolution.

(20) RESOLUTION 703 - PRESERVATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 703 be referred.

HOD ACTION: Resolution 703 referred.

Resolution 703 asks that our AMA, 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.

Testimony on Resolution 703 was supportive of the study called for in Resolution 703. Your Reference Committee received an alternative resolution from the author to study, from the perspective of both the patient and physician, the adequacy of the time allotted to or spent in direct patient-physician contact, with a goal of establishing a minimum time required for a clinical encounter that is effective and satisfactory to both parties. As such, your Reference Committee recommends that Resolution 703 be referred for study and requests that the proposed alternative resolution be considered with the referral.

(21) RESOLUTION 719 - INTERFERENCE WITH PRACTICE OF MEDICINE BY THE NUCLEAR REGULATORY COMMISSION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 719 be referred for decision.

HOD ACTION: Alternate Resolution 719 adopted in lieu of Resolution 719.

RESOLVED, That our AMA express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission (NRC) which would weaken the requirements for Authorized Users of Radiopharmaceuticals (AUs), including shortening the training and experience requirements, the use of alternative pathways for AUs, and expanding the use of non-physicians, with AMA advocacy for such

opposition during the open comment period ending July 3, 2019.

Resolution 719 asks that our AMA advocate for a follow-up review by the Institute of Medicine of the Nuclear Regulatory Commission's medical use program, specifically evaluating effects of the Nuclear Regulatory Commission's regulatory policy in the last 25 years on the current state of nuclear medicine in the U.S. and patients' access to care.

Testimony was supportive of Resolution 719. An additional Resolve clause offered very specific instructions to the AMA to oppose a proposed rule open for comment until July 3, 2019. Given the complexity and timeliness of the issues raised in Resolution 719 and the proposed amendment, your Reference Committee recommends that the item be referred for decision.

(22) RESOLUTION 705 - PHYSICIAN REQUIREMENTS FOR COMPREHENSIVE STROKE CENTER DESIGNATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 705 be not adopted.

HOD ACTION: Resolution 705 not adopted.

Resolution 705 asks that our AMA 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.

There was considerable and mixed testimony on Resolution 705. Your Reference Committee heard varying testimony on the use of volume requirements, the levels of stroke center designation, and patient care and safety. Importantly, your Reference Committee heard testimony from relevant specialty societies that this resolution is highly specific and complex, and best dealt with by the relevant specialty societies not our AMA. Your Reference Committee strongly agrees and therefore recommends that Resolution 705 not be adopted.

(23) RESOLUTION 709 - PROMOTING ACCOUNTABILITY IN PRIOR AUTHORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-285.987 and H-285.939 be reaffirmed in lieu of Resolution 709.

1 **HOD ACTION: Alternate Resolution <u>adopted in lieu of</u>**
2 **<u>Resolution 709</u>.**
3
4 **<u>RESOLVED, That our AMA study the frequency by</u>**
5 **<u>which health plans and utilization review entities</u>**
6 **<u>are using peer-to-peer review prior authorization</u>**
7 **<u>processes, and the extent to which these processes</u>**
8 **<u>reflect AMA policies, including H-285.987</u>**
9 **<u>("Guidelines for Qualifications of Managed Care</u>**
10 **<u>Medical Directors"), H-285-939 ("Managed Care</u>**
11 **<u>Medical Director Liability"), H-320.968 ("Approaches</u>**
12 **<u>to Increase Payer Accountability"), and the AMA</u>**
13 **<u>Code of Medical Ethics Policy 10.1.1 ("Ethical</u>**
14 **<u>Obligations of Medical Directors"), with a report</u>**
15 **<u>back to the House of Delegates at the 2020 Annual</u>**
16 **<u>Meeting. (Directive to Take Action)</u>**
17
18
19 Resolution 709 asks that our AMA amend Policy H-320.968 to advocate that any
20 physician who recommends a denial as to the medical necessity of services on behalf of
21 a utilization review entity or health plan be of the same specialty and have expertise to
22 treat the medical condition or disease as the practitioner who provided the services
23 under review; and that our AMA and its Council on Judicial and Ethical Affairs study the
24 ethical and medicolegal responsibilities of physicians who participate in the prior
25 authorization process on behalf of utilization review entities or health plans, particularly
26 with regard to determinations of medical necessity, and report back to the HOD at the
27 2020 Annual Meeting with guidance for physicians who provide utilization review
28 services.
29
30 Your Reference Committee heard a significant amount of testimony for Resolution 709
31 recognizing the importance of health plan decision-makers having the appropriate level
32 of education and experience when making prior authorization denials. Of note, the
33 Committee recognizes the importance of the amendment seeking to explicitly require all
34 denials to be made by a physician, and when possible, that the physician be of the same
35 specialty and have expertise in the condition under review. Your Reference Committee
36 agrees with this sentiment and the largely supportive testimony received on the
37 resolution. However, as invoked by the Council on Legislation's testimony, we believe
38 that current policy and ongoing AMA advocacy initiatives already accomplish this
39 Resolution's intent.
40
41 The AMA has been extremely active in advocating to reduce physician and patient
42 harms caused by prior authorization. This work includes the development of physician
43 surveys on negative impacts of prior authorization, an AMA Grassroots website
44 (www.fixpriorauth.org) enabling physicians to provide testimonials to be used in AMA
45 advocacy, the development and promotion of state legislative efforts, and collaboration
46 amongst the healthcare industry to improve prior authorization processes. Amongst the
47 most common aspects of these efforts has been the need to ensure that health plans
48 utilize properly trained physician experts when denying care. For example, the Prior
49 Authorization and Utilization Management Reform Principles explicitly call for any
50 physician making a decision on a prior authorization appeal to be of the same specialty,

and subspecialty whenever possible, as the prescribing/ordering physician. Additionally, as highlighted in testimony, the Council on Legislation has model legislation requiring an adverse decision on a prior authorization to be made by a physician with a current and valid non-restricted license to practice medicine and must be board certified in the same specialty as the health care provider who typically manages the denied medical condition.

In addition to these active advocacy efforts, the AMA has relevant and overlapping policy and ethical opinions on the issues raised in Resolution 709. Policy H-285.987 establishes detailed guidelines for physicians to follow when serving as medical directors/decision-makers for managed care plans, with requirements that they be licensed and credentialed in the same state as network physicians over whose care they are making decisions. Policy H-285.939 calls on the AMA to undertake federal and state legislative and regulatory measures necessary to hold health plan medical directors liable for medical decisions regarding contractually covered medical services. Additionally, this resolution is extensively addressed by the AMA Code of Medical Ethics Policy 10.1.1 “Ethical Obligations of Medical Directors,” which explicitly details the ethical considerations that physicians must take into account when making benefit determinations on behalf of health plans.

As a result of these policies and the ongoing initiatives, your Reference Committee recommends that H-285.987 and H-285.939 be reaffirmed in lieu of Resolution 709.

> Guidelines for Qualifications of Managed Care Medical Directors H-285.987
> The AMA has adopted the following "Guidelines for Qualifications of Medical Directors of Managed Care Organizations:”
> To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall:
> (1) hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state;
> (2) meet credentialing requirements equivalent to those met by plan providers;
> (3) be familiar with local medical practices and standards in the plan's service area;
> (4) be knowledgeable concerning the applicable accreditation or "program approval" standards for preferred provider organizations and health maintenance organizations;
> (5) possess good interpersonal and communications skills;
> (6) demonstrate knowledge of risk management standards;
> (7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management;
> (8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review;
> (9) be able to establish fair and effective grievance resolution mechanisms for enrollees;
> (10) be able to review, advise, and take action on questionable hospital admissions, medically unnecessary days, and all other medical care cost issues; and

(11) be willing to interact with physicians on denied authorizations.
The AMA strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors.

Managed Care Medical Director Liability H-285.939
AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. (1) Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; (2) that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and (3) that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.

(24) RESOLUTION 713 - SELECTIVE APPLICATION OF PRIOR AUTHORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-320.939 be reaffirmed in lieu of Resolution 713.

HOD ACTION: Policy H-320.939 reaffirmed in lieu of Resolution 713.

Resolution 713 asks that our AMA support policies such that prior authorization requirements will not be applied to items or services ordered by physicians and other health care practitioners: (i) whose prescribing or ordering practices align with an evidence-based guideline established or approved by a national professional medical association; or (ii) who meet quality (eg gold standard) criteria; or (iii) whose orders or prescriptions are routinely approved; or (iv) who adhere to a high quality clinical care pathway; or (v) who participate in an alternative payment model or care delivery model that aims to improve health care quality.

Testimony on Resolution 713 was significantly supportive of pursuing ways of eliminating prior authorization requirements for physicians whose conduct does not warrant their application, a belief with which your Reference Committee agrees. The committee notes that both the resolution and the author's testimony referred to the Consensus Statement on Improving the Prior Authorization Process as a particularly relevant resource in the development of Resolution 713. This resource, which was spearheaded and co-authored by the AMA, specifically calls for the selective application of prior authorization and calls for programmatic exemptions for physicians in risk-based contracts. Your Reference Committee notes that the creation of this resource was directly spurred by advocacy efforts coordinated with the release of the AMA Prior Authorization and Utilization Management Reform Principles.

Policy H-320.939 establishes that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the

1 Prior Authorization and Utilization Management Reform Principles. As highlighted in
2 testimony from the Council on Medical Service, these principles call for health plans to
3 restrict prior authorization programs to physicians whose prescribing patterns routinely
4 deviate from protocol (Principle 19), call for gold-carding exemptions and non-application
5 to physicians using clinical decision support systems or pathways (Principle 20), and
6 does not apply to physicians in risk-based contracts (Principle 21).
7
8 Because these Principles already address the concepts, your Reference Committee
9 recommends reaffirmation of H-320.939 in lieu of Resolution 713.
10
11 Prior Authorization and Utilization Management Reform H-320.939
12 1. Our AMA will continue its widespread prior authorization (PA) advocacy and
13 outreach, including promotion and/or adoption of the Prior Authorization and
14 Utilization Management Reform Principles, AMA model legislation, Prior
15 Authorization Physician Survey and other PA research, and the AMA Prior
16 Authorization Toolkit, which is aimed at reducing PA administrative burdens and
17 improving patient access to care.
18 2. Our AMA will oppose health plan determinations on physician appeals based
19 solely on medical coding and advocate for such decisions to be based on the
20 direct review of a physician of the same medical specialty/subspecialty as the
21 prescribing/ordering physician.
22 3. Our AMA supports efforts to track and quantify the impact of health plans' prior
23 authorization and utilization management processes on patient access to
24 necessary care and patient clinical outcomes, including the extent to which these
25 processes contribute to patient harm.
26
27 (25) RESOLUTION 718 - ECONOMIC DISCRIMINATION IN
28 THE HOSPITAL PRACTICE SETTING
29
30 RECOMMENDATION:
31
32 Madam Speaker, your Reference Committee recommends
33 that Policies H-180.963, H-230.971, H-230.975, and H-
34 230.976 be reaffirmed in lieu of Resolution 718.
35
36 **HOD ACTION: Resolution 718 referred.**
37
38
39 Resolution 718 asks that our AMA actively oppose policies that limit a physician's
40 access to hospital services based upon the number of referrals made, the number of
41 procedures performed, the use of any and all hospital services or employment affiliation.
42 Testimony on Resolution 718 was limited to the resolution's author. Your Reference
43 Committee takes issue with use of the term "referrals," and believes that the intent of the
44 resolution is addressed by existing AMA policy. Accordingly, your Reference Committee
45 recommends that Policies H-180.963, H-230.971, H-230.975, and H-230.976 be
46 reaffirmed in lieu of Resolution 718.
47
48 H-180.963 Volume Discrimination Against Physicians
49 The AMA recommends that volume indicators should be applied only to those
50 treatments where outcomes have been shown by valid statistical methods to be

significantly influenced by frequency of performance; and affirms that volume indicators should not be used as the sole criteria for credentialing and reimbursement and that, when volume indicators are used, allowances should be made for physicians starting practice. (Res. 101, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: BOT Rep. 3, A-09; Reaffirmed: Res. 703, A-18)

H-230.971 Economic Credentialing
Our AMA will work with The Joint Commission to assure, through the survey process, that any criteria used in the credentialing process are directly related to the quality of patient care. (BOT Rep. 15, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Modified: CMS Rep. 1, A-15)

H-230.975 Economic Credentialing
The AMA (1) adopts the following definition of economic credentialing: economic credentialing is defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges; (2) strongly opposes the practice of economic credentialing; (3) believes that physicians should continue to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data collected be reviewed by professional peers and shared with the individual physicians from whom it was collected; (4) believes that physicians should attempt to assure provision in their hospital medical staff bylaws of an appropriate role for the medical staff in decisions to grant or maintain exclusive contracts or to close medical staff departments; (5) will communicate its policy and concerns on economic credentialing on a continuing basis to the American Hospital Association, Federation of American Health Systems, and other appropriate organizations; (6) encourages state medical societies to review their respective state statutes with regard to economic credentialing and, as appropriate, to seek modifications therein; (7) will explore the development of draft model legislation that would acknowledge the role of the medical staff in the hospital medical staff credentialing process and assure various elements of medical staff self-governance; and (8) will study and address the issues posed by the use of economic credentialing in other health care settings and delivery systems. (CMS Rep. B, I-91; Reaffirmed by BOT Rep. 14, A-98; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17)

H-230.976 Economic Credentialing
The AMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges. (Res. 2, A-91; Reaffirmed: CME Rep. 8, I-93; Reaffirmed by BOT Rep. 14, A-98; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17)

1 Madam Speaker, this concludes the report of Reference Committee G. I would like to
2 thank Michael Bishop, MD, Jayne Courts, MD, Sterling Ransone Jr., MD, Stephen
3 Tharp, MD, Brett Youngerman, MD, and all those who testified before the Committee.

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