Reference Committee G

BOT Report(s)

17 Hospital Website Voluntary Physician Inclusion

CMS Report(s)

02 Mitigating the Negative Effects of High-Deductible Health Plans
04 Economic Discrimination in the Hospital Practice Setting

Resolution(s)

701 Degradation of Medical Records
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REPORT OF THE BOARD OF TRUSTEES

B of T Report 17, November 2020

Subject:	Hospital Website Voluntary Physician Inclusion (Resolution 819-I-19)
Presented by:	Russ Kridel, MD, Chair
Referred to:	Reference Committee G

At the 2019 Interim Meeting, the House of Delegates (HOD) referred Alternate Resolution 819-I-19, "Hospital Website Voluntary Physician Inclusion." Resolution 819 was sponsored by the Organized Medical Staff Section and asked the AMA to:

> advocate for regulation and/or legislation requiring that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites…

The resolution further asked the AMA to:

> study a requirement that all credentialed physicians (employed and voluntary) of a hospital and/or other healthcare facility be equally included on the websites and physician search engines, such as Find a Doctor sites with a report back at the 2020 Annual Meeting.

Testimony around Resolution 819 was supportive of having all credentialed physicians included in hospital and healthcare facility websites and search functions. Speakers recalled anecdotes of hospitals that only advertised employed physicians with the suggestion that this practice may be part of a plan to encourage voluntary physicians to consolidate with larger healthcare facilities. Additional testimony noted the practice of omitting non-employed physicians from websites and search functions was not transparent, making it hard to ascertain why a facility engaged in the practice. Testimony also reflected that omissions of physicians in this way could lead to a more confusing experience for patients who may have a more difficult time locating a physician for the first time or returning to one later.

Original iterations of Resolution 819 called more forcefully for the AMA to engage in the policymaking and regulatory process at the state and federal level to ensure that all credentialed physicians are included on healthcare facilities' websites. Some believed, however, that a fully engaged legislative and advocacy campaign was an inappropriate remedy for the problem and encouraged that the AMA do more to understand physician inclusion on websites first before committing to more involved action.

This report addresses the request to study requirements and practices around physician inclusion in hospital and healthcare facility websites and search functions with attention paid to recommendations for future action. For the purposes of this report, a "voluntary physician" can be understood to be any physician who is credentialed and privileged to practice at a hospital or health facility for any period of time but who is not employed or is otherwise financially independent on that hospital or health system.

DISCUSSION

Resolution 819 follows the experiences of several voluntary physicians in New York who found that their names were not included in the "Find a Doctor" search functions of at least one, and in some cases more than one, healthcare facility they practiced in. By contrast, names and information for physicians who were employed by the facilities were listed. When the voluntary physicians reached out to understand why, they heard a variety of reasons, including that the website was being updated. In each of the anecdotal cases, the issue was resolved, and voluntary physicians were eventually also included in the web search function.

These incidents raised a few concerns: first, that credentialed physicians were being, intentionally or otherwise, deprived of potential new patients because they were harder to find online. Second, that patients themselves may lose out on needed care due to the difficulties of locating a physician or returning to one in the future. Third, that excluding voluntary physicians from facility websites may put undue pressure on voluntary physicians to consolidate their practices into larger systems or facilities.

To better understand this issue, we reached out to the ten largest hospitals in the United States by number of beds according to Becker's Hospital Review[1]. These hospitals were chosen simply as a sample of the kinds of facilities that could potentially have a wide variety of employed and voluntary physicians working in them and not due to any suspected bad policies or inappropriate actions. (In point of fact, the healthcare facilities that were mentioned in the New York physicians' anecdotes all tended to be much smaller facilities.) All ten had "Find a Doctor" search functions on their websites. We attempted to speak with someone who could explain how these hospitals make determinations about management of their web search functions; however, we did not receive responses.

In examining the current regulatory landscape, we again were unable to identify any significant body of work that directly governed how physicians were listed on websites from state, local, or federal sources. While some guidance exists for certain standards, such as listing credentials, disclosures, or conflicts of interest in a public forum, very little is codified as to when and in what manner physicians' general information should be included or presented. Likewise, the AMA itself has not, prior to the Interim Meeting in 2019, established any guiding principles or policy on the subject.

While it does not relate directly to web searches and "Find a Doctor" sites, it is worth mentioning that one area of public reporting that is seeing a significant amount of attention involves reporting of quality metrics and performance measures. Federal and state mandates about how physicians and health systems may rank against each other are increasingly becoming more searchable and easier to find. Voluntary physicians should pay special attention to how they are listed on hospital websites to ensure that they are presented with the same contact information and quality measures as all other providers.

[1] 50 Largest Hospitals in America. *Becker's Hospital Review*. Accessed June 25, 2020: https://www.beckershospitalreview.com/lists/50-largest-hospitals-in-america.html

CONCLUSION

With few standards and almost no regulation from professional bodies, or state, local, or federal governments, it is difficult to fully grasp the effect of listing physicians' names in search functions. It is a potentially fruitful area for further academic research, as it is currently difficult to fully articulate how hospital and healthcare facilities' internal practices could affect not only physicians but patients seeking care as well. Additionally, none of the hospitals examined during this research responded to any requests to better understand how physicians are included in their websites and search functions. This gap in policy and practice uniquely positions the AMA to provide leadership and establish best practices for all medical staff in healthcare facilities. In the absence of public regulations and policy, the AMA can proactively establish standards for medical staff inclusion in public-facing promotional efforts like websites.

Because it is difficult to demonstrate how widespread the practice of limiting voluntary physicians on hospital websites is, it is also difficult to draw conclusions about the harm or benefit. Regardless, promoting access to practicing physicians, whether they are employed by a facility or voluntary, should be considered a best practice by the AMA. Any actions the AMA can take to promote the availability of credentialed and practicing physicians in any practice setting should ultimately be considered for the benefit of all physicians and their patients.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted in lieu of Resolution 819-I-19 and that the remainder of the report be filed:

1. That our AMA (1) work with relevant stakeholders to encourage decision-makers at all appropriate levels that all credentialed physicians be included in healthcare organizations' website listings and search functions in a fair, equal, and unbiased fashion; and (2) support efforts to ensure that physicians, through their medical staffs, are able to provide input on what information is published. (Directive to Take Action)

2. That our AMA work with relevant stakeholders to encourage healthcare organizations to notify credentialed physicians when a website is about to be changed if there is reason to believe that such a change could affect how physicians are listed or if they are listed at all. (Directive to Take Action)

3. That our AMA, through its Organized Medical Staff Section, produce and promote educational materials, trainings, and any other relevant components to help physicians advocate for their own inclusion on facilities' websites and search functions. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-20)
Mitigating the Negative Effects of High-Deductible Health Plans
(Resolution 125-A-19)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting, the House of Delegates referred the enclosed Resolution 125, which was sponsored by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Resolution 125-A-19 directed the American Medical Association (AMA) to advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2020 Annual Meeting.

While increasing access to health insurance has been beneficial to patients, critical challenges persist regarding health care access. Even when a service is covered by a health plan, patients may incur significant costs in the form of copayments, coinsurance, and/or large medical bills that they must pay before meeting their deductibles. Such costs have been shown to cause people, especially those with low incomes and/or chronic conditions, to forgo necessary care, and these challenges can be exacerbated in the context of high-deductible health plans (HDHPs).

This report examines clinical and financial challenges associated with HDHPs, explores several potential strategies for improvement, and makes recommendations to mitigate the negative effects of HDHPs. Specifically, in addition to reaffirming highly relevant policy, this report recommends that the AMA encourage further research and advocacy to develop and promote innovative health plan designs; that employers be encouraged to provide robust education to help patients make good use of their benefits to obtain the care they need, collaborate with their employees to understand employees' health insurance preferences and needs, tailor benefit designs to employees' preferences and needs, and pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs out across the plan year; and that state and national medical specialty societies be encouraged to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2, November 2020

Subject: Mitigating the Negative Effects of High-Deductible Health Plans (Resolution 125-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates referred the enclosed Resolution 125, which was sponsored by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Resolution 125-A-19 directed the AMA to advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments. The Board of Trustees assigned this item to the Council on Medical Service (CMS) for a report back to the House of Delegates at the 2020 Annual Meeting. This report examines clinical and financial challenges associated with high-deductible health plans (HDHPs), explores several potential strategies for improvement, and makes recommendations to mitigate the negative effects of HDHPs.

BACKGROUND

HDHPs are insurance plans associated with lower premiums, higher deductibles, and greater cost-sharing requirements as compared with traditional health plans.[1] Both enrollment in HDHPs and the size of deductibles has increased dramatically in recent years. In 2019, approximately 30 percent of enrollees in employer-sponsored health plans were covered by HDHPs, compared to 4 percent in 2006.[2] The imposition of greater consumer cost-sharing is frequently described as a means of ensuring that those receiving health care services "have skin in the game," and used as a lever to minimize the growth of health insurance premiums.

However, while an HDHP's lower premium may be enticing, higher patient cost-sharing can lead to significant challenges. Reductions in health care spending achieved through HDHPs have been found to be due to patients simply receiving less medical care.[3] Moreover, HDHPs appear to reduce health care spending by decreasing the use of both appropriate care (such as recommended cancer screenings) and less appropriate care (such as low-severity emergency department visits).[4] Studies have found that families who have members with chronic disease and who are enrolled in HDHPs are more likely to go without care due to cost and/or face substantial financial burdens, such as trouble paying bills, than families enrolled in traditional plans.[5] Another study found that enrollment in an HDHP combined with a savings account led to significant increases in out-of-pocket (OOP) spending, with more than half of the enrollees with lower-incomes and more than one-third of the enrollees with chronic conditions facing "excessive financial burden."[6]

The challenges of underinsurance and cost-related nonadherence (CRN) which can negatively affect patient care in general can be exacerbated in the context of HDHPs. Rates of underinsurance (e.g. OOP costs that are high relative to income) have risen. Even when a service is covered by a health plan, patients may incur significant costs in the form of copayments, coinsurance, and/or

large medical bills that they must pay before meeting their deductibles. Such costs have been shown to cause people, especially those with low incomes and/or chronic conditions, to forgo necessary care.[7] Similarly, CRN refers to a state in which patients are unable to pursue recommended medical care due to financial barriers.[8] CRN and sub-optimal patient use of evidence-based medical services can lead to negative clinical outcomes, increased disparities, and in some cases, higher aggregate costs.[9] CRN has been identified across the entire continuum of clinical care, including physician visits, preventive screenings, and prescription drugs,[10] and the challenges of CRN may be magnified by the COVID-19 pandemic as payers experience financial pressure and strive to lower medical spending.[11] CRN is especially problematic for vulnerable populations, such as those with multiple chronic conditions, lower socioeconomic status, and/or belonging to diverse racial or ethnic groups.[12] For example, a recent study found that HDHPs were associated with cost-related barriers to care for cancer survivors, and these barriers were significantly greater for Black patients.[13] Additionally, greater OOP costs for medication to treat certain chronic conditions has been found to reduce initiation and adherence, lower the likelihood of achieving desired health outcomes, and sometimes, increase utilization of acute care services.[14] At the same time, studies have demonstrated that reducing or eliminating cost-sharing leads to improvements in medication adherence[15] and reductions in health disparities based on socioeconomic status and race.[16]

In addition to increases in deductible spending, total patient OOP spending has also risen significantly in recent years. Total OOP spending, which includes pre-deductible spending, copayments, and coinsurance, increased by 54 percent between 2006 and 2016.[17] Intensifying this challenge is the fact that over the past decade, growth in OOP costs has outpaced increases in workers' wages.[18] The COVID-19 pandemic highlighted critical shortcomings, with many health plans not providing affordable coverage for services to treat many chronic conditions and COVID-19-related illness.[19] In fact, 68 percent of adults said that OOP costs would be very or somewhat important in their decision to get care if they had COVID-19 symptoms.[20]

To help offset the burdens of higher deductibles and greater cost-sharing that patients face when enrolled in HDHPs, plans and employers can make available one or more of several tax-advantaged savings accounts including: Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), Flexible Spending Arrangements (FSAs), and for certain small employers or self-employed individuals, Medical Savings Accounts (MSAs).[21] Each of these savings accounts has unique benefits and drawbacks, and the "best option" is very case specific. However, many patients do not, or cannot, optimally utilize savings accounts to help them offset OOP costs associated with HDHPs.[22] In light of these significant financial concerns, more needs to be done to ensure access to necessary, high-value care.

POTENTIAL STRATEGIES FOR IMPROVEMENT

Resolution 125-A-19 recommended that outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments in an effort to improve patient health and decrease total health care costs. The AMA supports innovative benefit designs that could allow certain physician services and prescription drugs to be provided pre-deductible. Moreover, in CMS Report 1-I-20, the Council is recommending that health plans be incentivized to offer pre-deductible coverage including physician services in their bronze plans, to maximize the value of zero-premium plans to plan enrollees. This is similar to the requirement that catastrophic plans sold on health insurance exchanges must cover at least three primary care visits per year pre-deductible.[23] Pre-deductible coverage for certain physician visits in these specific contexts, however, is a significant departure from pre-deductible coverage for all physician visits in all contexts.

When health plans become more generous in exempting additional items and services from a deductible, other elements of benefit design become less generous (ie, more costly to the enrollee) to counterbalance the additional cost. In theory, over a long time horizon with a consistent enrollee base, a health plan might find long-term cost savings, such as through decreases in hospital admissions or emergency department visits, to offset short-term cost increases associated with increased generosity in services exempt from deductibles. However, when short-term costs are critical, such as in health insurance exchanges and among plans sponsored by employers in industries that experience high levels of employee turnover, short-term costs heavily influence benefit design. In the health insurance exchanges, increases in plan generosity cause an increase in actuarial value (AV) of a health plan, and the plan must become less generous in other domains to maintain its AV. For example, in a study designed to test how plans could provide more generous coverage for high-value services, the more generous coverage for some services had to be offset by less generous coverage of other services in order to maintain required AV.[24] Similarly, in the private market, health plans might increase premiums or impose greater cost-sharing on some items or services to compensate for decreased cost-sharing for other items and services.

While high deductibles and OOP costs pose a significant challenge to many, this challenge is not universal, so it is important to recognize that blunt instruments that simply cause health care costs to shift among deductibles, cost-sharing, and premiums will be reallocating the burden of health care costs among a general population with very disparate health care utilization. US health care spending is dramatically concentrated, with very few individuals incurring very large shares of spending, while other large portions of the population incur very little spending. In fact, in 2016, half of the population had health spending under $971, accounted for only 2.8 percent of total health spending in the US, and incurred average OOP health care spending of only $73.[25] In contrast, 10 percent of the population had health spending of at least $12,024, accounted for 66 percent of total US spending, and incurred average OOP spending of $2,380.[26]

Benefit Design Initiatives

Rather than applying a blunt instrument that categorically shifts health care costs, health plans could be designed with "clinical nuance," a principle of value-based insurance design (VBID). "Clinical nuance" recognizes that medical services may differ in the amount of health produced, and that the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.[27] The same service could be high-value to one patient and low-value to another, and the ability of patients and their physicians to make this determination on a case-by-case basis is critical and well-supported by AMA policy. Achieving truly nuanced plan design is a laudable goal and one that VBID researchers have been pursuing for over a decade[28] with some progress. For example, the US Department of Treasury recently released Notice 2019-45, allowing HSA-HDHP plans the flexibility to cover specified medications and services used to treat chronic diseases prior to meeting the plan deductible.[29] While the list of specified medications and services is limited, it is a decisive step in the direction of expanding health plan flexibility to improve affordable access to high-value care.

More recently, legislative and regulatory changes have further expanded HSA-HDHPs' capacity for clinical nuance in the context of COVID-19. Explicitly recognizing the potential administrative and financial barriers to care present for individuals enrolled in HSA-HDHPs, the Internal Revenue Service (IRS) issued Notice 2020-15 to remove those barriers in the context of the unprecedented public health emergency.[30] Specifically, Notice 2020-15 makes another limited exception to the general rules governing qualification for HSA-HDHPs to allow health plans the flexibility to cover testing and treatment of COVID-19 pre-deductible and without imposition of patient cost sharing. Many of the nation's leading insurance companies pursued this opportunity and waived patient

cost-sharing for COVID-19-related testing, but the scope and duration of these waivers varies across insurers.[31] IRS Notice 2020-29 further clarified that the testing and treatment of COVID-19 that can be provided pre-deductible includes the panel of diagnostic testing for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV).[32] Additionally, the Coronavirus Aid, Relief and Economic Security (CARES) Act created a temporary safe harbor allowing HDHPs to cover telehealth services and other remote care without cost to participants before their deductibles are met.[33] The safe harbor is currently in effect until the end of 2021.[34] It is up to payers, though, to implement plan changes to take advantage of this legal flexibility, and it remains to be seen how much relief patients will experience. As understanding of the clinical impacts of COVID-19 continues to evolve and patients begin experiencing long-term impacts from the infection, patients have reported receiving medical bills totaling tens of thousands of dollars for treatment for COVID-19 and complications.[35]

A second key consideration is that to effectively enhance patients' access to high-value care, health plans must make high-value care across the clinical continuum affordable. Making physician visits more affordable is therefore a necessary, but insufficient, step toward achieving the improved access goal of Resolution 125-A-19. If only physician office visits are targeted for deductible exemption, some patients and physicians may be frustrated to realize that they can identify a problem but lack the resources to resolve it. For example, consider the scenario where patients can visit their physician and learn that they are at risk for diabetes without incurring costs under their health plan, but to pursue necessary testing, pharmaceuticals, and medical devices, they must pay OOP until reaching their deductibles. In fact, a recent study found that patients enrolled in an HDHP who received a prescription for a brand name antihyperglycemic medication were less likely to refill that prescription than were patients enrolled in non-HDHP plans who were prescribed the same medicine.[36] This study suggests that HDHP enrollment can impact the quality and delivery of care for patients with type 2 diabetes when branded antihyperglycemic medications offer optimal disease management.[37] Similarly, another study found that patients with diabetes experienced minimal changes in outpatient visits and disease monitoring after switching to an HDHP, but low-income, high-morbidity, and HSA-HDHP subgroups experienced major increases in emergency department visits or expenditures for preventable acute diabetes complications.[38]

However, VBID can be applied to reduce some of the negative impacts of HSA-HDHPs and reduce health care disparities. A recent study found that when HSA-HDHPs incorporate a preventive drug list (PDL) which exempts specific high-value classes of medications from deductibles, patients experienced substantial decreases in annual OOP costs, increased medication utilization, and lower barriers to initiating treatment.[39] The study authors emphasized the importance of these findings for patients with lower incomes and encouraged employers to consider tailoring their benefit designs to concentrate PDL coverage in lower-income employees who may benefit most from the subsidized coverage. Additionally, a recent study demonstrated that an "HDHP+," a hypothetical HSA-HDHP that would reduce cost-sharing for certain high-value items and services intended to treat chronic conditions, would likely save the federal government money, and at a minimum, be cost neutral.[40] Moreover, plans that apply VBID principles to HDHPs could improve health equity by ensuring that all enrollees can afford high-value services, even during the deductible phase of their coverage.[41] At the same time, especially with such complex benefit designs, active counseling to help enrollees understand the value of their benefits may be critical to the success of these programs.[42] Collectively, these studies reinforce the principle that mitigating the deleterious effects of HDHPs will require efforts from stakeholders from across the health care continuum.

Payer-Driven Initiatives

In addition to considering alternative benefit design strategies that incentivize use of high-value care, payers can adopt strategies to minimize the deleterious effects of high deductibles. Given the trend of increasing patient OOP spending, payers could nevertheless soften the burden of these increasing OOP costs on patients and their physicians. Two key variables add to the stress of increasing OOP patient spending – first, the extent to which health care expenditures may need to be paid in large lump sums, and second, the extent to which patients and their physicians are unable to anticipate how much a given item or service will cost a patient OOP. When deductibles reset every year on January 1, many patients, including the 60 percent of Americans living with at least one chronic condition, may face significant OOP costs.[43] Patients may delay or forgo necessary care early in the year when they are facing the full OOP burden of their deductibles and have not accumulated funds in health savings accounts. In fact, it has been shown that nearly all incremental reductions in high-deductible health care spending occur while patients are subject to their deductibles.[44] Moreover, for patients enrolled in plans with coinsurance, the cost of health care items and services often cannot be known in advance, even after they have met their deductibles. In contrast, plans designed with copayments allow patients and their physicians to anticipate patient OOP costs.

Copayments are the most common form of patient cost-sharing associated with physician visits,[45] but with the increasing use of HDHPs, increasing numbers of patients and physicians are facing high deductibles and unpredictable bills for coinsurance. From 2007 to 2017, among patients with large employer coverage, coinsurance, deductible, and patient OOP spending increased, and copayment spending decreased.[46] In 2019, approximately 15 percent of patients enrolled in an HDHP paired with a savings account were subject to copayments for a physician office visit, with 68 percent subject to coinsurance.[47] The opposite pattern is present for patients enrolled in non-HDHP plans – between 86 and 95 percent of patients in non-HDHP plans paid copayments for physician office visits, with only 4 to 11 percent paying coinsurance.[48] With patients bearing increasing OOP health care costs, health plans that allow patients to predict their OOP costs in advance and also spread their OOP expenses over time may present a more patient-friendly and physician practice-friendly benefit design.

Employers, in specific, play a unique role as designers of employee health care benefits, and employers can choose to deploy a variety of strategies to encourage patients to pursue the care they need. Benefit packages are increasingly important to employees, with employees seeking choice and personalization, and looking to their employers to provide the tools they need to make good decisions.[49] Employers can take a variety of actions to make the health insurance benefits they offer valuable and accessible to their employees. For example, in 2019, JPMorgan Chase provided employees with health plans that applied lower deductible and coinsurance maximum amounts to lower-income employees.[50] For 2020, some JPMorgan Chase and Amazon employees have even more innovative plan options via the Haven Healthcare program, the venture among JPMorgan Chase, Amazon, and Berkshire Hathaway. Few details are available, but reporting indicates that the JPMorgan Chase plans remove patient deductibles, and copayments for most services range from $15 to $110.[51] Employers have a variety of more incremental options for tailoring the health plans they offer to their employees' needs. Some potential options for employers to consider include:

- Seed and/or match employee contributions to one or more types of savings accounts that can be used for health care expenses to encourage savings and use of these savings accounts. Employers contributing to employees' HSAs can improve employee awareness, consideration, and ultimately adoption and self-funding of HSAs.[52] Research indicates that on average, employees contribute 10 percent more to their HSAs each year when their

employer seeds money to their HSAs, and 59 percent of employees would contribute more to their HSAs if their employer provides a matching contribution.[53] However, a recent study found that 55 percent of employers offering HSA-HDHPs do not make contributions toward their employees' HSAs.[54]

- When possible, grant employees access to the full annual employer and/or employee contribution to a savings account at the beginning of a plan year so that patients can pursue care as they need it, rather than delaying care until savings have accumulated.
- Provide, and perhaps incentivize employees to participate in, robust health insurance and financial literacy campaigns that give them tools to choose the plan that best meets their needs and identify affordable care options throughout the plan year. When making decisions about health care savings, patients must navigate a complex set of choices, and even those with high financial literacy have trouble deciding where to save and how to spend.[55] For example, a 2018 study found that 69 percent of employees who did not enroll in an HSA say they chose not to enroll because they did not see any benefits to an HSA, did not understand what HSAs do, or simply did not take the time to understand the HSA. Moreover, only 15 percent of employees with high financial literacy choose to save their HSA money for the future.[56] Educational campaigns could include practical information regarding which items and services are available without patient cost-sharing pre-deductible and information about how funds placed in an HSA, HRA, FSA, MSA, or other savings account can be used to pay for health expenses. Via online and in-person education, employers can provide decision support and care navigation tools to help their employees at the time of health insurance enrollment and throughout the year.[57]
- Consider how predictable copayments vs. variable coinsurance can influence patient tendencies to pursue necessary health care and provide patients with a variety of health plan design options whenever possible.
- Collaborate with organized medicine to ensure that their innovations in plan design are likely to achieve intended clinical goals, as well as enhanced access to affordable care.

Physician Practice Initiatives

Physician practice initiatives focused on helping patients with high deductibles can serve physicians and the patients in their care. High deductibles burden patients and their physicians when patient fears about cost of care impair joint patient-physician decision-making and care planning. High deductibles also pose billing and collection challenges for physician practices. Fortunately, there are tools available that can help physicians and their practices. The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) related to standard electronic transactions and associated operating rules empower health care providers to obtain real-time information regarding patients' health plan coverage and financial obligations. Specifically, the operating rules for the electronic eligibility standard transaction require health plans to respond in real-time (within 20 seconds)[58] to health care providers' electronic requests for information about patients' health plan benefits.[59] Implementation of this legal requirement has been imperfect[60] – challenges persist – but the eligibility operating rules provide physicians with an avenue to obtain necessary data to inform their practice and their physician-patient joint decision-making. Specifically, physician practices can ascertain the patient's portion of the financial responsibility, including copayment, coinsurance and patient-specific remaining deductible. This information can help practices estimate patient costs before treatment decisions are made, and in some cases, collect patient deductibles and/or coinsurance before patients leave the office.[61] To empower physicians to implement and exercise their rights under the HIPAA administrative simplification provisions and to streamline their practices' billing processes, the AMA has published several toolkits and educational resources,

including those entitled, "What you need to know about electronic eligibility verification," "Managing patient payments," and "Electronic transaction toolkits for administrative simplification, which includes a resource on Compliance in standard electronic transactions: Responsibilities of health plans and physicians."[62]

RELEVANT AMA POLICY

AMA policy strongly supports value-based care, VBID, and innovative insurance design. Policy H-185.939 broadly supports flexibility in the design and implementation of VBID programs and outlines a series of guiding principles including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements. Policy D-185.979 also supports clinical nuance in VBID to respect individual patient needs and supports legislative and regulatory flexibility to accommodate VBID, including innovations that expand access to affordable care, such as changes needed to allow HSA-HDHPs to provide pre-deductible coverage for preventive and chronic care management services. Policy D-185.979 also encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. Consistent with calls to remove legislative and regulatory barriers to innovative plan design, Policy H-165.856 states that the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements and further states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. Policy H-450.938 provides principles to guide physician value-based decision-making, and Policy H-155.960 supports value-based decision-making among other broad strategies for addressing rising health care costs. Moreover, this policy recognizes the role of physician leadership and collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives. The policy encourages third-party payers to use targeted benefit design, whereby patient cost-sharing is determined based on the clinical value of a health care service or treatment, with consideration given to further tailoring cost-sharing to patient income and other factors known to impact compliance. AMA policy also supports value-based pricing for pharmaceuticals (Policy H-110.986) and providing patients with information and incentives to encourage appropriate utilization of preventive services (Policy H-390.849).

Policy H-165.846 states that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. Policy H-165.828 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. That policy also supports education regarding deductibles, cost-sharing, and HSAs. Policy H-165.852 supports, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance, legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses. That policy also supports the enhancement of activities to educate patients about the advantages and opportunities of HSAs. In addition, Policy H-165.854 supports HRAs as a mechanism for empowering patients to have greater control over their health care decision-making.

DISCUSSION

The Council lauds the sponsors of Resolution 125-A-19 for highlighting key challenges that HDHPs present to both patients and physicians, and it shares the goal of reducing barriers to

necessary health care. The Council is committed to developing AMA policy to mitigate the negative impacts of HDHPs that is consistent with the broader context of AMA policy on health reform and value-based decision-making. To accomplish this goal, the Council believes that the AMA should encourage further research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients. Such policy would be consistent with AMA policy regarding "clinical nuance" in VBID (Policy D-185.979) and policy encouraging private market innovation in product development and purchasing arrangements (Policy H-165.856). Recognizing that more than half of Americans under age 65 get their health insurance through an employer,[63] employers have a powerful role to play in designing health plans to meet their employees' needs and educating their employees about the benefits provided by the health plans. Accordingly, the Council recommends that employers should be encouraged to collaborate with their employees in ways that help them to better understand their employees' health insurance preferences and needs, tailor the benefits they offer to meet the preferences and needs of employees and their dependents, and provide robust education to help patients make good use of their benefits to obtain the care they need. Moreover, to ease the financial burden of large lump sum expenditures, the Council recommends that employers pursue strategies to help enrollees spread the costs associated with high OOP costs across the plan year. Additionally, consistent with Policy H-155.960, which highlights the importance of collaboration among physicians and employers in successful cost-containment and quality-improvement initiatives, the Council encourages state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care. In addition, to emphasize the importance of health plans designed with "clinical nuance," the need for legislative and regulatory flexibility to accommodate innovations in health plan design that expand access to affordable care, and the critical role of collaboration among national medical specialty societies and payers in designing innovative health plans, the Council recommends reaffirming Policy D-185.979. Similarly, to highlight the importance of robust education regarding deductibles, cost-sharing, and health care savings accounts, and to amplify the AMA's support for funding health savings accounts, the Council recommends reaffirming Policy H-165.828. Moreover, the Council notes that in CMS Report 1-I-20, it recommends incentivizing health plans to offer pre-deductible coverage, including physician services in bronze plans, to maximize the value of zero-premium plans to plan enrollees.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 125-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients. (New HOD Policy)

2. That our AMA encourage employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. (New HOD Policy)

3. That our AMA encourage state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care. (New HOD Policy)

4. That our AMA reaffirm Policy D-185.979, which supports health plans designed to respect individual patient needs and legislative and regulatory flexibility to accommodate innovations in health plan design that expand access to affordable care, and which encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-165.828, which supports education regarding deductibles, cost-sharing, and health savings accounts (HSAs), and 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. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4, November 2020

Subject: Economic Discrimination in the Hospital Practice Setting (Resolution 718-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates referred Resolution 718, "Economic Discrimination in the Hospital Practice Setting," which was introduced by the Organized Medical Staff Section. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2020 Annual Meeting. Resolution 718 asked that our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation.

This report addresses concerns regarding the use of case and volume metrics to limit access to hospital services by private practice physicians on hospital staff, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Relationships between hospitals and physicians have changed over the years as health care payment and delivery systems have evolved, more care has moved to outpatient settings, and physician practice ownership has shifted away from physician-owned practice and toward working for a hospital or hospital-owned practice. The shift toward hospital employment is evidenced by AMA's Physician Practice Benchmark Surveys, which show that 35 percent of physicians worked either directly for a hospital or in a practice at least partially owned by a hospital in 2018, up from 29 percent in 2012.[1]

Hospital care has similarly evolved over time, such that inpatients are now sicker, hospital stays are shorter, and the hospitalist model—which was introduced in the 1990s—is in place in a majority of hospitals. Although primary care physicians and other generalist physicians still serve as inpatient attendings, far fewer specialists do so,[2] and most inpatient care is managed by hospitalists.[3] Prior to these shifts and the advent of hospital medicine, physicians largely practiced independently and managed patient care across outpatient and inpatient settings. Although many private practice physicians remain members of hospital medical staffs and have clinical privileges, most hospitals (approximately 75 percent in 2016) utilize hospitalists.[4]

Recently, concerns have been raised in the House of Delegates regarding hospital-physician relationships and hospitals giving preference to their employed physicians to the detriment of private practice physicians and patient-physician relationships. Referred Resolution 718-A-19 focuses specifically on concerns regarding hospitals using case and volume metrics to limit access to hospital services by private practice physicians who are on staff. The *AMA Physician's Guide to Medical Staff Organization Bylaws* speaks to similar concerns:

> In exclusive contracting situations, some hospitals argue that exclusive rights to use hospital resources, such as radiology equipment or operating rooms, can be awarded by contract to some holders of privileges, while others with the same privileges are barred from their use.[5]

Such actions by hospitals violate the intent of Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges. To address these concerns, the *AMA Physician's Guide to Medical Staff Organization Bylaws* includes the following sample bylaw regarding clinical privileges:

> Clinical privileges or privileges means the permission granted to medical staff members to provide patient care and includes unrestricted access to hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.[6]

The Guide consists of sample bylaw language on self-governance and other issues relevant to hospital-medical staff relationships. A seventh iteration of the Guide was being developed at the time this report was written.

Physicians need full access to hospital services in order to provide high quality care to their patients. Additionally, physicians must have access to hospital services to maintain medical staff memberships and privileges. Case in point is The Joint Commission's Ongoing Professional Practice Evaluation (OPPE) requirements, which are factored into decisions to maintain existing privileges. Data used for the OPPE process must include physician activities performed at the hospital where privileges have been requested.

RELEVANT AMA POLICY

In addition to defining clinical privileges and addressing access to hospital resources, Policy H-230.982 states that privileges can be abridged only upon recommendation of the medical staff for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff.

An extensive collection of AMA medical staff policy aims to protect the rights of physicians who are members of hospital medical staffs. Policy H-225.942 delineates medical staff member rights and responsibilities, including fundamental rights that apply to individual medical staff members regardless of employment, contractual, or independent status. Policy H-225.950 includes principles for physician employment; Policy H-225.957 outlines principles for strengthening the physician-hospital relationship; and Policy H-225.997 addresses physician-hospital relationships. Policy H-220.951 requests The Joint Commission to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws. Policy H-230.953 encourages The Joint Commission 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 maintain credentials and privileges. Policy H-225.984 encourages hospital medical executive committees to regularly examine hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices. Policy H-230.987 supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting exclusive contracts by the hospital governing body.

The AMA also has extensive policy on economic credentialing and volume discrimination. Policies H-230.975 and H-230.976 strongly oppose economic credentialing, defined in policy as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for hospital medical staff membership or privileges. Policy H-230.971 asks the AMA to work with The Joint Commission to assure that criteria used in the credentialing process are directly related to the quality of patient care. Under Policy H-225.949, medical staffs are encouraged to develop medical staff membership categories for physicians who provide a low volume or no volume of clinical services in the hospital, and also encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities.

Policy H-285.964 states that hospitalist programs should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff, and that hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to hospitalists. This policy also opposes any hospitalist model that disrupts patient/physician relationships or continuity of care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

As a benefit of membership, the AMA provides assistance, such as information and advice (but not legal opinions or representation) to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities (Policy D-215.990).

DISCUSSION

Although the Council was unable to find more than anecdotal information regarding physicians being subjected to the discrimination discussed in referred Resolution 718-A-19, it agrees that new policy is needed. The Council also believes that economic discrimination may be based on the type, as well as number of referrals made. Accordingly, the Council recommends actively opposing policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. Having heard broader concerns about fairness and the need to protect physicians serving on medical staffs, the Council also recommends new policy recognizing that physician onboarding, credentialing, and peer review should not be tied in a discriminatory manner to hospital employment status.

The Council acknowledges the strength of existing AMA medical staff policy and recommends reaffirmation of Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. To address the OPPE issue, the Council recommends reaffirmation of Policy H-230.953, which encourages The Joint Commission 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 maintain credentials and privileges. Finally, the Council recommends reaffirmation of Policies H-230.975 and H-230.976, which strongly oppose economic credentialing.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 718-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. (New HOD Policy)

2. That our AMA recognize that physician onboarding, credentialing and peer review should not be tied in a discriminatory manner to hospital employment status. (New HOD Policy)

3. That our AMA reaffirm Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-230.953, which encourages the Joint Commission 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 maintain credentials and privileges. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-230.975, which strongly opposes economic credentialing and believes that physicians should attempt to assure provisions in hospital medical staff bylaws of an appropriate role of the medical staff in decisions to grant or maintain exclusive contracts. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-230.976, which opposes use of economic criteria not related to quality to determine a physician's qualification for the granting or renewal of medical staff membership or privileges. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1]Kane C. Updated data on physician practice arrangements: For the first time, fewer physicians are owners than employees. American Medical Association Policy Research Perspectives. 2019. Available online at: https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf.
[2] Wachter, RM. Zero to 50,000—The 20th anniversary of the hospitalist. The New England Journal of Medicine 375;11 September 2016.
[3] Stevens JP, Nyweide DJ et al. Comparison of hospital resource use and outcomes among hospitalists, primary care physicians, and other generalists. JAMA Internal Medicine. Vol. 177, No. 12: 1781-1787. Nov. 2017. Available online at: https://pubmed.ncbi.nlm.nih.gov/29131897-comparison-of-hospital-resource-use-and-outcomes-among-hospitalists-primary-care-physicians-and-other-generalists/.
[4] Wachter, RM. Zero to 50,000—The 20th anniversary of the hospitalist. The New England Journal of Medicine 375;11 September 2016.
[5] American Medical Association. Physician's guide to medical staff organization bylaws, Sixth Edition. Updated March 2017.
[6] Ibid.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(November 2020)

Introduced by: Illinois

Subject: Degradation of Medical Records

Referred to: Reference Committee G

Whereas, Medical records have traditionally served to help the physician in the care of patients; and

Whereas, The electronic health record (EHR) was initially viewed and welcomed as an asset assisting the care of patients; and

Whereas, EHRs have not been an asset in assisting in the care of patients because of the subsequently mandated and marked increase in documentation which effectively obliterated the intended benefit; and

Whereas, Adding the additional component of data entry to patient visits was apparently done without providing financial reimbursement for the required time to complete; and

Whereas, The reality is that the need for extra data entry often impairs the physician's ability to care for the patient given the time pressure of the appointments; and

Whereas, The burden of documentation impairs the doctor-patient relationship; and

Whereas, The doctor-patient relationship has been a major incentive to practice primary care medicine; and

Whereas, There is power in nomenclature and language; and

Whereas, Mandated EHR documentation now more accurately represents "insurance and government reports" rather than "medical records" in the traditional sense; therefore be it

RESOLVED, That our American Medical Association publish available data about the amount of time physicians spend on data entry versus direct patient care, in order to inform patients, insurers, and prospective primary care physicians about the real expectations of the medical profession. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 07/17/20

RELEVANT AMA POLICY

D-478.966 - Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records
Our AMA will work with health care leaders and policymakers to use industrial engineering principles and evidence-based best practices to study and then propose systematic reforms to reduce physicians' electronic health record workload. Alt. Res. 716, A-17

H-478.981 - Health Information Technology Principles
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.
Our AMA will AMA utilize HIT principles to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."
Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules. BOT Rep. 19, A-18 Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(November 2020)

Introduced by: Oklahoma

Subject: Eliminating Claims Data for Measuring Physician and Hospital Quality

Referred to: Reference Committee G

Whereas, The US Centers for Medicare and Medicaid Services has been publishing mortality data of hospitalized patients since 2008; and

Whereas, Public reporting has been expanded to cover multiple quality measures by many entities over the past few years; and

Whereas, The debate rages over whether to focus on outcomes versus care processes when assessing quality; and

Whereas, The validity of outcomes measures is under scrutiny when the data used for reporting purposes is claims data; and

Whereas, Any models that are used for assessing quality should be reliable and valid; and

Whereas, Models using data on severity of illness consistently outperform models using only comorbidity data; and

Whereas, Factors associated with severity of illness are the strongest predictors of quality; and

Whereas, Data from hospital billing systems contain no factors associated with the severity of illness; and

Whereas, Because of the variability of information in the medical record, claims data cannot reliably code comorbid conditions; and

Whereas, It is time to eliminate measures based on claims data from public reporting and other programs designed to hold physicians and hospitals accountable for improving outcomes; therefore be it

RESOLVED, That our American Medical Association collaborate with the Centers for Medicare & Medicaid Services (CMS) and other appropriate stakeholders to ensure physician and hospital quality measures are based on the delivery of care in accordance with established best practices (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action)

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

Received: 08/27/20

Reference:
https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2757527?resultClick=1

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(November 2020)

Introduced by: Georgia

Subject: Medicare Advantage Record Requests

Referred to: Reference Committee G

Whereas, Medicare Advantage rules for plans do not stipulate how record requests are handled, nor any limits to number or repetitiveness of these requests; and

Whereas, Complying with these record requests can require extensive staff time and other associated costs; and

Whereas, Practices are not reimbursed by Medicare Advantage companies for the staff time involved in complying with these requests; and

Whereas, Each Medicare Advantage plan has different rules for record requests governed by the contract between the plan and provider; therefore be it

RESOLVED, That our American Medical Association advocate for the relevant agencies and stakeholders to prevent Medicare Advantage plans from requesting records from practices solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise advocate that the plan will reimburse the practices for their efforts in obtaining additional requested information. (Directive to Take Action)

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

Received: 09/28/20

RELEVANT AMA POLICY

Limiting Access to Medical Records H-315.987
Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills.
Citation: Sub. Res. 222, I-94; Appended: Res. 218, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 06, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(November 2020)

Introduced by: New York

Subject: Government Imposed Volume Requirements for Credentialing

Referred to: Reference Committee G

Whereas, The government will sometimes create volume requirements for credentialing; and

Whereas, Depending on the details, these requirements may or may not be appropriate and justified; and

Whereas, The AMA has no policy or guideline for determining whether such requirements would or would not be appropriate; therefore be it

RESOLVED, That our American Medical Association create guidelines and standards for evaluation of government-imposed volume requirements for credentialing that would include at least the following considerations:

(a) the evidence for that volume requirement

(b) how many current practitioners meet that volume requirement

(c) how difficult it would be to meet that volume requirement

(d) the consequences to that practitioner of not meeting that volume requirement

(e) the consequences to the hospital and the community of losing the services of the practitioners who can't meet that volume requirement

(f) whether volumes of similar procedures could also reasonably be used to satisfy such a requirement. (Directive to Take Action)

Fiscal Note: Moderate - between $5,000 - $10,000

Received: 10/09/20

RELEVANT AMA POLICY

Reentry into Physician Practice H-230.953
Our AMA encourages: (1) 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 (2) 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.
Res. 717, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(November 2020)

Introduced by: New York

Subject: The Quadruple Aim – Promoting Improvement in the Physician Experience of Providing Care

Referred to: Reference Committee G

Whereas, In 2008, Donald Berwick and the Institute of Healthcare Improvement provided a framework for the delivery of high value care in the USA, the *Triple Aim*, centered around three overarching goals: improving the individual experience of care; improving the health of populations; and reducing the per capita cost of healthcare; and

Whereas, The *Triple Aim*, adopted as a set of principles for health system reform within many organizations around the world, fails to acknowledge the critical role of physicians in healthcare transformation and ignores the threats of psychological and physical harm that are common in medical practice; and

Whereas, For decision makers in healthcare (hospital leaders, EMR and other medical vendors, lawmakers and insurance companies) to abide by the *Triple Aim* is to ignore the threats of psychological and physical harm that are common to [clinicians] and patients; and

Whereas, The focus on productivity and efficiency, fueled by the pressures of decreasing reimbursement, has reduced intimate caregiving relationships to a series of transactional demanding tasks; and

Whereas, That by ignoring the experience of providing care in our healthcare delivery framework, this has eliminated consideration of human limitations in the delivery of care and this deficit in the framework of healthcare delivery results in unreasonable expectations upon physicians that affects them personally and the patients they serve; and

Whereas, The *Triple Aim* framework perpetuates the high occupational stress environment currently experienced by physicians when this framework is followed by all decision makers in healthcare, be they hospital leaders, electronic medical record and other medical device vendors, as well as law makers; and

Whereas, Intimate caregiving relationships have been reduced to a series of transactional demanding tasks, with a focus on productivity and efficiency, fueled by the pressures of decreasing reimbursement; therefore be it

RESOLVED, That to the *Triple Aim* which was established by Dr. Berwick and the Institute of Healthcare Improvement, our American Medical Association adopt a fourth goal: namely the goal of improving physicians' experience in providing care. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(November 2020)

Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

Whereas, Repetitive Strain (Stress) Injury or RSI is defined as a category of injuries "to the musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful exertions, vibrations, mechanical compression, or sustained or awkward positions; and

Whereas, RSI is a known work-related injury which falls under the purview of the Occupational Safety and Health Administration (OSHA); and

Whereas, Most RSI results from cumulative trauma rather than a single event; and

Whereas, Repeated exposure to work-related stressors can result in physician burnout; and

Whereas, Cerebral centers and activity are most certainly within the domain of the nervous system; and

Whereas, Physician burnout resulting from work-related stressors should be regarded as RSI and, as such, should fall under the aegis of OSHA; therefore be it

RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action)

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

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(November 2020)

Introduced by: New York

Subject: Physician Well-Being as an Indicator of Health System Quality

Referred to: Reference Committee G

Whereas, Physician well-being is measurable and existing instruments can assess physician wellness at a system level; and

Whereas, The Triple Aim, now adopted as a set of principles for health system reform within many organizations around the world, fails to acknowledge the critical role of physicians in healthcare transformation and ignores the threats of psychological and physical harm that are common in medical practice; and

Whereas, Intimate caregiving relationships have been reduced to a series of transactional demanding tasks, with a focus on productivity and efficiency, fueled by the pressures of decreasing reimbursement; and

Whereas, These forces have led to an environment which exhibits a lack of teamwork, disrespect between colleagues, and lack of workforce engagement from the level of the front-line caregivers, doctors and nurses, who are burdened with non-caregiving work, to the healthcare leader with bottom-line worries and disproportionate reporting requirements; and

Whereas, By ignoring the experience of providing care in our healthcare delivery framework, this has eliminated consideration of human limitations in the delivery of care and this deficit in the framework of healthcare delivery results in unreasonable expectations upon physicians that affects them personally and the patients they serve; and

Whereas, The Triple Aim framework perpetuates the high occupational stress environment currently experienced by physicians when this framework is followed by all decision makers in healthcare, be they hospital leaders, electronic medical record and other medical device vendors, as well as law makers; and

Whereas, Physician burnout can be a drag on health system quality and outcomes; therefore be it

RESOLVED, That our American Medical Association support policies that acknowledge physician well-being is both a driver and an indicator of hospital and health system quality (New HOD Policy); and be it further

RESOLVED, That our AMA promote dialogue between key stakeholders (physician groups, health-system decision makers, payers, and the general public) about the components needed in such a quality-indicator system to best measure physician and organizational wellness (Directive to Take Action); and be it further

RESOLVED, That our AMA (with appropriate resources) develop the expertise to be available to assist in the implementations of effective interventions in situations of suboptimal physician wellness. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(November 2020)

Introduced by: New York

Subject: Reducing Prior Authorization Burden

Referred to: Reference Committee G

Whereas, A prescription drug may require an insurance prior authorization; and

Whereas, Patients on chronic therapy experience a change in the rules during the interval between office visits and this results in extra work for a physician to review forms, medical records, complete paperwork, provide documentation and create an entry in the medical record so that a patient's therapy not suffer interruption; and

Whereas, The documentation process can be as resource intensive as a patient encounter; and

Whereas, The prior authorization diverts physician time away from direct patient care, thereby diminishing patient access and physician job satisfaction; and

Whereas, Reducing prior authorizations can protect patients from unnecessary delays in care; therefore be it

RESOLVED, That our American Medical Association seek regulation or legislation that:

- restricts insurance companies from requiring prior authorizations for generic medications;

- contains disincentives for insurers demanding unnecessary prior authorizations, including payments to physicians' practices for inappropriate prior authorizations;

- requires payment be made to the physician practice for services related to prior authorization when those services do not coincide with a visit; and

- ensures a requirement for an independent external review organization to review disputes involving prior authorizations and require insurer payments be made to the practice when the review organization agrees with the physician practice. (Directive to Take Action)

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

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(November 2020)

Introduced by: New York

Subject: Addressing Inflammatory and Untruthful Online Ratings

Referred to: Reference Committee G

Whereas, More than 70 percent of consumers search for health information online, according to Pew Research Center, and 77 percent of consumers say they use online reviews as the first step in finding a new physician*; and

Whereas, Online reviews are an open public forum that allows patients to share their stories and photos regarding their experiences with doctors; and

Whereas, Often these reviews are negative and accuse the doctors of complications or mismanagement of medical visits, treatments and procedures that they have had; and

Whereas, Bad online ratings can wreak havoc on doctors' businesses, in extreme cases driving physicians to leave a state to practice elsewhere; and

Whereas, Ratings sites will take down reviews that use profanity or can be proven fake, but they typically won't edit or remove a review simply because a doctor (or any business) disputes what is in it; and

Whereas, Critics of public airing of patient comments argue that it puts a doctor in an untenable position because federal privacy laws such as HIPAA prohibit doctors from compromising patient confidentiality by responding directly to a patient's complaint, leaving physicians with limited ability to rebut complaints; and

Whereas, Physicians are uniquely vulnerable to public criticism and potential adverse publicity regarding their professional abilities and find this extremely unfair and unjust; and

Whereas, Change.org (a petition website operated by for-profit Change.org, Inc., which hosts sponsored campaigns for organizations and serves to facilitate petitions by the general public) has posted a petition signed by over 42,000 physicians calling for an immediate end to online reviews of ALL doctors and providers who are subject to HIPAA and medical privacy laws, stating further that reviews should not be posted until physicians can defend themselves or respond; and

Whereas, The problem of addressing unfair online reviews is faced by physicians throughout the country transcending regions and states; therefore be it

RESOLVED, That our American Medical Association take action that would urge online review organizations to create internal mechanisms ensuring due process to physicians before the publication of negative reviews. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 10/12/20

* 2015 survey of 1,438 patients by Software Advice, a software research and advisory firm.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(November 2020)

Introduced by: Virginia

Subject: A Resolution to Amend the AMA's Physician and Medical Staff Bill of Rights

Referred to: Reference Committee G

Whereas, According to the *Washington Post*, approximately 77,800 health care workers have tested positive for the coronavirus[1], but data collected by the Centers for Disease Control and Prevention suggests higher rates of infection for HCP's at 142,946 cases and 705 deaths as of August 23, 2020[2]; and

Whereas, The shortage of personal protective equipment, as a contributing factor to the infection and deaths of frontline workers, has been noted on multiple occasions. Occurrences where organizations and hospitals have disciplined health workers for failure to comply with restrictions on the use of PPE mandated by limited supply have also been documented in multiple cases including in Virginia. In the absence of adequate supplies of PPE health care workers are struggling with ethical decisions about how to provide safe care for their patients, themselves, their families and their communities. They should not have to make these in isolation; and

Whereas, Beauchamp and Childress have articulated 4 principals of medical ethics; autonomy, non-malfeasance, beneficence and justice[3]. The Emergency Medicine Society adds virtue and teamwork. For the individual provider ethical questions include: What is my ethical duty to care for patients during the pandemic and in the absence of having proper PPE? If I am in a high-risk group due to age or medical history, should I continue to care for patients in the absence of having proper PPE? If I live with family members who are in a high-risk group due to age or medical history, should I continue to care for patients in the absence of having proper PPE? If I believe that I might be spreading the virus to patients, patient family members, colleagues and/or community members, should I continue to care for patients in the absence of having proper PPE?; and

Whereas, The individual provider interfaces with, and is dependent on, organizations such as hospitals and health plans that provide supplies and dictate standards for distribution. The organizations are, in turn, dependent on governmental structures that establish legislation and public health policy that can facilitate, or limit, the clinician's ability to provide necessary and safe care to the patient and the community; and

Whereas, The IOM report of 2008 addressed issues altering adherence to PPE protocols distinguishing 1. Individual factors (i.e. knowledge and beliefs) 2. environmental factors (i.e. availability of equipment and negative pressure rooms) and 3. Organizational factors (i.e. workplace policies); and

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[1] https://www.washingtonpost.com/graphics/2020/health/healthcare-workers-death-coronavirus/

[2] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

[3] Beauchamp T, Childress J. Principles of Biomedical Ethics, 7th Edition. New York: Oxford University Press, 2013.

Whereas, The ethics of governmental support via the public health, policy and legislative sectors has come to light recently as the glaring deficiencies have been revealed with the recent pandemic. OSHA has not set enforceable standards. Workers may refuse to work but have no guarantee of job protection if they refuse. State rules on unemployment insurance my limit rights of those who refuse to work; and

Whereas, CDC provided guidelines for optimizing supply in a period of shortage but logistics and supply lines were not in the purview of this agency. There was discussion of enactment the Defense Production Act without action. It is to be hoped that policies would be scientific and ethical as well as coherent, however, uncoordinated policies across multiple agencies have failed to provide required equipment and services. Physicians have had to resort to personal appeals for donations of equipment; therefore be it

RESOLVED, That our American Medical Association amend Policy H-225.942, "Physician and Medical Staff Member Bill of Rights" by addition to read as follows:

Physician and Medical Staff Member Bill of Rights H-225.942

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patient's best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

<u>The AMA recognizes the responsibility to provide for the delivery of high quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body, and relies on accountability and inter-dependence with government and public health agencies that regulate and administer to these organizations.</u>

The AMA supports the right to advocate without fear of retaliation by the health care organization's administrative or governing body including the right to refuse work in unsafe situations without retaliation.

The AMA believes physicians should be continuously provided with the resources necessary to continuously improve patient care and outcomes and further be permitted to advocate for planning and delivery of such resources not only with the health agency but with supervising and regulating government agencies.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organizations governing body.
b. The responsibility to provide leadership and work collaboratively with the health care organizations administration and governing body to continuously improve patient care and outcomes.
c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

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

a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organizations administration or governing body.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organizations governing body.

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

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

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

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

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organizations administration or governing body.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/14/20

RELEVANT AMA POLICY

Physician and Medical Staff Member Bill of Rights H-225.942
Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:
Preamble
The organized medical staff, hospital governing body and administration are all integral to the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.
The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.
Medical staff self-governance is vital in protecting the ability of physicians to act in their patients best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.
From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:
I. Our AMA recognizes the following fundamental responsibilities of the medical staff:
a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organizations governing body.
b. The responsibility to provide leadership and work collaboratively with the health care organizations administration and governing body to continuously improve patient care and outcomes.
c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.
II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staffs ability to fulfill its responsibilities:
a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organizations administration or governing body.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organizations governing body.
f. The right to engage the health care organizations administration and governing body on professional matters involving their own interests.

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

a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization.
e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

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

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organizations administration or governing body.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(November 2020)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Prevent Medicare Advantage Plans from Limiting Care

Referred to: Reference Committee G

Whereas, There are Medicare guidelines for most treatments for patients including appropriate diagnoses for admission to inpatient rehabilitation units and criteria for procedures; and

Whereas, Medicare Advantage plans do not consistently follow Medicare guidelines meaning that patients who are insured by Medicare Advantage plans do not receive the same level of treatment as patients insured by standard Medicare; and

Whereas, When asked about denial of services, the Medicare Advantage plans state that Medicare guidelines ALLOW them to approve a service but do not REQUIRE them to do so; and

Whereas, Medicare Advantage plans often use proprietary criteria (such as Milliman and InterQual) or NaviHealth algorithms to determine eligibility of Medicare beneficiaries for procedures and admissions to hospitals and IRF's, which is an additional layer that limits access to services and often does not agree with the professional judgement of the patient's physician; therefore be it

RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services to more tightly regulate Medicare Advantage Plans so that Medicare guidelines are followed for all Medicare patients and care is not limited for patients who chose an Advantage Plan (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that applying proprietary criteria to determine eligibility of Medicare patients for procedures and admissions should not overrule the professional judgment of the patient's physician. (Directive to Take Action)

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

Received: 10/13/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(November 2020)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Increase Insurance Company Hours for Prior Authorization for Inpatient Issues

Referred to: Reference Committee G

Whereas, Acute care hospitals are open 24 hours a day every day of the year, including holidays and weekends; and

Whereas, Patients are admitted and discharged from hospitals 365 days a year; and

Whereas, Physicians working in hospitals are there to evaluate and treat patients 365 days a year; and

Whereas, Prior authorization is required by most insurance companies to admit patients to inpatient rehabilitation facilities and skilled nursing facilities for further rehabilitation before returning home; and

Whereas, Insurance companies close their offices from Friday noon to Monday morning and even longer around holidays (Thanksgiving from Wednesday noon until Monday morning); and

Whereas, These limited office hours adversely affect patient care as the delay in prior authorization either keeps the patient in the acute hospital more days than necessary or causes discharge to an inappropriate location due to pressures about length of stay; and

Whereas, Current House Bill, H.R. 3107: Improving Seniors' Access to Timely Care, provides for the Medicare Advantage (MA) Prior Authorization Program to “provide real-time decisions with respect to requests identified by the Secretary [...] if such requests contain all information required by an MA plan; therefore be it

RESOLVED, That our American Medical Association advocate that all insurance companies that require prior authorization for patients in acute care hospitals have prior authorization staff available to do approvals for hospitalized patients every day of the year, including holidays and weekends. (Directive to Take Action)

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

Received: 10/13/20