

Integrated Physician Practice Section (IPPS) Meeting Handbook

The following includes policy items for discussion during the IPPS meeting.

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- IPPS Res 01, Audio-only Telehealth for Risk Adjusted Payment Models
- IPPS Res 02, Developing Best Practices for Prospective Payment Models
- IPPS Report A (includes HOD items of interest to the IPPS)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 01
(June 2021)

Introduced by: Integrated Physician Practice Section

Subject: Audio-only Telehealth for Risk Adjusted Payment Models

1 WHEREAS, Telehealth services, including audio-only, have expanded dramatically during the
2 COVID-19 Public Health Emergency (PHE) and now remain central to continuity of care while
3 the Centers for Medicare and Medicaid Services (CMS) estimates up to 30% of visits during the
4 pandemic have been audio-only¹; and

5
6 WHEREAS, Audio-only telehealth services have been critical to delivering healthcare to the
7 underserved, and thus limiting audio-only telehealth services exacerbates health inequities.
8 According to one study, during the pandemic, federally qualified health center audio-only visits
9 accounted for 65.4% for all primary care visits and 71.6% of behavior health visits²; while
10 another found that patients of all ages, races, payment types, and geographical locations
11 accessed care using a telephone only³; and

12
13 WHEREAS, in 2018, the Federal Communications Commission (FCC) estimated that one-
14 quarter of rural Americans—and one-third of Americans living on tribal lands—did not have
15 access to broadband. Due to the lack of broadband availability, tens of millions of rural
16 Americans aren't able to "see" their doctor during a telehealth visit⁴.

17
18 WHEREAS, Lack of access to broadband services in underserved settings both urban and rural
19 may result in audio-only care for patients with complex medical problems that may not be
20 considered for risk adjustment; and

21
22 WHEREAS, While Medicare Advantage has allowed both audio and audio/video telehealth
23 services, audio-only has not been allowed for risk adjustment, which impairs appropriate funding
24 for health care delivery to the most vulnerable; and

25
26 WHEREAS, Our AMA has existing policy that states "telemedicine services should be covered
27 and paid for" under appropriate circumstances (H-480.946), "support and advocate with all
28 payers the right of physicians to obtain payment for telephone calls not covered by payments for
29 other services" (H-390.889), as well as support of the "use of telehealth to reduce health
30 disparities and promote access to health care" and "equitable coverage that allows patients to
31 access telehealth services wherever they are located" (D-480.963), there is not specific policy to

¹ Verma, S. Early Impact of CMS Expansion of Medicare Telehealth During COVID-19. Health Affairs Blog 2020. <https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/>

² Uscher-Pines L, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. JAMA. 2021;325(11):1106-1107.

³ Koma, W., Cubanski, J. & Neuman, T. Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. Kaiser Family Foundation. May 19, 2021. Accessed on May 19: <https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/>

⁴ Federal Communications Commission, FCC 18-181, December 12, 2018. Accessed: <https://docs.fcc.gov/public/attachments/FCC-18-181A1.pdf>

1 allow audio-only telehealth services to be used for diagnosis submission in risk adjusted models
2 outside of a fee-for-service system.

3

4 RESOLVED: That our AMA advocate that audio-only telehealth encounter diagnoses be
5 included in risk adjusted payment models. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 4/2/21

AUTHOR'S STATEMENT OF PRIORITY

AMA advocacy staff speculate that the best hope for Congressional action on important Medicare payment decisions related to telehealth will be through a legislative mega-package at the end of September or calendar year. Either way, the legislative language is being drafted now and it is important for the HOD to establish the proposed new policies to help guide AMA advocacy. The request for the AMA to advocate specifically for audio-only telehealth for purposes of determining patient risk in risk adjusted payment models, is a distinct area of focus not covered under existing telehealth policy. All physicians participating in Medicare Advantage and other risk-adjusted models are impacted by this issue.

RELEVANT AMA POLICY

Medicare Reimbursement of Telephone Consultations H-390.889

It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; (2) continue to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services; (3) continue to work with CMS, other third party payers and appropriate medical specialty societies to establish the criteria by which certain telephone calls would be considered separate services for payment purposes; (4) request the CPT Editorial Panel to identify or consider developing the additional service code modifiers that may be required to certify specific types of telephone calls as separate from other services; and (5) seek enactment of legislation as needed to allow separate Medicare payment for those telephone calls that can be considered discrete and medically necessary services performed for the patient without his/her presence.

Citation: CMS Rep. N, A-92; Reaffirmed: Res. 122, I-97; Reaffirmed: A-99; Reaffirmed: I-99; Reaffirmed: A-01; Reaffirmed: A-07; Reaffirmed in lieu of Res. 824, I-11

Coverage of and Payment for Telemedicine H-480.946

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
 - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
 - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
 - Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the

identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

- b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
- c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
- d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
- e) The delivery of telemedicine services must be consistent with state scope of practice laws.
- f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
- g) The standards and scope of telemedicine services should be consistent with related in-person services.
- h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
- i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
- j) The patient's medical history must be collected as part of the provision of any telemedicine service.
- k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
- l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
- m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CMS Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmed: A-18; Reaffirmed: CMS Rep. 1, I-19

COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Citation: Alt. Res. 203, I-20

Improving Risk Adjustment in Alternative Payment Models H-385.907

Our AMA supports: (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications; (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost; (3) risk adjustment systems that use risk corridors that use fair and accurate

payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy.

Citation: CMS Rep. 03, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 02
(June 2021)

Introduced by: Integrated Physicians Practice Section

Subject: Developing Best Practices for Prospective Payment Models

1 WHEREAS, The COVID-19 pandemic has reduced visits and revenues for all specialties,
2 especially primary care; and

4 WHEREAS, During the pandemic, as financial losses mounted in practices relying primarily on
5 fee-for-service payments, preliminary studies found that systems operating under full
6 prospective payment models and partial prospective payment models appear to have fared
7 better; and

9 WHEREAS, The reduction in fee for service payments is a threat to physician practice financial
10 sustainability; and

12 WHEREAS, The Centers for Medicare and Medicaid Services (CMS) has promulgated value-
13 based payment mechanisms and prospective payment models such as diagnosis-related
14 groups and global payments; however it has been difficult for physicians and health systems to
15 manage the tension between these models and effectively implement them; and

17 WHEREAS, Significant barriers to moving toward prospective payment persist, such as
18 ensuring correct attribution of patients to a particular physician, and

20 WHEREAS, Global capitation may not work well in health systems that enter into various
21 contracts to provide different contracted services to different patients, and

23 WHEREAS, Medicare Advantage patients benefit from physician access to and use of plan data
24 and more robust risk-adjusted budgets that allow physicians and health systems to develop
25 programs that improve care and decrease total expenditures; and

27 WHEREAS, CMS's method of setting the base in the prospective payment models is flawed
28 because it is based on a health system's own benchmark, thus disincentivizing highly efficient
29 systems to move toward prospective payment; and

31 WHEREAS, The COVID-19 pandemic has precipitated a change in health care delivery and
32 physician practice that creates opportunities to redesign physician practice and payment
33 models; and

35 WHEREAS, Prospective payment or some permutation of advance payment can be an effective
36 payment arrangement that may also help sustain health systems and physician practice; and

38 WHEREAS, Our AMA has the representative credibility and resources to design and advocate
39 in this process; therefore, be it

40

1 RESOLVED, That our AMA study and identify best practices for financially viable models for
2 prospective payment health insurance, including but not limited to appropriately attributing and
3 allocating patients to physicians, elucidating best practices for systems with multiple payment
4 contracts, and determining benchmarks for adequate infrastructure, capital investment, and
5 models that accommodate variations in existing systems and practices (Directive to Take
6 Action); therefore be it also
7
8 RESOLVED, That our AMA use recommendations generated by its research to actively
9 advocate for expanded use and access to prospective payment models (Directive to Take
10 Action).

Fiscal Note: Not yet determined

Received: 4/14/21

AUTHOR'S STATEMENT OF PRIORITY

Physician practices and health systems in a fee-for-service payment model suffered immense financial loses during 2020. Inversely, physicians and systems using prospective payment models were shielded or had some measure of protection from the financial ravages of COVID. Many barriers still exist to PPM. To help physicians succeed in PPM and to safeguard against further financial loses, the AMA should act now to develop best practices for prospective payment models.

RELEVANT AMA POLICY

Medicare Prospective Payment System for Skilled Nursing Facilities H-280.956

Our AMA: (1) advocates for the prospective payment systems being developed by CMS for skilled nursing facilities and home health agencies accurately reflect the costs of care for patients with multiple comorbidities and high medical complexity; and (2) advocates that CMS, the Medicare Payment Advisory Commission, and the Congress monitor the effects of the home health interim payment system and the new prospective payment systems on quality of care and patient access to medically necessary services.

Citation: Sub. Res. 108, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

Prospective Payment System and DRGs for Physicians H-390.992

The AMA (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost and access to medical care have been adequately evaluated.

Citation: Sub. Res. 70, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: A-05; Reaffirmed: I-13

REPORT OF THE INTEGRATED PHYSICIAN PRACTICE SECTION
GOVERNING COUNCIL

GC IPPS Report A- IPPS June 2021 Meeting

Subject: IPPS Review of House of Delegates Resolutions & Reports

Presented by: Michael Glenn, MD, Chair

1 IPPS Governing Council Report A identifies resolutions and reports relevant to integrated health
2 care delivery groups or systems that have been submitted for consideration at the AMA House of
3 Delegates (HOD) at the June 2021 Meeting. This report is submitted to the Assembly for further
4 discussion and to facilitate the instruction of the IPPS Delegate regarding the positions to take in
5 representing the Section in the HOD.

6

7

8 **REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS**
9 **(AMA CONSTITUTION, AMA BYLAWS, ETHICS)**

10

11 **No items under consideration by Reference Committee on Amendments to the Constitution**
12 **and Bylaws**

13

14

15 **REFERENCE COMMITTEE A (MEDICAL SERVICE)**

16

17 **(1) Resolution 102 – Bundling Physician Fees with Hospital Fees**
18 **Introduced by: New York**

19

20 RESOLVED, That our American Medical Association oppose bundling of physician payments with
21 hospital payments, unless the physician has agreed to such an arrangement in advance. (New HOD
22 Policy)

23

24 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the***
25 ***AMA House of Delegates be instructed to support the intent of Resolution 102.***

26

27 **(2) Resolution 110 – Healthcare Marketplace Plan Selection**
28 **Introduced by: Georgia**

29

30 RESOLVED, That our American Medical Association advocate for patients to have expanded plan
31 options on the Healthcare Marketplace beyond the current options based solely on the zip code of
32 their primary residence or where their physician practices, including the interstate portability of
33 plans. (Directive to Take Action)

34

35 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the***
36 ***AMA House of Delegates be instructed to oppose the intent of Resolution 110.***

37

38 **(3) Resolution 113 - Support for Universal Internet Access**
39 **Introduced by: Medical Student Section**

1 RESOLVED, That our American Medical Association amend policy H-478.980, "Increasing Access
2 to Broadband Internet to Reduce Health Disparities," by addition and deletion to read as follows:
3

4 **INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES,**
5 H-478.980

6

- 7 1. Our AMA recognizes internet access as a social determinant of health and will advocate for
8 universal and affordable access to the expansion of broadband and high-speed and wireless
9 internet and voice connectivity, especially in to all rural and underserved areas of the United
10 States while at all times taking care to protecting existing federally licensed radio services
11 from harmful interference that can be caused by broadband and wireless services.
- 12 2. Our AMA will advocate for federal, state, and local policies to support infrastructure that
13 reduces the cost of broadband and wireless connectivity and covers multiple devices and
14 streams per household. (Modify Current HOD Policy)

15

16 ***Recommendation: The Governing Council recommends that the AMA-Assembly discuss.***

17

18 **REFERENCE COMMITTEE B (LEGISLATION)**

19

20 **(4) BOT 14 – Pharmaceutical Advertising in Electronic Health Record Systems**

21

22 The Board of Trustees recommends that Policy D-478.961 be amended as follows and the remainder
23 of the report be filed:

24

25 Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic
26 health records (EHR); and (2) opposes direct-to-prescriber pharmaceutical and promotional content
27 in medical reference and e-prescribing software, unless such content complies with all provisions in
28 Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices (H
29 105.988); and (3) encourages the federal government to study of the effects of direct-to-physician
30 prescriber advertising at the point of care, including advertising in Electronic Health Record Systems
31 (EHRs), on physician prescribing, patient safety, data privacy, health care costs, and EHR access for
32 small-physician practices; and (2) will study the prevalence and ethics of direct to physician
33 advertising at the point of care, including advertising in EHRs.

34

35 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the***
36 ***AMA House of Delegates be instructed to support the intent of BOT 14.***

37

38 **(5) Resolution 201 - Ensuring Continued Enhanced Access to Healthcare via Telemedicine**
39 **and Telephonic Communication**

40 **Introduced by: Maryland**

41

42 RESOLVED, That our American Medical Association address the importance of at least a 365-day
43 waiting period after the COVID-19 public health crisis is over before commencement of audits aimed
44 at discovering the use of non-HIPAA compliant modes and platforms of telemedicine by physicians.
45 (Directive to Take Action)

46

47 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the***
48 ***AMA House of Delegates be instructed to support the intent of Resolution 201.***

1 **(6) Resolution 204 - Insurers and Vertical Integration**

2 **Introduced by: New York**

3

4 RESOLVED, That our American Medical Association seek legislation and regulation to prevent
5 health payers (except non-profit HMO's) from owning or operating other entities in the health care
6 supply chain. (Directive to Take Action)

7

8 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the***
AMA House of Delegates be instructed to seek referral of Resolution 204.

10

11 **REFERENCE COMMITTEE C (MEDICAL EDUCATION)**

12 **No items under consideration by Reference Committee C.**

15 **REFERENCE COMMITTEE D (PUBLIC HEALTH)**

16 **No items under consideration by Reference Committee D.**

19 **REFERENCE COMMITTEE E (SCIENCE AND TECHNOLOGY)**

20 **No items under consideration by Reference Committee E.**

24 **REFERENCE COMMITTEE F (FINANCE)**

25 **No items under consideration by Reference Committee F.**

29 **REFERENCE COMMITTEE G (MEDICAL PRACTICE)**

30 **(7) Resolution 704 -Eliminating Claims Data for Measuring Physician and Hospital Quality**
31 **Introduced by: Oklahoma**

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

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

38

39 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the***
AMA House of Delegates be instructed to support the overall concept but seek referral of
Resolution 704.

1 **(8) Resolution 706 - Prevent Medicare Advantage Plans from Limiting Care**
2 **Introduced by: American Academy of Physical Medicine and Rehabilitation**
3

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

8 RESOLVED, That our AMA advocate against applying proprietary criteria to determine eligibility
9 of Medicare patients for procedures and admissions when the criteria are at odds with the professional
10 judgment of the patient's physician. (Directive to Take Action)

12 ***Recommendation: The Governing Council recommends that the AMA-IPPS Delegate to the
13 AMA House of Delegates be instructed to oppose the intent of Resolution 706.***

16 **(9) CMS 9 - Addressing Payment and Delivery in Rural Hospitals**

- 18 1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our
19 AMA to support state efforts to expand Medicaid eligibility as authorized by the Affordable
20 Care Act. (Reaffirm HOD Policy)
- 22 2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical
23 providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)
- 25 3. That our AMA support that public and private payers take the following actions to ensure
26 payment to rural hospitals is adequate and appropriate:
 - 28 a. Create a capacity payment to support the minimum fixed costs of essential services,
29 including surge capacity, regardless of volume;
 - 30 b. Provide adequate service-based payments to cover the costs of services delivered in
31 small communities;
 - 32 c. Pay for physician standby and on-call time to enable very small rural hospitals to deliver
33 quality services in a timely manner;
 - 34 d. Use only relevant quality measures for rural hospitals and set minimum volume
35 thresholds for measures to ensure statistical reliability;
 - 36 e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be
37 assessed due to low statistical reliability; and
 - 38 f. Create voluntary monthly payments for primary care that would give physicians the
39 flexibility to deliver services in the most effective manner with an expectation that some
40 services will be provided via telehealth or telephone. (New HOD Policy)
- 42 4. That our AMA encourages transparency among rural hospitals regarding their costs and
43 quality outcomes. (New HOD Policy)
- 45 5. That our AMA support better coordination of care between rural hospitals and networks of
46 providers where services are not able to be appropriately provided at a particular rural
47 hospital. (New HOD Policy)
- 49 6. That our AMA encourage employers and rural residents to choose health plans that
50 adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

1 *Recommendation: The Governing Council recommends that the AMA-IPPS Assembly*
2 *discuss.*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(JUN-21)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

1 Whereas, There is some thought about bundling the fees of physicians with those of the hospital
2 in which the services are provided; and
3
4 Whereas, Such "bundled" payments will go to the hospital which will then control the
5 payments; and
6
7 Whereas, Such a policy will likely make it not only harder for the physician to get paid, but also
8 much more dependent on the hospitals; and
9
10 Whereas, Hospitals would similarly never agree to bundled payments that went directly to
11 physicians; therefore be it
12
13 RESOLVED, That our American Medical Association oppose bundling of physician payments
14 with hospital payments, unless the physician has agreed to such an arrangement in advance.
15 (New HOD Policy)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

New York rates this resolution as a number one priority requiring action to ensure that physicians are compensated fairly and accurately. This issue is vital and affects all physicians who have a relationship of any type with a hospital or hospital system. Physicians have no visibility to bundled payments and cannot therefore verify that their share of a payment is paid properly. Only the hospital would have information about what share of a bundled payment belonged to the appropriate physician or the hospital. The proposed 17% share of the hospital payment is inadequate in terms of payment and does not specify how the bundled payment would be disbursed. Bundled payments to hospitals do not account for how many physicians were involved in the care of a hospitalized patient and would make it very difficult for practices to claim secondary or supplemental benefits under any coordinated benefits the patient might have. This would increase physician stress since income would be affected and increased time would be required on the part of physicians to verify that they are paid fairly. Data used for the purposes of Fairhealth cost estimates could be affected by bundling of payments to hospitals. This issue would have far-reaching consequences if implemented.

RELEVANT AMA POLICY

Health Care Reform Physician Payment Models D-385.963

1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

Citation: Sub. Res. 128, A-10; Appended: Res. 819, I-10; Appended: CMS Rep. 8, A-11; Appended: CMS Rep. 1, A-11; Reaffirmation A-11; Modified: BOT Rep. 18, A-12; Reaffirmation: I-12; Appended: Res. 702, A-13; Appended: Res. 827, I-14; Modified: Speakers Rep., I-15; Reaffirmed: CMS Rep. 09, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(JUN-21)

Introduced by: Georgia

Subject: Healthcare Marketplace Plan Selection

Referred to: Reference Committee A

1 Whereas, Insurance plans purchased on the Healthcare Marketplace often have very narrow
2 networks; and

3
4 Whereas, These narrow networks often require patients to only see physicians within the county
5 in which the plan was purchased; and

6
7 Whereas, Patients are required to purchase a plan based on the county in which they reside;
8 and

9
10 Whereas, Some patients must pay for care in cash outside their plan to keep their doctor of
11 choice making their comprehensive plan more of an expensive catastrophic plan; and

12
13 Whereas, This limits patient choice by preventing patients from choosing their plan based on
14 access to their physician of choice; therefore be it

15
16 RESOLVED, That our American Medical Association advocate for patients to have expanded
17 plan options on the Healthcare Marketplace beyond the current options based solely on the zip
18 code of their primary residence or where their physician practices, including the interstate
19 portability of plans. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The current Healthcare Marketplace plans often have very narrow networks affecting most physicians and their patients by limiting their patients' ability to choose a plan that includes their preferred physician. With patients currently required to purchase a plan based on the county in which they reside, this can result in the patients being unable to see their physician of choice if that physician does not practice in that county even if that physician practices in close proximity to the patient's residence. Ensuring that patients can utilize the physician of their choice is important in maintaining healthy patients who receive the right care at the right time. The AMA has no current policy regarding the expansion of plans that patients can choose from in the marketplace and the AMA is in the best position to advocate for these changes, especially for the many states that currently utilize the federally-run marketplaces. The public health is greatly improved where patients are able to access the physicians they are most comfortable with and this can also improve public health measures such as vaccination rates by improving patient confidence in the care they receive. Finally, with open enrollment typically occurring in late fall, any delay in adopting this policy would delay any possibility of implementing these changes to the marketplace until at least 2022, if not later.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(JUN-21)

Introduced by: Medical Student Section

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

1 I. Issues of internet access as a human right

2 Whereas, The United Nations has declared internet access as a human right¹; and

3

4 Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack

5 home internet access²; and

6

7 Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households

8 that make less than \$25,000 of annual income having access to internet as opposed to 93.5%

9 of households with over \$50,000 of annual income^{3,4}; and

10

11 Whereas, One in three families who earn less than \$50,000 annually do not have high-speed

12 home internet⁵; and

13

14 II. Broadband as a social determinant of health

15

16 Whereas, The United States congress defines broadband as a service that enables users to

17 originate and receive high-quality voice, data, graphics, and video telecommunications⁶; and

18

19 Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies

20 as broadband at 25mbps upstream and 3mpbs downstream^{7,8}; and

21

22 Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the

23 deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data

24 allowances, or latency for either fixed or mobile broadband services, because "[w]hile factors

25 such as data allowances or pricing may affect consumers' use of [broadband] or influence

26 decisions concerning the purchase of these services in the first instance, such considerations

27 do not affect the underlying determination of whether [broadband] has been deployed and made

28 available to customers in a given area."⁷; and

29

30 Whereas, Healthy People 2020 has identified internet access as a social determinant of health⁹;

31 and

32

33 Whereas, Internet access is critical for receiving telehealth services, accessing childhood

34 education, and applying for job opportunities, all of which contribute to health¹⁰⁻¹³; and

35

36 Whereas, During the current pandemic, telehealth and virtual education have become

37 necessary to promote health and well-being¹⁴; and

1 Whereas, A majority of government applications for programs and benefits which affect health
2 are available mostly or sometimes only online, especially during the COVID pandemic^{12,13,15,16};
3 and

4
5 Whereas, The AMA has committed itself to health equity and improving social determinants of
6 health, stating in H-65.960 that “optimizing the social determinants of health is an ethical
7 obligation of a civil society”; and

8
9 III. Broadband use in healthcare delivery

10 Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the
11 divide between patients with and without internet access¹⁷; and

12
13 Whereas, A study comparing the demographics of patients with completed telemedicine
14 encounters in the current COVID-19 era at a large academic health system found that those
15 with completed telemedicine video visits, when compared to telephone-only visits, were more
16 likely to be male (50% versus 42%; P=0.01), were less likely to be black (24% versus 34%;
17 P<0.01), and had higher median household income (21% versus 32% with income <\$50 000,
18 54% versus 49% with income of \$50 000–\$100 000, 24% versus 19% with income ≥\$100 000)¹⁸;
19 and

20
21 Whereas, A study commissioned by the US Chamber of Commerce found broadband has
22 helped to further broaden the scope of healthcare and has led to dramatic cost savings by
23 facilitating the fast and reliable transmission of critical health information, multimedia medical
24 applications, and lifesaving services to many parts of the country¹⁹; and

25
26 Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher
27 show rates, shorter wait times, increased clinical efficiency, and higher convenience – all
28 affecting quality of patient care^{20,21}; and

29
30 Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker
31 exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment
32 (PPE), and reduce use of hospital beds and other limited resources^{14,20}; and

33
34 IV. Broadband use in education

35 Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system,
36 forcing more than 55 million students to transition to home-based remote learning⁵; and

37
38 Whereas, One in five households with school-age children (ages 6-18), including 1.6 million
39 immigrant families, do not have personal broadband internet access at home during the COVID-
40 pandemic^{20,22}; and

41
42 Whereas, There are 4.6 million households with school aged children that access internet at
43 home solely through cell phones, and 1.5 million households with school aged children who
44 have no internet access of any kind at all, including cell phones²²; and

45
46 Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have
47 home internet access sufficient to support online learning during the COVID-19 pandemic²³; and

48
49 V. COVID-19 pandemic has exacerbated disparities in internet access

50 Whereas, The United States internet usage has increased 34% between January 2020 and
51 April 2020 during the COVID-19 pandemic²⁴; and

1 Whereas, The FCC Lifeline program provides a choice between either discounted mobile
2 internet access or discounted broadband access for qualifying low-income recipients²⁵; and
3
4 Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile
5 broadband services are full substitutes in all cases⁷; and
6
7 Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for
8 approximately 15 of the estimated 21.3 million people that lack home internet access^{26,27}; and
9
10 Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized
11 program for which there is a significant backlog in applications and delay in application
12 approvals, as well as a lack of an automatic application or automatic appeal process²⁵; and
13
14 Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still
15 only allows 1 stream of 25mbps per household, limiting access for households with more than
16 one person working/attending school from home²⁸; and
17
18 Whereas, In the 2020 legislative session as of October 2020, 43 states have considered
19 legislation on broadband access²⁹; and
20
21 Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in
22 light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered
23 government subsidized free broadband service for COVID impacted people^{30,31}; and
24
25 Whereas, It is probable that a stimulus package be proposed in the near future, which will likely
26 include internet access as part of this package, between 2020 elections and the next meeting of
27 the AMA House of Delegates^{32,33}; and
28
29 Whereas, AMA policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health
30 Disparities," sets precedent for the AMA advocating for internet access, and acknowledges the
31 health benefit of internet access, but only asks for expansion of internet infrastructure in
32 rural/underserved communities to provide "connectivity" rather than pushing for universal
33 access to internet for those with significant limitations in access or financial constraints; and
34
35 Whereas, Universal coverage of home internet access would increase accessibility to this tool
36 that is critical for patient health; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-478.980, "Increasing
2 Access to Broadband Internet to Reduce Health Disparities," by addition and deletion to read as
3 follows:

4
5 INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH
6 DISPARITIES, H-478.980

7 1. Our AMA recognizes internet access as a social determinant of health and will
8 advocate for universal and affordable access to the expansion of broadband and
9 high-speed and wireless internet and voice connectivity, especially in to all rural
10 and underserved areas of the United States while at all times taking care to
11 protecting existing federally licensed radio services from harmful interference that
12 can be caused by broadband and wireless services.

13 2. Our AMA will advocate for federal, state, and local policies to support
14 infrastructure that reduces the cost of broadband and wireless connectivity and
15 covers multiple devices and streams per household. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses the issue of internet access within healthcare and education, especially given the context of the COVID-19 pandemic. Our delegation considers this resolution a priority given our nation's increased usage of internet and need to mitigate rising disparities. The resolution highlights how much of day-to-day healthcare and education access has shifted to an online format. While the United States internet usage has increased 34% between January and April 2020 during the COVID-19 pandemic among families with access to broadband, one in five households with school-age children (ages 6-18) still do not have personal broadband internet access at home during the COVID-19 pandemic.

Moreover, the current administration is considering a \$100B proposal for broadband infrastructure. This resolution provides our AMA the opportunity to highlight and support legislation to reduce barriers and increase access to broadband internet to reduce healthcare inequities.

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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

Res. 208, I-18

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Res. 021, A-19

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
 - A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
 - B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
 - C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this

technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation, A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation, A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation, I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-JUN-21

Subject: Pharmaceutical Advertising in Electronic Health Record Systems

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 At the 2019 Interim Meeting Policy D-478.961, “Pharmaceutical Advertising in Electronic Health
4 Record Systems,” was adopted by the House of Delegates (HOD). The policy directs our American
5 Medical Association (AMA) to study the prevalence and ethics of direct-to-physician advertising at
6 the point of care, including advertising in electronic health record (EHR) systems.

7
8 This report provides information about the prevalence and ethical implications of direct-to-
9 physician pharmaceutical advertising, with specific attention to advertisements and alerts in the
10 EHR.

11 BACKGROUND

12
13 Pharmaceutical companies have a long history of marketing to physicians in the clinical setting. In
14 recent years access to physicians has become more challenging for pharmaceutical companies—
15 nearly half of physicians restrict visits from pharmaceutical sales representatives.¹ Perhaps making
16 up for the decline in direct access, the amount of money spent on marketing and advertising to
17 physicians continues to increase. Pharmaceutical companies spent \$20.3 billion on marketing to
18 physicians in 2016 through advertisements, samples, direct payments, personal visits and gifts from
19 pharmaceutical representatives, up from \$15.6 billion 20 years earlier.² Spending on advertising in
20 digital channels such as search engines and social media platforms also continues to increase.³ The
21 EHR system has risen as a unique opportunity to directly provide information about prescription
22 drugs to prescribers, given that physicians spend more than 15 minutes per patient in the EHR.⁴
23 However, there are ethical concerns with pharmaceutical advertising in the EHR, and whether this
24 is a common practice or a sustainable business model for EHRs has yet to be explored.

25 AMA POLICY

26
27 The AMA supports the American pharmaceutical manufacturing industry in its efforts to develop
28 and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit
29 of the American people (Policy H-100.995, “Support of American Drug Industry”). In addition, the
30 AMA supports a ban on direct-to-consumer advertising for prescription drugs and implantable
31 medical devices (H-105.988, “Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and
32 Implantable Devices”).

33
34 AMA *Code of Medical Ethics* Opinion 9.6.7, “Direct-to-Consumer Advertisements of Prescription
35 Drugs,” states physicians should remain objective about advertised tests, drugs, treatments, and
36 devices, avoiding bias for or against advertised products. The Opinion also states physicians should

1 resist commercially-induced pressure to prescribe tests, drugs, or devices that may not be indicated.
2 Although this Opinion does not specifically address physician-directed pharmaceutical
3 advertisements, the substance and meaning are applicable. Similarly, *Code of Medical Ethics*
4 Opinion 9.6.2, “Gifts to Physicians from Industry,” asserts that gifts from industry, including
5 pharmaceutical organizations, can create conditions in which professional judgment can be put at
6 risk of bias. This Opinion suggests that to preserve the trust that is necessary in patient care,
7 physicians should decline gifts from entities that have a direct interest in physicians’ treatment
8 recommendations. AMA policy also states that no gifts should be accepted if there are strings
9 attached. For example, physicians should not accept gifts if they are given in relation to the
10 physician’s prescribing practices (H-140.973, “Gifts to Physicians from Industry”).

11
12 In Policy H-175.992, “Deceptive Health Care Advertising,” the AMA encourages physicians and
13 medical societies to monitor and report to the appropriate state and federal agencies any health care
14 advertising that is false and/or deceptive in a material fact and encourages medical societies to keep
15 the Association advised as to their actions relating to medical advertising.

16
17 To mitigate adverse effects of pharmaceutical advertisements on women’s health, the AMA also
18 urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes
19 specifics outlining whether testing of drugs prescribed to both sexes has included sufficient
20 numbers of women to assure safe use in this population and whether such testing has identified
21 needs to modify dosages based on sex (Policy D-105.996, “Impact of Pharmaceutical Advertising
22 on Women’s Health).

23
24 DISCUSSION

25
26 *Pharmaceutical industry influence on physicians*

27
28 Pharmaceutical companies spend billions of dollars every year trying to influence physicians
29 through a variety of tactics. For decades, physicians have been a prime target for pharmaceutical
30 advertisers, made evident by the frequent placement of ads in medical journals. Pharmaceutical
31 companies historically have had a presence in physician offices through visits by sales
32 representatives, gifts, drug samples, sponsorship of continuing medical education, token items such
33 as notepads and pens, and more valuable incentives such as travel or dinners. This access to
34 physicians gave these companies key opportunities to influence physicians’ prescribing behaviors.

35
36 Although they still accept payments, gifts, samples, and other incentives from pharma, most
37 physicians do not believe they are affected by pharmaceutical industry interactions and believe they
38 are immune to the influence of their marketing strategies.⁵ Multiple studies, however, have found
39 associations between exposure to information provided by pharmaceutical companies and higher
40 prescribing frequency, higher costs, or lower prescribing quality.⁶ For example, exposure to
41 physician-directed advertising has been shown to be associated with less effective, lower-quality
42 prescribing decisions.⁷ This evidence suggests that some physicians, particularly those faced with
43 interactions with pharmaceutical advertising, are susceptible to influence by various types of
44 interactions with pharmaceutical companies, whether it be from gifts, payments, sponsorships, drug
45 samples, travel, or research funding. These interactions can influence physicians’ clinical decision
46 making, potentially leading to greater prescriptions of certain types of drugs.⁵

47
48 Pharmaceutical influence on physician decision-making was tested in a case study by Merck,
49 which partnered with Practice Fusion in a public health initiative to test the incorporation of EHR
50 messages alerting each provider during a patient visit when the patient might be due for a vaccine.⁸
51 The message alerts, while not considered formal advertisements, suggested specific treatment to

1 prescribers in an intervention group at the point of care, demonstrating that the alerts functioned
2 primarily to influence prescriber behavior. The test program, which included more than 20,000
3 health care providers divided into intervention and control groups, led to a 73 percent increase in
4 recorded vaccinations and the administration of more than 25,000 additional vaccines. Whether the
5 increase in vaccinations is a positive outcome is not the question to be debated in this report;
6 however, the appropriateness of the pharmaceutical company's influence in the decisions about
7 patient care should be questioned.

8

9 *Prevalence of advertising in the EHR*

10

11 One health care marketing agency that focuses in part on pharmaceutical clients described the EHR
12 as an opportunity to influence the prescribing decision with advertisements. In its report, they
13 describe banner advertisements within the administrative or consultation workflow as reminders
14 that can be targeted by physician specialty, geography, past prescribing behavior, patient
15 demographic, current therapy, or diagnosis. Their report continues, "When a [health care provider]
16 is reached in a clinical prescribing environment, the opportunity to impact behavior is greater." The
17 agency recommends prioritizing the moment within either the health records or e-prescribing
18 interface that is most meaningful based on brand objective.⁹ It is clear from these descriptions that
19 the patient-physician visit, particularly a vulnerable moment such as the discussion of medications,
20 is viewed by pharmaceutical marketers as an opportunity for financial gain.

21

22 It is estimated there are currently more than 300 EHR system vendors in the U.S.¹⁰ The vast
23 number of EHR products makes it challenging to determine the exact number of ad-supported
24 EHRs. It is known to pharma marketers that the largest EHRs do not have a business model that
25 supports advertising.⁹ Physician advisers to the AMA were consulted about the presence of
26 advertisements in the top five EHR systems, which comprise 85 percent of the market share.¹¹
27 None were aware of advertisements featured in these commonly used platforms. There may be a
28 small portion of the remaining 15 percent of EHR platforms that generate revenue through ads, but
29 currently only a handful offer partnerships with pharmaceutical companies.¹⁰

30

31 Considering the volume of information required in pharmaceutical advertisements to health care
32 professionals, as regulated by the FDA¹², pharmaceutical manufacturers and advertisers may look
33 for other means by which to promote their products at the point of care. In addition to traditional
34 banner ads, there are points of interaction between a prescriber and the EHR throughout the clinical
35 encounter that present opportunities for promotion of specific pharmaceuticals, such as clinical
36 decision support (CDS) alerts in the patient information screens. Information about specific drugs
37 may also appear during the prescribing workflow in an e-prescribing system.

38

39 Practice Fusion, a San Francisco-based company that was purchased by Allscripts in 2018, was a
40 free EHR software that provided space for pharmaceutical text and banner ads within certain
41 screens of the EHR.¹³ Practice Fusion was found to be the market share leader for solo and small
42 practices in 2015.¹⁴ In a broad search of articles about free or low-cost EHRs featuring an ad-
43 supported revenue model, Practice Fusion is repeatedly referenced as the prime example and is the
44 only EHR consistently mentioned throughout the literature.

45

46 Although many articles referenced Practice Fusion in positive light and touted it as an innovative
47 solution to the decrease in access to physicians, they all pre-dated recent legal developments
48 involving Practice Fusion. In early 2020, after months of federal investigation, Practice Fusion
49 admitted to soliciting and receiving kickbacks from a major opioid manufacturer, later discovered
50 to be Purdue Pharma, in exchange for CDS alerts that promote unnecessary opioids at the point of
51 prescribing in their EHR system.¹⁵ The Pain CDS in Practice Fusion's EHR displayed alerts more

1 than 230,000,000 times between 2016 and 2019. Health care providers who received the Pain CDS
2 alerts prescribed extended release opioids at a higher rate than those that did not,¹⁶ suggesting that
3 the alerts succeeded in influencing prescribing behavior.

4
5 This activity by Practice Fusion demonstrates how the EHR can present opportunities for
6 stakeholders to abuse the system, inappropriately influence physicians' decisions, and put patients
7 at risk. The practice of generating revenue by placing advertisements in the EHR was a key feature
8 of the system developed by Practice Fusion. Like the CDS alerts, the ads were tailored to display
9 information about specific drugs, using patient and physician data and targeting the prescriber at
10 the point of care. This ad-supported business model was abandoned by Practice Fusion in 2018
11 after its purchase by Allscripts.¹⁷

12
13 The literature search conducted in writing this report showed no evidence that ad-supported EHRs
14 have a significant presence in the EHR market or are on the rise. There was little to no mention of
15 specific ad-supported EHRs other than articles written about Practice Fusion, suggesting this single
16 company, which is now virtually defunct, had the bulk of this market captured. The conduct of
17 Practice Fusion and its extreme consequences may, for other EHR providers, put into question
18 prospective partnerships with pharmaceutical companies and slow potential growth in adoption of
19 ad-supported models.

20
21 *Advertising in other physician-facing channels*

22
23 Sometimes during patient encounters physicians require just-in-time education or review of drug
24 indications, dosage, interactions, contraindications, and pharmacology at the point of care.
25 Prescribers may consult with peers and medical experts, search for and read about drug information
26 in an authoritative medical journal, or simply search online for relevant information. In addition,
27 point-of-care medical reference applications, such as Epocrates or Medscape Mobile, provide easy
28 access to drug prescribing and safety information that physicians can use quickly during a patient
29 visit. These applications often feature advertisements for pharmaceutical products. Seventy percent
30 of Epocrates' revenue is from selling point of care pharmaceutical advertising, in the form of
31 "DocAlerts."¹⁸ Anecdotal feedback from physician users of Epocrates suggests that while they
32 appreciate using the app at no cost, they do question the appropriateness of the advertisements.^{18,19}

33
34 *Ethical implications*

35
36 Advertising at the point of care, through EHRs or other mechanisms, carries the risk of influencing
37 physician judgment inappropriately and undermining professionalism, which may ultimately
38 compromise quality of care and patient trust. While there are few data yet available about the
39 specific influence of advertisements in EHRs, studies do suggest that distributing sample
40 medications to physicians' offices, an indirect form of such advertising, does affect physicians'
41 treatment recommendations in ways that can be problematic. For example, data suggest that
42 physicians who have access to samples prefer prescribing brand name drugs over alternatives, even
43 when the branded sample is not their drug of choice or is not consistent with clinical guidelines.
44 Moreover, as one article has noted, physicians may be "less aware of when they are encountering
45 digital marketing than they are with traditional marketing."²⁰

46
47 Advertising at the point of care can undermine physicians' ethical responsibility "to provide
48 guidance about what they consider the optimal course of action for the patient based on the
49 physician's objective professional judgment."²¹ Whether a physician prescribes a medication or
50 device should rest "solely on medical considerations, patient need, and reasonable expectations of
51 effectiveness for the particular patient."²² By influencing decision making, such advertising can

1 also undermine physicians' responsibility to be prudent stewards of health care resources and to
2 "choose the course of action that requires fewer resources when alternative courses of action offer
3 similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual
4 patient but require different levels of resources."²³

5
6 There are emerging regulations at the state and federal levels that will require prescription cost
7 information to be visible in the EHR at the point of prescription. While the AMA is largely in
8 support of drug price transparency, and has clear policy encouraging EHR vendors to include
9 features that facilitate price transparency (D-155.987, "Price Transparency"), the availability of this
10 information at the point of care has the potential to influence a prescriber's decision. This potential
11 influence and its effects on prescriber patterns should be considered in future study.

12
13 While physicians have a clear ethical responsibility to ensure safe, evidence-based care, developers
14 of EHRs also have ethical responsibilities to patients. The stated goal of electronic records is to
15 facilitate seamless patient care to improve health outcomes and contribute to data collection that
16 supports necessary analysis²⁴—not to serve as a vehicle for promoting the interests of third parties.
17 Practices and health care institutions that deploy EHRs have a corresponding responsibility to
18 ensure that their record systems are directed in the first instance to serving the needs of patients.
19

20 *Implications for patient safety*

21
22 Studies of advertising in EHRs were not identified at the time of writing this report, so it is
23 premature to describe or quantify associated patient safety risks. However, physician-directed
24 pharmaceutical advertising has been commonplace in medical journals for decades, and there is an
25 abundance of research about the implications for patient safety and ethics of such ads.
26 Pharmaceutical advertisements, including those in medical journals, are regulated by the Food and
27 Drug Administration (FDA). A 2011 cross-sectional analysis of medical journals evaluated the
28 adherence of these advertisements to FDA regulations. The analysis showed few physician-directed
29 journal advertisements adhered to *all* FDA guidelines and over half of them failed to quantify
30 serious risks of the advertised drug.²⁵ Given the high risk associated with many advertised drugs,
31 and the observation that many ads do not adhere to FDA regulations or disclose known risks, any
32 propensity of pharmaceutical ads to influence prescribing—regardless of the channel—may pose
33 threats to patient safety. Thus, it is up to the physician or prescriber to base their prescribing
34 decisions on clinical evidence and sound judgment, rather than marketing tactics.
35

36 The Practice Fusion scheme is a prime example of an EHR vendor allowing commercial interests
37 to take precedence over patient safety. Although CDS tools are not advertisements in the traditional
38 sense, if the drug information in the CDS popup is presented in a way that the prescriber has little
39 choice but to view the product displayed, it is in effect an advertisement. The U.S. Department of
40 Justice highlighted the risk to patient safety in its January 2020 press release. "During the height of
41 the opioid crisis, the company took a million-dollar kickback to allow an opioid company to inject
42 itself in the sacred doctor-patient relationship so that it could peddle even more of its highly
43 addictive and dangerous opioids. The companies illegally conspired to allow the drug company to
44 have its thumb on the scale at precisely the moment a doctor was making incredibly intimate,
45 personal, and important decisions about a patient's medical care, including the need for pain
46 medication and prescription amounts."²⁶

47
48 *Implications for physician and patient data privacy*

49
50 There are important implications for the privacy of physician prescribing data and patient data
51 when it is used by advertisers to provide timely patient-specific advertisements. If an EHR vendor

1 is collecting and sharing prescribing patterns of an individual physician, or even specific patient
2 information, with the pharmaceutical company, this invites the risk of physician and/or patient data
3 misuse. Currently, there is little known about what data is being collected for this purpose, to
4 whom it is being provided, and how it is being used.

5
6 The AMA published privacy principles that define what it considers appropriate guardrails for the
7 use of patient health information outside the traditional health care setting. The principles shift the
8 responsibility for privacy from individuals to data holders, meaning that third parties who access an
9 individual's data should act as responsible stewards of that information, just as physicians promise
10 to maintain patient confidentiality.²⁷ It is AMA's position that these principles apply to any entity
11 that collects, retains, and uses patient and/or physician prescribing data for marketing and other
12 purposes.

13

14 CONCLUSION

15

16 Although some EHRs and e-prescribing programs may present opportunities for advertisers to
17 inappropriately influence patient care, they appear to have a small presence in today's EHR market.
18 And while pharmaceutical companies continue to advertise to physicians through other digital
19 channels, such as journals or medical reference applications, prescribers should continue to provide
20 care and prescribe treatments using evidence-based information and their best judgment, and
21 practices should be intentional in deploying systems that function primarily to serve patient care.
22 There is little evidence that ad-supported EHR systems are highly prevalent or gaining popularity.
23 However, where pharmaceutical advertisements *are* present at the point of care, they can present
24 significant threats to patient safety and the integrity of patient care. In addition, it is evident that
25 despite prescribers' best intentions there are instances in which decision-making can be influenced
26 by external factors such as CDS alerts or advertisements. Considering the information presented in
27 this report, it is recommended that AMA establish policy opposing the practice of pharmaceutical
28 advertising in electronic systems used at the point of care and continue to monitor the practice in
29 the future.

30

31 RECOMMENDATIONS

32

33 The Board of Trustees recommends that Policy D-478.961 be amended as follows and the
34 remainder of the report be filed:

35

36 Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic
37 health records (EHR); and (2) opposes direct-to-prescriber pharmaceutical and promotional content
38 in medical reference and e-prescribing software, unless such content complies with all provisions
39 in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices
40 (H-105.988); and (3) encourages the federal government to study of the effects of direct-to-
41 physicianprescriber advertising at the point of care, including advertising in Electronic Health
42 Record Systems (EHRs), on physician prescribing, patient safety, data privacy, health care costs,
43 and EHR access for smallphysician practices; and (2) will study the prevalence and ethics of
44 direct to physician advertising at the point of care, including advertising in EHRs.

Fiscal note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(JUN-21)

Introduced by: Maryland

Subject: Ensuring Continued Enhanced Access to Healthcare via Telemedicine and Telephonic Communication

Referred to: Reference Committee B

1 Whereas, Across the U.S., states passed telemedicine legislation in 2020 (pre-pandemic) that
2 allows providers to use telehealth, including asynchronous technology, to establish the
3 physician-patient relationship; and
4
5 Whereas, The ability to access health care via telemedicine prior to the pandemic was available,
6 but not widely used; and
7
8 Whereas, Payments to physicians for telemedicine vary by carrier and were significantly less
9 than in-person visits prior to COVID-19; and
10
11 Whereas, The onset and severity of COVID-19 caused a rapid implementation of telemedicine
12 by physicians of many specialties, and patients rapidly embraced the technology as often the
13 only means to access non-emergent medical care; and
14
15 Whereas, Through directives of the federal and state governments, payors waived co-pays and
16 deductibles and increased payment for telemedicine and telephonic services equal to in-person
17 visits during COVID-19 which reduced barriers for patients to access medical care; and
18
19 Whereas, The federal government and states took action to allow physicians and other health
20 care clinicians to use non-HIPAA compliant platforms if necessary to enhance patients' use of
21 technology to access health care; therefore be it
22
23 RESOLVED, That our American Medical Association address the importance of at least a
24 365-day waiting period after the COVID-19 public health crisis is over before commencement of
25 audits aimed at discovering the use of non-HIPAA compliant modes and platforms of
26 telemedicine by physicians. (Directive to Take Action)

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

Received: 04/07/21

AUTHOR'S STATEMENT OF PRIORITY

Due to urgent need, many physician practices implemented non-HIPAA-compliant telehealth platforms during the initial stages of the pandemic state of emergency in an attempt to ensure continuation of services and quality care for their patients. This resolution asks for the AMA to advocate for a 365-day waiting period after the COVID-19 pandemic crisis ends before commencement of HIPAA audits relating to telehealth usage. It is important that the AMA establish this policy platform before states of emergency expire and pandemic-related administrative flexibilities are terminated.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(JUN-21)

Introduced by: New York

Subject: Insurers and Vertical Integration

Referred to: Reference Committee B

1 Whereas, Insurers already enjoy significant marketplace advantages, such as keeping
2 healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony
3 power; and

4 Whereas, These advantages have not resulted in cost savings (or even stability) for
5 consumers--in fact cost increases born by consumers have been outsized and correlated with
6 consolidation; and

7 Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting
8 efficiency; and

9 Whereas, These “efficiencies” rarely, if ever, benefit the consumer; and

10 Whereas, These combined entities (especially vertical ones) are more competitive among their
11 competitors than the uncombined ones (accelerating further consolidation); and

12 Whereas, The combined entities are also positioned (due to their superior access to capital) to
13 unfairly disrupt entities at other points in the supply chain such as medical practices, community
14 pharmacies, and safety net hospitals; therefore be it

15 **RESOLVED**, That our American Medical Association seek legislation and regulation to prevent
16 health payers (except non-profit HMO's) from owning or operating other entities in the health
17 care supply chain. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

As a matter of protecting public health and reducing health payor interference in patient care delivery, it is critical that AMA continue to actively work to prevent large entities from creating these monopolies. While the AMA has taken important steps in recent years to challenge these mergers and acquisitions, existing AMA policy is four years old. The efforts on the part of health payers to absorb practices, pharmacy benefit managers, medical equipment suppliers etc. continues and will create a health care market without any competition. This will not be good for our patients nor for physicians. These entities should be controlled by nothing more than the competitive free market system. Allowing health insurers to control more and more elements of the health care supply chain will result in even greater interference in the physician-patient relationship and decrease access to care for our patients. AMA is strongly urged to take immediate action to update its policy on this subject.

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920

Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.

Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(JUN-21)

Introduced by: Oklahoma

Subject: Eliminating Claims Data for Measuring Physician and Hospital Quality

Referred to: Reference Committee G

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

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

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

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

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

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

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

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

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

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

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

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

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

Received: 05/05/21

AUTHORS STATEMENT OF PRIORITY

Thank you for your consideration of the prioritization matrix for Eliminating Claims Data for Measuring Physician and Hospital Quality. Currently, physicians are being graded and assessed on claims data; however, claims data has no place in the assessment of quality of care delivery. Coders typically generate claims data. Measuring and ranking physicians on claims data says little about the quality of the care delivered. CMS and other stakeholders should replace the use of claims data with outcomes measures in determining the quality of care delivery. This matter is urgent as claims data is currently utilized in determining physician reimbursement. In the deleterious economic climate of the COVID-19 pandemic, revenue stream sustainability is of high importance, especially to economically vulnerable rural practices. This issue is timely and is affecting all physicians nationwide. We feel our AMA is most appropriate entity to tackle this issue and will have a positive impact.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(JUN-21)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Prevent Medicare Advantage Plans from Limiting Care

Referred to: Reference Committee G

1 Whereas, There are Medicare guidelines for most treatments for patients including, but not
2 limited to criteria for admissions, diagnostic testing, medications, and procedures; and

4 Whereas, Medicare Advantage plans may not consistently follow Medicare guidelines
5 resulting in patients who are insured by Medicare Advantage plans not receiving the same
6 level of treatment as patients insured by standard Medicare; and

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

11 Whereas, Medicare Advantage plans often use proprietary criteria (such as Milliman and
12 InterQual) or NaviHealth algorithms to determine eligibility of Medicare beneficiaries for
13 admissions, diagnostic testing, medications, and procedures, which is an additional barrier that
14 limits access to services and is often at odds with the professional judgement of the patient's
15 physician; and

17 Whereas, Patients who have symptoms consistent with Post-Acute Sequelae of SARS-CoV-2
18 infection ("PASC" or "Long COVID") could be denied necessary treatment by the use of
19 proprietary criteria; therefore be it

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

26 RESOLVED, That our AMA advocate against applying proprietary criteria to determine eligibility
27 of Medicare patients for procedures and admissions when the criteria are at odds with the
28 professional judgment of the patient's physician. (Directive to Take Action)

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

Received: 05/11/21

AUTHOR'S STATEMENT OF PRIORITY

We believe that this resolution should be included for the June 2021 Special Meeting of the AMA HOD because there are ongoing access to care issues for many Medicare patients who are in high risk categories for poor health outcomes due to the COVID-19 pandemic and those suffering from Long COVID. This affects all physicians who care for Medicare patients. Ensuring equal access to care for all those covered by Medicare and Medicare Advantage (MA) plans is timely and imperative, because all patients deserve equal access to medically necessary care. MA and other private plans account for 40 percent of all Medicare beneficiaries. Other private plans consist of private fee-for-service plans, cost plans, Medicare medical savings account plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare-Medicaid plans participating in CMS's financial alignment demonstration. MA enrollment represents 39 percent of all 62.2 million Medicare beneficiaries (and 42 percent of all 56.5 million beneficiaries enrolled in both Medicare Part A and Part B). Enrollment in MA plans that are paid on an at-risk capitated basis reached 24.0 million enrollees in February 2020. The most recent data for 2021 indicated there was a 13% increase in MA plans compared to 2020, which equates to 3,550 total MA plans¹.

¹ Biniek, J., Freed, M., Damico, A. and Neuman, T., 2020. *Medicare Advantage 2021 Spotlight: First Look*. [online] KFF. Available at: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look/> [Accessed 11 May 2021].

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-JUN-21

Subject: Addressing Payment and Delivery in Rural Hospitals

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

1 Despite legislative advances such as the Affordable Care Act (ACA) and Medicaid expansion
2 bringing insurance coverage and health care accessibility to millions of Americans, rural
3 Americans and the health care system intended to serve them continue to face a health care crisis.
4 By most measures, the health of the residents of rural areas is significantly worse than the health of
5 those in urban areas.¹ Though the American Medical Association (AMA) has policy on stabilizing
6 and strengthening rural health, it does not have policy specifically addressing changes to payment
7 and delivery for rural providers and hospitals to address the growing rural health crisis.
8

9 This report, initiated by the Council, provides background on the unique obstacles facing rural
10 hospitals including financial challenges, the rural hospital payer mix, the costs of delivering
11 services in the rural setting, and quality measurement and risk adjustment challenges. The report
12 also details relevant AMA policy and provides recommendations to improve the rural hospital
13 payment and delivery systems.

14 BACKGROUND

15 Sixty million Americans, almost one-fifth of the US population, live in a rural area. On average,
16 rural residents are older, sicker, and less likely to have health insurance. They stay uninsured for
17 longer and are less likely than their urban and suburban counterparts to seek preventive services.
18 Moreover, they are more likely than urban and suburban residents to encounter possibly
19 preventable deaths from heart disease, cancer, unintentional injuries, chronic lower respiratory
20 disease, and stroke. Disparities in health outcomes continue to increase for this population
21 compared to those living in urban and suburban areas. Rural residents tend to have higher rates of
22 smoking, hypertension, and obesity. They also report less physical activity and have higher rates of
23 poverty. Rural residents are also more likely to be Medicare or Medicaid beneficiaries. For
24 example, Medicare and Medicaid make up over half of rural hospitals' net revenue.^{2,3} Additionally,
25 45 percent of children in rural areas are enrolled in Medicaid or Children's Health Insurance
26 Program compared to 38 percent of children in urban areas.⁴

27 Those living in rural areas often must travel long distances to access the emergency department
28 (ED) and physician offices, a barrier to care that can lead to delayed or forgone care, which can
29 worsen their health status and increase the cost of care when they do receive it. They are more
30 likely than urban and suburban residents to say that access to good doctors is a major problem in
31 their community.⁵ Rural residents live an average of 10.5 miles from the nearest hospital compared
32 with 5.6 miles and 4.4 miles for those in suburban and urban areas respectively.

33 From 2018 to 2020, 50 rural hospitals closed, a more than 30 percent increase in the number of
34 closures compared to the 3 years prior.⁶ The closure of hospitals was generally preceded by

1 financial losses caused by a combination of decreasing rural population and inadequate payments
2 from health insurers. There are more than 2,000 rural hospitals across the country, and more than
3 800 (40 percent) of them are estimated to be at risk of closing. Most of the hospitals at risk of
4 closing are small rural hospitals serving isolated rural communities.

5
6 These hospitals are frequently the principal or sole source of health care in their communities,
7 including primary care as well as hospital services. The closure of these rural hospitals could cause
8 the vulnerable populations they serve to lose access to health care and worsen health disparities.⁷
9 Rural hospitals also have more difficulty attracting physicians of varying specialties, which are
10 essential to providing care to rural populations. Often, when a rural hospital closes, recruiting and
11 retaining physicians in the local community becomes increasingly difficult, and the result is
12 decreased access to care for the surrounding population.⁸ In addition, rural hospitals often serve as
13 economic anchors in their communities, providing both direct and indirect employment
14 opportunities and supporting the local economy.⁹ Rural hospitals are hubs of employment, public
15 health, and community outreach initiatives.¹⁰ Their closure puts the already vulnerable populations
16 they serve at increased risk of losing access to health care, worsening health disparities, and
17 negatively impacting the economy of the local area.¹¹

18
19 Meanwhile, the novel coronavirus (COVID-19) pandemic has highlighted the fragility of the rural
20 health system and increased the financial threat to an unstable system. All hospitals experienced
21 lower revenue due to canceled elective procedures and some routine care, while simultaneously
22 facing higher expenses due to supplies, equipment, and staff to care for COVID-19 patients. Unlike
23 large urban hospitals, small rural hospitals do not have financial reserves that they can use to cover
24 these higher costs and revenue losses. Rural patients are also more likely to experience more severe
25 impacts from COVID-19 because they are more likely to be obese and have chronic conditions
26 such as diabetes and hypertension.¹² Temporary federal assistance during the pandemic helped
27 many rural hospitals avoid closure during 2020, but the underlying financial problems may cause
28 an increase in closures after the public health emergency ends. The financial impact of the
29 pandemic on individuals living in rural areas has been significant, as many may have experienced
30 unemployment or under employment on hourly jobs with limited benefits.

31
32 **IMPACT OF PAYER MIX**

33
34 A higher proportion of patients at rural hospitals are insured by Medicare and Medicaid than at
35 urban hospitals.¹³ While having a high proportion of Medicare patients would be viewed as
36 financially problematic at large hospitals, for many small rural hospitals, Medicare is their “best”
37 payer because Medicare explicitly pays more to cover the higher costs of care in small rural
38 hospitals.

39
40 About 75 percent of rural hospitals are classified as Critical Access Hospitals (CAHs), which
41 provides cost-based payment for services provided to Medicare beneficiaries. To be designated as a
42 CAH, a hospital must meet a set of criteria including but not limited to being located either more
43 than 35 miles from the nearest hospitals (or CAH) or more than 15 miles in areas with mountainous
44 terrain; maintain no more than 25 inpatient beds; furnish 24-hour emergency care 7 days a week;
45 and operate a psychiatric or rehabilitation unit of up to 10 beds.¹⁴ It is important to note, however,
46 that CAH payments apply only to beneficiaries with traditional Medicare, not those with private
47 Medicare Advantage (MA) plans.

48
49 Most small rural hospitals lose money on Medicaid patients, but in some states, small rural
50 hospitals also receive cost-based payments for Medicaid patients, and some states provide special
51 subsidies to offset losses on Medicaid and uninsured patients.

1 For many small rural hospitals, the leading cause of negative margins is insufficient payment from
2 private health insurance plans and MA plans. Many private health insurance plans pay less than the
3 cost to deliver essential services in small rural hospitals, whereas private plan payments at most
4 large hospitals are higher than the cost of delivering services.¹⁵ Although most hospitals lose
5 money on Medicaid and care to the uninsured, larger hospitals can use profits on privately insured
6 patients to cover those losses. In contrast, many small rural hospitals cannot cover losses on
7 Medicaid and uninsured patients because the payments from private payers do not generate
8 significant profits or may not even cover the costs of providing services to the privately insured
9 patients.

10

11 COST OF DELIVERING SERVICES IN RURAL HOSPITALS AND CLINICS

12

13 Low patient volume represents a persistent challenge to the financial viability of rural hospitals.
14 There is a minimum level of cost needed to maintain the staff and equipment required to provide a
15 particular type of service, whether it be an ED, a laboratory, or a primary care clinic. As a result,
16 the average cost per service will be higher at a hospital that has fewer patients. In addition, the
17 hospital will need to incur a minimum level of overhead costs that include accounting and billing,
18 human resources, medical records, information systems, and maintenance. These costs are
19 allocated to each hospital service line, so the fewer services the hospital offers, the higher the cost
20 for each service.¹⁶

21

22 The mix of fixed costs paired with low volumes can result in instances where the current fee-for-
23 service payments are often not large enough to cover the cost of delivering services in small rural
24 communities. For example, a hospital ED must be staffed by at least one physician around the
25 clock regardless of how many patients visit the ED. Generally, a small rural hospital will have
26 fewer ED visits, but the standby capacity cost remains fixed, which means the average cost per
27 visit will be higher. Therefore, a payment per visit that is high enough to cover the average cost per
28 service at a larger hospital will fail to cover the costs of the same services at a smaller rural
29 hospital. Exacerbating this issue is that some private plans pay small rural hospitals less than they
30 pay larger hospitals for delivering the same services even though the cost per service at the rural
31 hospital is intrinsically higher.¹⁷

32

33 Due to the low population density in rural areas, it is impossible for many rural hospitals to have
34 enough patients to use the full minimum capacity of services such as an ED. Medicare explicitly
35 pays small rural hospitals more to compensate for the higher average costs, but most other payers
36 do not, which is why small rural hospitals have greater financial problems.

37

38 QUALITY MEASUREMENT CHALLENGES IN RURAL HOSPITALS

39

40 Current quality measurement systems are problematic for small rural hospitals. Many commonly
41 used quality measures cannot be used in small rural hospitals because there are too few patients to
42 reliably measure performance, and some measures are not relevant at all for small rural hospitals
43 because they do not deliver the services being measured.¹⁸

44

45 Rural hospital volume varies significantly for several reasons including the population of the
46 community, the age and health status of the population, the availability of other primary care
47 options, and the accessibility of the hospital. Many currently used quality measures are not
48 applicable to numerous types of patients and aspects of care, and many focus on a specific
49 condition or service. Accordingly, many rural hospitals cannot achieve a meaningful sample size
50 because they do not have enough patients with that specific condition. Moreover, rural hospitals

1 often face challenges reporting quality measurement data due to limited staff, time, and
2 infrastructure.
3
4 The typical value-based payment system of bonuses and penalties often penalizes rural providers
5 and hospitals. Again, the small patient panels inherent in rural care mean that providers can easily
6 be penalized for random variation over which they have no control.¹⁹
7

8 RISK ADJUSTMENT CHALLENGES IN RURAL HOSPITALS 9

10 In addition to the reliability problems in measurement caused by small populations, the differences
11 between rural and urban populations with respect to age, health status, and ability to access services
12 makes risk adjustment of quality and spending measures essential. Random variation and outlier
13 patients make risk adjustment scores less accurate at small hospitals than at hospitals with large
14 patient populations.²⁰ The greater statistical variation at rural hospitals often leads to quality
15 incentive payments going to higher volume hospitals that can achieve lower standard deviations but
16 are not necessarily delivering higher quality care.
17

18 Moreover, risk adjustment is based on diagnosis codes recorded on claims forms. Since payments
19 to CAHs do not depend on what diagnoses a patient has, diagnosis codes tend to be underreported
20 by rural hospitals.²¹ Also, the use of diagnosis codes can fail to capture risk appropriately including
21 the lack of a comorbid condition diagnosis due to barriers to care such as distance from the health
22 care setting and lack of support services in the community. As a result, rural hospitals and clinics
23 can appear to have healthier patients or worse outcomes than they really do. Risk adjustment can
24 also make spending in rural communities appear higher than it is. For example, MA risk adjustment
25 scores fail to accurately measure the true differences in patient health because the hierarchical
26 condition category coding used in MA payments are retrospective based on past chronic
27 conditions, not acute or new chronic conditions. Therefore, there is no risk adjustment for patients
28 with injuries, acute conditions, or those newly diagnosed with cancer or diabetes, among other
29 conditions. Likewise, the higher barriers for rural patients to obtain preventive care can cause a
30 more severe presentation of diseases once finally diagnosed, requiring higher costs of care and
31 poorer absolute outcomes.
32

33 RELEVANT AMA POLICY 34

35 The AMA has significant policy on rural health. Policy H-465.994 supports the AMA's continued
36 and intensified efforts to develop and implement proposals for improving rural health care. AMA
37 policy specific to rural hospitals includes Policy H-165.888 stating that any national legislation for
38 health system reform should include sufficient and continuing financial support for rural hospitals.
39 Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals
40 to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach
41 toward certification of small, rural hospitals. Policy H-465.979 recognizes that economically viable
42 small rural hospitals are critical to preserving patient access to high-quality care and provider
43 sustainability in rural communities. Policy D-465.999 calls on the Centers for Medicare &
44 Medicaid Services to support individual states in their development of rural health networks;
45 oppose the elimination of the state-designated CAH "necessary provider" designation; and pursue
46 steps to require the federal government to fully fund its obligations under the Medicare Rural
47 Hospital Flexibility Program.
48
49 Policy H-385.913 discusses payment and delivery reform in the context of the shift away from
50 volume to value. The policy states that alternative payment models (APMs) must provide
51 flexibility to physicians to deliver the care their patients need. Policy H-385.913 also calls for

1 APMs to be feasible for physicians in every specialty and for practices of every size to participate
2 in. Importantly, Policy D-385.952 directs the AMA to continue encouraging the development and
3 implementation of APMs that provide services to improve the health of vulnerable and high-risk
4 populations, including those in rural areas.

5

6 Finally, the AMA has long-standing policy in support of reasonable and adequate Medicaid
7 payments. Policy H-290.976 advocates that Medicaid payments to medical providers be at least
8 100 percent of Medicare payment rates. Policy H-290.997 promotes greater equity in the
9 Medicaid program through adequate payment rates that assure broad access to care. Further,
10 Policy D-290.979 supports state efforts to expand Medicaid eligibility as authorized by the ACA.

11

12 DISCUSSION

13

14 Long-term solutions are needed to effectively address the health needs of the rural population.
15 Preventing the closure of rural hospitals that provide essential services is a first step. Rural
16 hospitals must be paid adequately to support the costs of delivering essential services, and they
17 should have the flexibility to tailor available services to the needs of their local populations.

18

19 To begin accomplishing its goal of providing adequate payment for rural hospital services, the
20 Council recommends reaffirming Policy D-290.979 directing our AMA to support state efforts to
21 expand Medicaid eligibility, and reaffirming Policy H-290.976 stating that Medicaid payments be
22 at least 100 percent of Medicare payment rates. Medicaid eligibility and enrollment are evidence-
23 based factors strengthening the viability of rural hospitals. Medicaid expansion, particularly if it is
24 accompanied by adequate payments, will improve hospital financial performance and
25 sustainability, and lower the likelihood of closure, especially in those rural markets with large
26 numbers of uninsured patients. For example, since 2010, of the eight states with the highest levels
27 of rural hospital closures, none are Medicaid expansion states. A key cause of financial losses at
28 most rural hospitals is the volume of care provided to uninsured patients, so a key component of
29 any strategy for sustaining rural health care services is increasing the number of insured residents.

30

31 The Council identified the need for better and more reliable payment for rural hospitals that support
32 their sustainability and recommends that a series of policies be adopted to ensure that payment to
33 rural hospitals is adequate and appropriate. Since small rural hospitals need to sustain essential
34 services even with low volumes of services, the Council recommends that health insurance plans
35 provide such hospitals with a capacity payment to support the minimum fixed costs of essential
36 services, including surge capacity, acknowledging that a small rural hospital requires a baseline of
37 staffing and expenses to remain open regardless of volume. It is also recommended that payers
38 provide adequate service-based payments to cover the costs of services delivered in small
39 communities. The Council also recommends that the capacity payment provide adequate support
40 for physician standby and on-call time to enable very small rural hospitals to deliver quality
41 services in a timely manner. Regarding quality measurement, the Council recommends only using
42 quality measures that are relevant for rural hospitals and setting minimum volume thresholds for
43 measures to ensure statistical reliability and avoiding financial penalties that might occur from
44 failing to have met specific quality metrics due to lower volumes. To help effect these changes, the
45 Council recommends encouraging employers and rural residents to choose health plans that
46 adequately and appropriately pay the rural hospitals.

47

48 The Council notes that taking these steps to ensure adequate and reliable payment for rural
49 hospitals is critical to addressing the barriers to procedural service lines. A small patient population
50 and declining revenue stifles the ability of rural hospitals to add new service lines that not only
attract needed specialists to underserved areas but also aid in the financial sustainability of a rural

1 hospital. The Council believes that addressing payment issues for rural hospitals will help give
2 those hospitals the flexibility to offer more complex services. In turn, those services will boost
3 financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately
4 increase patient access to care.

5
6 The Council also reiterates the need to address payment for primary care services at rural facilities.
7 The Council recommends voluntary monthly payments for primary care providers so that
8 physicians have the flexibility to deliver services in the most effective manner, particularly for
9 those patients for whom travel is a significant barrier to care. Importantly, such monthly payments
10 should include an allowance and expectation that some services would be provided via telehealth
11 or telephone.

12
13 Additionally, the Council recommends policy that encourages transparency among rural hospitals
14 regarding their costs and quality outcomes. It will be essential that rural hospitals publicly
15 demonstrate that higher payments are needed to support the cost of delivering high quality care.
16

17 The challenges facing the rural health system are varied and complex. Although many steps are
18 needed to ensure access to care and quality outcomes for the rural population, the Council offers
19 these recommendations as a pragmatic step forward to address the needs of rural populations.
20

21 RECOMMENDATIONS

22

23 The Council on Medical Service recommends that the following be adopted and that the remainder
24 of the report be filed:
25

- 26 1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our
27 AMA to support state efforts to expand Medicaid eligibility as authorized by the
28 Affordable Care Act. (Reaffirm HOD Policy)
- 29 2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical
30 providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)
- 31 3. That our AMA support that public and private payers take the following actions to ensure
32 payment to rural hospitals is adequate and appropriate:
33
 - 34 a. Create a capacity payment to support the minimum fixed costs of essential services,
35 including surge capacity, regardless of volume;
 - 36 b. Provide adequate service-based payments to cover the costs of services delivered in
37 small communities;
 - 38 c. Pay for physician standby and on-call time to enable very small rural hospitals to
39 deliver quality services in a timely manner;
 - 40 d. Use only relevant quality measures for rural hospitals and set minimum volume
41 thresholds for measures to ensure statistical reliability;
 - 42 e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be
43 assessed due to low statistical reliability; and
 - 44 f. Create voluntary monthly payments for primary care that would give physicians the
45 flexibility to deliver services in the most effective manner with an expectation that
46 some services will be provided via telehealth or telephone. (New HOD Policy)
- 47 4. That our AMA encourages transparency among rural hospitals regarding their costs and
48 quality outcomes. (New HOD Policy)

- 1 5. That our AMA support better coordination of care between rural hospitals and networks of
- 2 providers where services are not able to be appropriately provided at a particular rural
- 3 hospital. (New HOD Policy)
- 4
- 5 6. That our AMA encourage employers and rural residents to choose health plans that
- 6 adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

Fiscal Note: Less than \$500.

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¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

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²⁰ *Supra* note 7.

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