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**The following is a preliminary report of actions taken by the House of Delegates at its November 2020 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (November 2020 Meeting)

Report of Reference Committee G

Nicolas Argy, MD, JD, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:
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3 **RECOMMENDED FOR ADOPTION**
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5 1. Board of Trustees Report 17 – Hospital Website Voluntary Physician Inclusion
6 2. Council on Medical Service Report 2 – Mitigating the Negative Effects of High-
7 Deductible Health Plans
8 3. Council on Medical Service Report 4 – Economic Discrimination in the Hospital
9 Practice Setting
10
11 **RECOMMENDED FOR ADOPTION AS AMENDED**
12
13 4. Resolution 712 – Increase Insurance Company Hours for Prior Authorization for
14 Inpatient Issues
15
16 **RECOMMENDED FOR REFERRAL**
17
18 5. Resolution 710 – A Resolution to Amend the AMA's Physician and Medical Staff
19 Bill of Rights

Click here to submit an amendment.

# RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 17 - HOSPITAL WEBSITE VOLUNTARY PHYSICIAN INCLUSION

**RECOMMENDATION:**

**Recommendations in Board of Trustees Report 17 be adopted and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Board of Trustees Report 17 adopted and the remainder of the report filed.**

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)

Your Reference Committee heard testimony that was supportive of Board of Trustees Report 17. In introducing the report, a member of the Board of Trustees explained that the issue raised by Resolution 819-I-19 is complicated by the lack of any identifiable local, state, or federal regulatory requirement around listing physicians on websites, outside of reporting on quality metrics. Moreover, a review of the ten largest hospitals failed to return any actionable information about their internal policies for listing physicians on websites. At the same time, the issue raised by Resolution 819-I-19 is a matter of fairness and importance to many independent physicians and found to be an issue in many localities across the country; the report recommendations were thought to alleviate the concerns raised in Resolution 819-I-19. Several delegates testified in support of the report. One amendment proposing an addition to recommendation 1, asking for distinctions relevant to practice availability, was proffered, but your Reference Committee believes that the addition is unnecessary. The articulated intention of the amendment is well-addressed by the current report recommendations, specifically in recommendation 1, part 2, which allows physicians to provide input on what information is published. Therefore, your Reference Committee recommends that Board of Trustees Report 17 be adopted.

(2) COUNCIL ON MEDICAL SERVICE REPORT 2 - MITIGATING THE NEGATIVE EFFECTS OF HIGH-DEDUCTIBLE HEALTH PLANS

**RECOMMENDATION:**

**Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Council on Medical Service Report 2 adopted and the remainder of the report filed.**

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)

Your Reference Committee heard testimony that was supportive of Council on Medical Service Report 2. In introducing the report, a member of the Council on Medical Service highlighted that the recommendations of the report would expand the AMA's leadership in mitigating the negative impacts of high-deductible health plans (HDHPs) by encouraging ongoing research, advocacy, and collaboration. Testimony explored Resolution 125-A-19's requested exemption of outpatient evaluation and management services from deductible payments. An author of Resolution 125-A-19 testified in favor of CMS Report 2, stating that the report is well-written and provides a strong explanation of the potential for unintended consequences if certain services are exempt from deductibles. While amendments were offered regarding delivery system collaboration, network adequacy, and fair and equitable compensation, a member of the Council on Medical Service explained that the offered amendments focused on concerns that are addressed by other AMA policy, and the offered amendments would detract from the specific goals of the report. Your Reference Committee agrees that strong AMA policy responds to concerns raised in the proposed amendments (e.g. AMA Policies D-385.963 Health Care Reform Physician Payment Models and H-285.908 Network Adequacy), and that the recommendations set forth in CMS Report 2 are appropriately crafted in broad terms to provide enduring advocacy guidance. Therefore, your Reference Committee recommends that Council on Medical Service Report 2 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - ECONOMIC DISCRIMINATION IN THE HOSPITAL PRACTICE SETTING

**RECOMMENDATION:**

**Recommendations in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.**

**HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted and the remainder of the report filed.**

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 718-A-19 and that 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)

Testimony on Council on Medical Service Report 4 was unanimously supportive. A member of the Council on Medical Service introduced the report stating that its report recommends actively opposing any 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. Additionally, 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 to hospital employment status.

An amendment was offered to the first recommendation to add language stating that the AMA oppose policies that limit a physician's access to hospital services based on the number of procedures performed beyond those needed to ensure clinical competence and quality outcomes. The stated rationale for the amendment was to provide a baseline of competency and quality in the interest of patient safety. The Council on Medical Service responded to the amendment asking that the report's original language be retained and not amended. The Council noted that questions of clinical competence and quality are valid but are assessed in other ways besides volume. The Council went on to state that the proposed amendment and qualifications in the language can be used as loopholes for economic credentialing and can disproportionately harm access in rural and community hospitals. Additional testimony echoed the Council's concerns with the amended language, and your Reference Committee finds this testimony persuasive.

Additional testimony noted that, at times, a relationship exists between volume and outcomes. Your Reference Committee agrees. However, a physician's work and therefore volume may be spread across multiple hospitals. Moreover, your Reference Committee notes that this report applies not only to those physicians practicing in large systems but also those practicing in rural areas and that many factors influence patient safety and outcomes. Therefore, your Reference Committee recommends that Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

# RECOMMENDED FOR ADOPTION AS AMENDED

(4) RESOLUTION 712 - INCREASE INSURANCE COMPANY HOURS FOR PRIOR AUTHORIZATION FOR INPATIENT ISSUES

**RECOMMENDATION A:**

**Resolution 712 be amended by addition and deletion as follows:**

**RESOLVED, That our American Medical Association advocate that all insurance companies and benefit managers that require prior authorization ~~for patients in acute care hospitals~~ have ~~prior authorization~~ staff available to process ~~do~~ approvals ~~for hospitalized patients~~ 24 hours a day, every day of the year, including holidays and weekends. (Directive to Take Action)**

**RECOMMENDATION B:**

**Resolution 712 be adopted as amended.**

**RECOMMENDATION C:**

**The title of Resolution 712 be changed to read:**

**~~INCREASE INSURANCE COMPANY HOURS FOR PRIOR AUTHORIZATION~~**
**PROCESSING PRIOR AUTHORIZATION DECISIONS**

**HOD ACTION: Resolution 712 adopted as amended with change in title.**

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)

Testimony on Resolution 712 was unanimously supportive. A few amendments were made to increase the scope of the resolution, which received widespread support. A member of the Council on Medical Service testified to broaden the resolution to include benefit managers and not only health insurers in the proposed policy. Additionally, the Council suggested an amendment that all insurance companies requiring prior authorization should have staff available to do approvals 24/7. Testimony highlighted that health care is 24/7. As such, it is imperative that health insurers who require prior authorization enable this to be obtained 24/7. Current limitations in operating hours lead to delays in prior authorization, impede timely transitions of care, delay approval for

interventions, and can result in adverse outcomes. Your Reference Committee agrees and recommends these amendments be adopted.

The Council on Medical Service also called to broaden this resolution by striking the mention of acute care hospitals and hospitalized patients thereby broadening the resolution to apply to both inpatient and outpatient settings. This amendment garnered considerable support. A few speakers questioned whether the broadening of the resolution beyond inpatient prior authorization was necessary. In response, a member of the Council on Medical Service highlighted that the lines between inpatient and outpatient are not always clearly delineated and that care status can exist on a continuum. For example, some speakers stated that hospitalized patients may have "outpatient" status while in psychiatric observation or those patients in extended recover after surgery, among other examples. Your Reference Committee believes that the designation between inpatient and outpatient is far less important than the issue of whether prior authorization is provided in a timely manner due to its affect on patient safety and quality, which your Reference Committee finds to be the underlying principle of Resolution 712. Accordingly, your Reference Committee recommends accepting the Council on Medical Service's amendment to broaden Resolution 712 to include all prior authorizations.

Further testimony asked that the Reference Committee consider the issue of prior authorization appeals. However, your Reference Committee finds this issue outside of the scope of Resolution 712 and highlights significant AMA policy on the issue of prior authorization appeals (See AMA Policies H-320.939 Prior Authorization and Utilization Management Reform, H-390.982 Payer Accountability, D-320.988 Preauthorization, and H-285.998 Managed Care). Another speaker brought up the issue of Peer Review Prior Authorization, and the Reference Committee notes that the Council on Medical Service has a forthcoming report on peer review prior authorization and therefore does not need to be addressed in Resolution 712. In addition, one speaker testified for model legislation on this issue. However, your Reference Committee notes that there is significant ongoing advocacy by the AMA regarding prior authorization, including at a state level.

Your Reference Committee agrees with the overwhelming supportive testimony on Resolution 712 and the proposed amendments to broaden its scope because all health care delivery is 24/7. Accordingly, your Reference Committee recommends that Resolution 712 be adopted as amended with a change in title to reflect the recommended amendments.

# RECOMMENDED FOR REFERRAL

(5) RESOLUTION 710 - A RESOLUTION TO AMEND THE AMA'S PHYSICIAN AND MEDICAL STAFF BILL OF RIGHTS

**RECOMMENDATION:**

**Resolution 710 be referred.**

**HOD ACTION: Resolution 710 referred.**

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.

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.

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)

Your Reference Committee heard testimony that overwhelmingly supported referral of Resolution 710, including the Resolution author, the Organized Medical Staff Section delegate, and a member of the Council on Medical Service. Other testimony was in support of Resolution 710 or offered amendments, but most speakers urged referral of Resolution 710. In recommending referral of Resolution 710, several delegates highlighted the complexity of the issues raised, including the fact that physicians practice in settings that assume varying degrees of inherent risk, and that while these issues are especially timely during the COVID-19 pandemic, the Physician and Medical Staff Member Bill of Rights is much broader and will endure into the future. Therefore, your Reference Committee recommends that Resolution 710 be referred so that this issue can be further studied and the resulting policy language be crafted with precision.

1 Mister Speaker, this concludes the report of Reference Committee G. I would like to thank
2 John Antalis, MD, Stuart Greenstein, MD, Virginia Hall, MD, Woody Jenkins, MD, Pratistha
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