AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(November 2020)

Introduced by: Organized Medical Staff Section

Subject: Crisis Payment Reform Advocacy

Referred to: Reference Committee B

Whereas, The American Medical Association's commitment to improving physician professional satisfaction and practice sustainability is a cornerstone of AMA's strategic plan and the AMA has developed policies supporting physician well-being; and

Whereas, Physicians are part of the 'safety net' of society as essential elements of the health care system of the United States. Loss of access to regular outpatient settings will lead to increased use of far more expensive emergency facilities. Insurers should fund MDs from savings garnered from reduction in outlays on care not delivered because of COVID-19, as they have shown exists by refunding policyholders[1]; and

Whereas, Lessons of COVID-19 reveal the fragile condition of many medical practices and health care institutions operating under narrow economic margins. Smaller practices, in particular, are at great risk from disruption in revenue streams, including related to volume of service (not) rendered, risk withholds and other incentive payments. More frequent, regular basic payments for patient care and more frequent incentive payments than yearly may partly attenuate that risk[2-6]; and

Whereas, Loss of independent practices likely will lead to more physicians working for a system, risking reduced medical professional control over quality of care, reduced access to medical care in certain areas, as well as potentially the attenuation of the doctor-patient relationship[7-8]; and

Whereas, Prior authorization as currently, indiscriminately, practiced siphons off clinical care time and support staff resources, creating expense at the point of service level, while frequently delaying or denying necessary care. Eliminating routine prior authorization would relieve both issues[9]; and

Whereas, Insufficient payment for episodes of care put further strain on both quality of care and survival of the individual medical practice[10]; and

Whereas, A 'real-time economic partnership' of physicians and third party payers could be one concept to settle health care system fragility, especially if coupled with a smaller feedback loop between the parties[11-12]; and

Whereas, Telehealth has been shown to be an effective means of delivering care to a large segment of the population, though for many others is not as effective, giving rise to a need for defining the appropriate use of telehealth going forward[13-15]; and

Whereas, Resource allocation planning to meet crises (e.g., ventilators, personal protective equipment, vaccine distribution) would be more likely to be effective if it included physicians and other health care providers as core participants, who should also be indemnified for that service[16]; and

Whereas, In an evolving health care system, inclusive of natural challenges and technological advances, the design of the medical office/clinic environment likely needs revision to remain efficient clinically and economically[17-20]; and

Whereas, Time-sensitive, accurate testing for communicable disease is important in the medical as well as social environment, along with access to adequate personal protective equipment (PPE)[21]; and

Whereas, Political gridlock has truncated governmental support of health care with no assurance of adequate funding going forward; therefore be it

RESOLVED, That our American Medical Association promote national awareness of the loss of physician medical practices due to COVID-19 that will disrupt healthcare availability to many patients (Directive to Take Action); and be it further

RESOLVED, That our AMA: (1) promote reform in our health care payment system that supports and sustains physician medical practices not only under routine circumstances but also in an extended crisis situation such as COVID-19; (2) advocate for, as a priority directive, a blueprint for action along those lines to the newly installed Presidential administration and Congress in early 2021 and beyond; and (3) monitor and aim to improve, along with other stakeholders, any new health care initiative(s) in a contemporaneously effective manner. (Directive to Take Action)

Fiscal Note: not yet determined

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RELEVANT AMA POLICY

Pandemic Preparedness for Influenza H-440.847

In order to prepare for a potential influenza pandemic, our AMA: (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, vaccine, drug, and data management capacity to prepare for and respond to an influenza pandemic or other serious public health emergency; (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH) and other appropriate federal agencies, to support implementation of an expanded capacity to produce the necessary vaccines and anti-viral drugs and to continue development of the nation's capacity to rapidly vaccinate the entire population and care for large numbers of seriously ill people; and (b) to bolster the infrastructure and capacity of state and local health department to effectively prepare for, respond to, and protect the population from illness and death in an influenza pandemic or other serious public health emergency; (3) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an influenza epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of physicians and medical office staff in ambulatory care settings; (4) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) take immediate action to assure that physicians, nurses, other health care professionals, and first responders having direct patient contact, receive any appropriate vaccination in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care providers; (6) will monitor progress in developing a contingency plan that addresses future influenza vaccine production or distribution problems and in developing a plan to respond to an influenza pandemic in the United States.
Citation: CSAPH Rep. 5, I-12; Reaffirmed: A-15

Domestic Disaster Relief Funding D-130.966
1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.
2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.
Citation: Res. 421, A-11; Reaffirmed: A-15

Emergency Preparedness D-130.974
Our AMA (1) encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children, the indigent, and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the Public Health Service, the Department of Health and Human Services, the Department of Homeland Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency.
Citation: Sub Res. 803, I-05; Reaffirmed: A-06; Reaffirmed: BOT Rep. 2, A-07; Reaffirmed in lieu of Res. 938, I-11; Modified: BOT action in response to referred for decision Res. 415, A-12

Hospital Disaster Plans and Medical Staffs H-225.941
Our AMA encourages: (1) appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community.
Citation: Res. 916, I-17