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EXECUTIVE SUMMARY

At the 2019 Annual Meeting Resolution 703-A-19, “Preservation of the Patient-Physician Relationship,” was introduced by the Organized Medical Staff Section and referred by the House of Delegates (HOD) for report back at the 2020 Interim Meeting. The 2020 Interim Meeting was replaced with a Special Meeting of the HOD due to restrictions resulting from the COVID-19 pandemic. This report was not presented during the Special Meeting so is now presented to the HOD at the June 2021 Special Meeting. The resolution asks the American Medical Association (AMA) to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, and to identify health care work environment factors that impact a physician’s ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter.

Many factors contribute to the patient-physician relationship, including the use of electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician’s ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients.
INTRODUCTION

At the 2019 Annual Meeting Resolution 703-A-19, “Preservation of the Patient-Physician Relationship,” was introduced by the Organized Medical Staff Section and referred by the House of Delegates (HOD) for report back. The resolution asks our American Medical Association (AMA) to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, and to identify health care work environment factors that impact a physician’s ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter.

This report discusses factors that contribute to patient-physician relationships and when those factors can detract from the physician’s ability to provide high quality care or result in barriers to communication that can threaten the patient-physician relationship. The AMA has dedicated significant resources and effort to identifying and addressing the barriers to patient care and effective patient-physician relationships, including the use of technology, documentation requirements, prior authorization, and other work environment factors. This report will in part describe those efforts and relevant outcomes.

BACKGROUND

The relationship between a patient and their physician is sacred. It requires trust, honesty, and communication. As the healthcare industry has changed in recent decades, so have external factors and internal dynamics that influence the patient-physician relationship. Both the patient’s and physician’s roles and experiences have evolved, as well as their perceptions and expectations of the communication and relationship with each other. Many factors contribute to the patient-physician relationship, including electronic devices and documentation assistance such as scribes. Sometimes these factors result in barriers to optimal communication that interfere with patient care. Barriers created by technology, resource allocation, regulations, and other external factors can detract from the communication and trust between physicians and their patients. These barriers often affect patient health outcomes and/or the physician’s ability to provide high-quality care and experience fulfillment and satisfaction in their medical practice. Overcoming the barriers that inhibit effective patient-physician communication is vital to preserving the special and trusted relationship between physicians and their patients.
The AMA Code of Medical Ethics provides a definition of the patient-physician relationship that exemplifies the spirit of this resolution. “The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare” (Code of Medical Ethics 1.1.1, “Patient-Physician Relationships”).

Health care technology has become integral to the practice of medicine and has improved many aspects of patient care and the patient-physician relationship. The AMA recognizes the important role technology has in modern health care and has established multiple policies to reflect this. For example, the AMA supports the establishment of coverage, payment, and financial incentive mechanisms to support the use of mobile health applications and associated devices, trackers, and sensors by patients, physicians and other providers that support the establishment or continuation of a valid patient-physician relationship (Policy H-480.943, “Integration of Mobile Health Applications and Devices into Practice”). AMA policies support telemedicine as a mechanism to deliver patient care and advocates for the widespread adoption of telehealth services in the practice of medicine (Policy D-480.965, “Reimbursement for Telehealth” and Policy D-480.963, “COVID-19 Emergency and Expanded Telemedicine Regulations”). The AMA Code of Medical Ethics also make it clear that these technologies should not compromise or interfere with the patient-physician relationship (AMA Code of Medical Ethics 1.2.12, “Ethical Practice in Telemedicine). It is AMA policy that new communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. The AMA provides detailed guidelines for the appropriate and optimal use of email and text messages for communicating with patients (Policy H-478.997, “Guidelines for Patient-Physician Electronic Mail and Text Messaging”). The AMA Code of Medical Ethics also provides guidance for the ethical and professional use of email and text message communications (Opinion 2.3.1, “Electronic Communication with Patients”).

The AMA supports protecting the patient-physician relationship by advocating for the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements (Policy H-165.837, “Protecting the Patient-Physician Relationship”). The AMA also supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization, or specialty consultation (Policy H-160.901, “Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care”).

Recognizing that government has a large influence on the practice of medicine, the AMA continuously works to reduce the burden of government and third-party regulation on medical practice and its intrusion into the patient-physician relationship and doctor-patient time (Policy...
H-180.973, “The “Hassle Factor”). The AMA will continue these efforts, with additional focus on
the prescription of medication (Policy H-100.971, “Preserving the Doctor-Patient Relationship”).
Furthermore, the AMA endorses principles concerning the roles of federal and state governments
in the patient-physician relationship:

A. Physicians should not be prohibited by law or regulation from discussing with or asking
their patients about risk factors, or disclosing information to the patient (including proprietary
information on exposure to potentially dangerous chemicals or biological agents), which may
affect their health, the health of their families, sexual partners, and others who may be in
contact with the patient.

B. All parties involved in the provision of health care, including governments, are responsible
for acknowledging and supporting the intimacy and importance of the patient-physician
relationship and the ethical obligations of the physician to put the patient first.

C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and
advocacy are central to the delivery of evidence-based, individualized care and must be
respected by all parties.

D. Laws and regulations should not mandate the provision of care that, in the physician’s
clinical judgment and based on clinical evidence and the norms of the profession, are either not
necessary or are not appropriate for a particular patient at the time of a patient encounter
(Policy H-270.959, “AMA Stance on the Interference of the Government in the Practice of
Medicine”).

It is AMA policy that the relationship between physicians and their patients should not be disrupted
by direct communications from health plans to patients regarding individual clinical matters
(Policy H-140.919, “Doctor/Patient/Health Plan Communications”).

DISCUSSION

To appropriately respond to the resolution referred by the HOD, this report will focus on describing
the factors that contribute to patient-physician relationships, including:

- Shared decision-making
- Online health/medical information
- Health literacy
- Trust
- Implicit bias
- Adequate time
- Physical clinic setting
- Communication
- External influences

Barriers to communication and an effective patient-physician relationship can be encountered at
many points during the interactions between a patient and physician. Barriers can also manifest
from inherent attitudes or outward behaviors, of the patient and/or physician. Finally, barriers that
affect the quality of patient-physician interactions are often external environmental elements, such
as technology or the availability of support staff.
Shared decision making

Sharing in the decision-making process can help patients feel their voice is heard and their physician cares what they think and feel about their condition and the options for treatment. Patients value having the opportunity to explain their illnesses, receive information, and be involved in their treatment plans. This requires deliberate attention and thoughtful consideration on the part of the physician. Barriers can arise if patients are simply presented with results and standard check-box choices without discussion. This approach can leave them feeling less than cared for. In addition, the use of decision support tools, while mostly beneficial when used appropriately, can get in the way of quality conversation in which patients and physicians decide together the best course of action. A study of physicians with a “participatory decision-making style” showed this approach resulted in better health outcomes and more satisfied physicians. This research also found that physicians with a more participatory decision-making style were 30 percent less likely to have patients leave their care.

Online health/medical information

An important part of the patient-physician relationship is ensuring patients have the right amount of appropriate and accurate information about their health and medical conditions. In today’s internet-driven and information-loaded environment, physicians are often not the initial source of information about medical conditions or potential treatments. Patients are increasingly arriving at a clinic visit after reading information on medical information websites, sometimes even with a specific diagnosis in mind. This can be either problematic or beneficial for the patient-physician relationship, depending on whether and how the patient discusses what they have learned with their physician. For example, 80 percent of physicians report that access to online information has increased the likelihood that patients question their diagnosis or treatment plans. Confirming this observation, a study of patient perspectives revealed that when patients valued information found on the internet above their physician’s, that information led them to ignore their physician’s expertise. On the other hand, if patients openly discuss their findings with their physician and the physician is receptive to that discussion, this open communication can benefit the patient-physician relationship. Some patients believe that information seeking and discussion about that information with their physician enhances their relationship with their physician and supports their physician’s advice. While it can sometimes create barriers, online health and medical information accessed and used appropriately can benefit patients and physicians, and enhance their communication and overall relationship.

Health literacy

Although many patients are increasingly discussing self-searched health information with their physicians, and physicians are more often sharing information with patients throughout decision-making, it does not mean that patients always understand or can accurately interpret the information they are learning. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions. Low health literacy, primarily affecting older adults, minority populations, medically underserved people, and those with low socioeconomic status, can create barriers between the patient and their physician. Reasons for low health literacy include language limitations, limited education, use of medical vernacular by health care staff and clinicians, hearing impairment and cultural differences. These patients may have trouble communicating their complaints and health history to the physician or they may not understand the risks their behaviors pose on their health. They may not understand insurance and how to use their benefits, and they may have difficulty understanding medications and their effects. For some, the increase in access to information has
improved understanding and knowledge of their health. Although there is more online health care content than ever, and mobile health applications give patients more access and control over their health information, medical information websites or mobile applications are not always available to everyone. Patients with low health literacy are less likely to use computers and web applications (e.g., email, search engines, and online patient portals), limiting the benefits these sources of information have for certain populations.

Trust

Trust between patients and their physicians is crucial. Patients may have a general distrust of the medical profession due to a bad experience. They may need time to build trust with their physician, or they may not feel their physician has their best interest in mind. Physicians, on the other hand, may lack trust in their patient if the patient ignores treatment or medication plans, cancels or doesn’t show up for appointments, or neglects to provide complete information about health history. Shared decision making and open, non-judgmental dialogue about health and medical information as previously discussed, can help foster trust between patients and physicians. In addition, physicians and patients alike may harbor distrust as a result of implicit bias against the other party.

Implicit bias

Implicit bias, on the part of the physician or the patient, negatively affects the patient-physician relationship for many reasons. For patients, biases about providers can have implications for access to care. For example, 29 percent of patients in one survey said they would avoid a certain provider based on personal characteristics such as race, gender, or age. Getting in the way of a caring and respectful relationship are biased remarks made toward clinicians based on characteristics like weight, gender, or ethnicity. Fifty-nine percent of clinicians have experienced bias due to their physical appearances and 70 percent of Black and Asian clinicians report hearing biased remarks. Some biases can exist based on accents or attire such as certain types of headwear. Physicians can also bring biases to their practice. Implicit attitudes about personal characteristics such as weight or race can affect the way they interact with and treat patients. Predisposed notions about patients based on these outward-facing characteristics can unfairly influence a physician’s judgment about the individual’s condition or the best course of treatment. This inhibits the quality of patient care and damages the patient’s trust that the physician has their best interest in mind.

Adequate time

Sufficient time to focus on the patient during a clinic visit is important for both the patient and physician to develop and maintain a healthy and productive relationship. The patient needs time to ask questions and discuss their symptoms, concerns, and history. If they feel rushed by the physician, even if the physician does not intend to send that signal, the patient may feel unimportant and not cared for. The effective use of the patient visit by the physician gives the patient the sense they have been heard and they can comfortably express their concerns and feelings. Feeling that they are the focus of the physician’s attention and that they have been heard is more important to patients than the actual amount of time spent together.

Likewise, physicians want to have sufficient time with their patients to gather important information, look their patients in the eyes, and really listen to their concerns. Research has shown that one of the primary sources of physician satisfaction is patient relationships and one of the primary sources of dissatisfaction is “time pressure.” Productivity requirements and pressure to keep appointments to short durations can put pressure on physicians to limit their visit lengths to
only a few minutes. In addition, documentation requirements force the physician to spend an
inordinate amount of time focused on their electronic health record (EHR) rather than their
patient.\textsuperscript{16}

Recent data show that 33 percent of physicians in the U.S. spend 17 to 24 minutes with each
patient. Twenty-nine percent spend 13 to 16 minutes, and just 11 percent spend 25 or more minutes
with each patient.\textsuperscript{17} Research shows that longer visits allow for more attention to several aspects of
care, including increased patient participation, patient education, preventive care, and performance
of immunizations. In addition, patients are more likely to feel they had inadequate time with their
physician in visits scheduled to last five minutes compared with visits scheduled to last 10 and 15
minutes.\textsuperscript{18, 19} In the U.S., visit rates above three to four per hour are associated with suboptimal visit
content. Because patient satisfaction is increased by increased patient participation and activities to
educate the patient, it is suggested that more than three to four visits per hour would be associated
with decreased patient satisfaction.\textsuperscript{20}

Despite the efforts to identify the “optimal” amount of time for patient visits, it remains an elusive
goal, owing much to variability in patient visit lengths across specialties and countries.\textsuperscript{20} In
addition, because every patient is different and every patient-physician encounter is unique, it is
difficult and not preferable, to designate a universal minimum time for patient visits. To improve
the patient-physician relationship, the focus of physicians’ energy should be on quality interactions
and value-added tasks, rather than monitoring how many minutes they spend with the patient for
billing purposes.

\textit{Physical clinic settings}

The way in which a physician’s office or patient room is designed and organized can create barriers
to optimal communication with patients. Patient rooms in which a desk is placed so that the
physician cannot look at the patient do not allow for valuable eye contact and hands-on interaction.
A similar effect may occur if the physician places the computer screen between themself and the
patient or looks at the computer screen while exchanging conversation. Research has shown that
patient-physician communication can improve when the computer is placed alongside the patient
and physician, rather than between.\textsuperscript{21} Patients often perceive higher quality care and have less
anxiety when visiting their physician when they find the practice environment attractive.\textsuperscript{22, 23} Other
design elements such as lighting can improve communication skills, mood, alertness, and
performance for the entire care team.\textsuperscript{23, 24}

\textit{Communication}

Communication between physicians and their patients is critical to the success of their relationship.
Communication can be verbal and non-verbal, and both types have an impact on the patient’s
outcomes and the effectiveness of the relationship. Verbal communication includes expression
through words of empathy, assurance, explanations, humor, friendliness, summarization of the
visit, and others. Non-verbal communication is seen in behaviors such as head nodding, direction
of gaze, leaning, arm and leg crossing, and others. Clear and open communication between patients
and physicians can enable better decisions about care\textsuperscript{25} and better communication between patients
and physicians is linked to both better patient outcomes\textsuperscript{26, 27} and lower rates of physician burnout.\textsuperscript{28}
Factors that inhibit effective communication include all of the previously mentioned elements. In
addition, general withholding of information by either the physician or patient diminishes the
quality and appropriateness of care, reduces trust, and can put the patient at risk. Doctors tend to
overestimate their abilities in communication. Tongue et al. reported that 75 percent of orthopedic
surgeons surveyed believed they communicated satisfactorily with their patients, but only 21
percent of the patients reported satisfactory communication with their doctors.\textsuperscript{29} Patient surveys have consistently shown that they want better communication with their doctors.\textsuperscript{30}

**External influences**

Regulatory requirements and technological interference are also known to create barriers between patients and their physicians. The EHR and other technologies like mobile devices or health applications accessed through mobile devices can sometimes enhance, but often interfere with, the communication and quality of visits between patients and physicians. External factors can detract from the quality of care physicians feel they can provide; nearly 40 percent of physicians report patient care is adversely impacted to a great degree by external factors such as third-party authorizations, treatment protocols, and EHR design.\textsuperscript{31}

Some of the external factors identified are significant inhibitors to the patient-physician relationship. EHRs, documentation requirements, and prior authorization each present specific challenges and outcomes that, from both the patient and physician perspective, are barriers to high-quality health care and communication. In addition, telemedicine has proven to be a valuable tool for delivering remote patient care, especially during the COVID-19 pandemic, but it presents its own challenges and barriers to the patient-physician relationship. A lack of access to technology or comfort with the use of technology can also hinder the patient-physician relationship and delay information exchange.

**Electronic Health Records**

In 2014 the AMA partnered with RAND to identify and describe obstacles to professional satisfaction and the ability to provide high-quality care. EHRs, when they interfere with face-to-face patient care, were found to detract from physician professional satisfaction.\textsuperscript{32} The amount of time physicians spend doing administrative work includes more than half their day on completing tasks in the EHR and almost 90 minutes of EHR work at home after clinic hours.\textsuperscript{33} Physicians also report that their EHRs have reduced or detracted from the quality of care, efficiency of practice, and interaction with patients.\textsuperscript{31, 34}

While the EHR is a documented source of physician frustration and dissatisfaction, the design and function of the EHR system are only one part of the problems physician users experience while using their EHR. Decisions made by regulators, administrators, and policymakers influence the end use of EHRs, adding to the ways EHR use can interfere with patient care. For example, documentation requirements mandated by federal policy and payers result in physicians spending much of the patient visit looking at their computer screen instead of the patient. The quality of the implementation and training can make a difference in the effective use of the EHR during patient interactions. If users are not trained effectively, or the rollout of upgrades impedes daily work, efficient use of the EHR is undermined. Poor or no interoperability with other patient information systems can detract from the physician’s access to current and relevant patient data.\textsuperscript{35} All of these factors have the potential to contribute to unsatisfactory patient-physician communication.

Despite this, evidence shows the use of an EHR has no impact on the patient’s satisfaction or perception of patient-physician communication, suggesting that EHRs may be more of an issue for physicians than patients.\textsuperscript{36} Similarly, the RAND research showed EHRs facilitated enhanced communication with patients, contributing to improved satisfaction for some physicians. This was particularly true for communication outside the patient room. Fifty-four percent of physicians surveyed indicated using an EHR enhances patient-doctor communication that is not face-to-face. An excerpt from the report describes this experience:
I think, if used correctly, [the EHR] definitely improves communication and helps in terms of patient care overall, with tracking what’s going on with the patient. I think it’s helped with patient-to-physician communication.

Documentation requirements

Increasing documentation requirements from Medicare and commercial payers have also added to physicians’ administrative workload. A 2013 survey indicated 92 percent of medical residents and fellows reported that documentation requirements were excessive. Clinical documentation requirements have increased over time with the mandated use of EHRs, increased quality reporting, and increased demand for data. Much of the U.S. medical coding system is time-based, which has led to overemphasis on the amount of time spent with each patient and excessive focus on “checking the boxes” to ensure documentation requirements are met. The Centers for Medicare and Medicaid Services (CMS) recently enacted changes to the documentation requirements for evaluation and management (E/M) services developed by the AMA’s CPT Editorial Panel. These changes will allow physicians to bill based on case complexity with less emphasis on the number of minutes spent. Physicians will only be required to enter medically necessary information, enabling them to spend more time connecting with their patient to collect high-value, relevant information instead of redundant information. Further discussion on the Medicare E/M coding changes and their anticipated benefits to the patient-physician relationship is presented in another section of this report.

To reduce the burden of documentation during patient visits, many physicians employ the use of documentation assistance tools or staff, such as speech recognition technology or medical scribes. It has been found that access to documentation support, such as that of a medical scribe, can increase the amount of direct face time with patients during a visit. Medical scribes work in a variety of practice settings, including hospitals, emergency departments, physician practices, long-term care facilities, ambulatory care centers, and others. In a 2015 retrospective comparative study, physicians with medical scribes saw 9.6 percent more patients per hour than physicians without a medical scribe. Physicians who use medical scribes say they “feel liberated from the constant note-taking that modern [EHRs] demand” and they can “think medically instead of clerically.”

When face-to-face time with the patient increases, physicians can listen and respond more thoroughly without the distraction of entering data into the EHR, giving patients a better experience. Physicians are in turn able to provide the level of care they find the most satisfying. There is evidence the use of speech recognition technology and medical scribes improves physician satisfaction, including clinic, face time with patients, time spent charting, and accuracy and quality of their charts. Patients also experience increased satisfaction with their physician visits when a scribe is present to document for the physician. In one study of patients surveyed about their physician’s use of documentation assistance, 85 percent felt that having a scribe type notes for the doctor improved the overall quality of their visit. Seventy-four percent also said that they would like their other doctors to have scribes to type the exam notes.

The evidence available suggests that documentation assistance, whether through the use of speech recognition technology or a medical scribe, can improve the communication and quality of visit between patients and their physicians. Board of Trustees Report 20-A-17, “Study of Minimum Competencies and Scope of Medical Scribe Utilization,” provides additional information about the use of medical scribes in the practice of medicine.
Prior authorization

It has been well-documented, by the AMA and others, that prior authorizations required by payers are another source of dissatisfaction and burden for physicians.\textsuperscript{44, 45} In addition to being a source of burden, a 2019 AMA survey showed 90 percent of physicians reported prior authorization has a negative impact on patient clinical outcomes. Seventy-four percent said prior authorization can lead to treatment abandonment, and 24 percent said prior authorization led to a serious adverse event for a patient in their care.\textsuperscript{45} The financial toll, emotional distress, and psychological effects on patients of treatment delays and confusing prior authorization procedures can be substantial.\textsuperscript{46} These effects could also lead to patients avoiding treatment or seeking care in the future, ultimately undermining the patient-physician relationship and the physician’s ability to provide the best care for their patients. Reducing the prior authorization burden would return some of the physician’s autonomy and help ensure the patient receives the appropriate care, helping to strengthen the relationship between patient and physician.

Telehealth

Telehealth has been a tool for delivering remote patient care for many years but was not widely adopted. The onset of the COVID-19 pandemic in early 2020 drastically expanded the use of telemedicine services for patient care delivery.\textsuperscript{47} Connectivity issues or general technological challenges may create barriers for effective telemedicine visits, and access to the technology may not be available for all patients, leading to the potential risk of jeopardizing the patient-physician relationship. Telehealth has proven its value to the practice of medicine, and there are many benefits to both the patient and physician,\textsuperscript{48} yet some concerns about telehealth contributing to the erosion of the patient-physician relationship remain. Although AMA policy supports establishing patient-physician relationships via telehealth when clinically appropriate, it is still recommended that the establishment of a new patient-physician relationship take place during an in-person visit.\textsuperscript{49} This in-person connection, a bond-forming element based on human awareness of personal space and the healing effects of human touch and face-to-face interactions, is integral to successful patient-physician relationships.\textsuperscript{50}

AMA advocacy, research, and resources

Our AMA has historically advocated on physicians’ behalf for changes in policy and practice that would improve and enhance the patient-physician relationship. AMA’s ongoing advocacy aims to reduce documentation burden, reform prior authorization requirements, increase transparency, and improve EHR technology so physicians can spend more time with their patients.

In addition to its tireless advocacy efforts, our AMA has worked on many levels to develop resources and education for physicians to help enhance their communication and relationship with their patients. In addition, the AMA has dedicated significant resources to researching the factors that detract from physicians’ ability to provide high-quality patient care, including but not limited to the studies previously referenced in this report. AMA supports and carries out research efforts aimed at understanding and identifying solutions to the issues that create barriers between physicians and their patients. The AMA has studied how physicians spend their time to quantify the administrative burdens during and after a physician’s work day.\textsuperscript{16} The AMA published a report on bullying in the practice of medicine and the effects it can have on physician well-being and their ability to provide high-quality patient care.\textsuperscript{51} The AMA has also published research on the burdens of EHRs, including the time to complete tasks, the usability of products, and the process of EHR development.\textsuperscript{33, 52} The AMA’s research includes a time-motion study to determine how much and in what ways physicians spend time completing tasks in their EHRs. The AMA has also published
eight EHR usability priorities, which outline and support the need for better usability,
interoperability, and access to data for both physicians and patients. If followed, these priorities
will enable the development of higher-functioning, more efficient EHRs, contributing to a
reduction in the burden that EHR use places on patient care.

In 2019 the AMA established the Center for Health Equity to embed health equity into the
processes, practices, innovations, and performance of our AMA. This unit works to help the AMA
address issues that contribute to health disparities and inequity, including bias, stereotyping, and
prejudice, which can all inhibit a successful patient-physician relationship. By helping to reduce
these implicit influences, AMA enhances its ongoing work to preserve the integrity of physicians’
relationships with their patients.

Multiple collaborations are in place to help foster better EHR design and innovative health
information technology (HIT) solutions to help make the EHR user experience better and more
efficient. The AMA has established collaborations and partnerships with the organizations such as
SMART Initiative, AmericanEHR Partners, Carequality, Sequoia Project and Medstar Health’s
National Center for Human Factors in Healthcare to help foster innovative HIT design
interoperability and transparent testing solutions which will to help ensure EHRs are designed and
implemented with physicians and patients in mind. The AMA Physician Innovation Network also
connects physician experts with industry innovators to facilitate the integration of the clinical voice
and the patient experience into HIT innovation. Finally, the AMA recently worked with various
industry stakeholders, including five EHR vendors, to develop a Voluntary EHR Certification
framework which will help catalyze an industry-wide shift to higher-quality EHR systems that
enable better, more efficient use.

The AMA, as part of its prior authorization reform initiatives, convened a workgroup of 17 state
and specialty medical societies, national provider associations, and patient representatives to
develop a set of Prior Authorization and Utilization Management Reform Principles. These
principles spurred conversations between health care professionals and insurers on the need for
prior authorization reform, which culminated in the release of the Consensus Statement on
Improving the Prior Authorization Process. The consensus document reflects an agreement
between national associations representing both providers and health plans on the need to reform
prior authorization programs in multiple ways, including reducing the overall volume of prior
authorizations and advancing automation to improve transparency and efficiency. The AMA, in
addition to providing an evidence base demonstrating the need for prior authorization reform,
offers multiple resources to help physicians understand prior authorization laws and improve
processes within their practices.

The AMA and CMS in 2019 worked together to achieve the first overhaul of E/M office visit
documentation and coding in more than 25 years. Specifically, Medicare began to allow physicians
to document review and verification of history entered into the medical record in lieu of re-entering
the same information. For established patients, history and examination already contained in the
medical record no longer needs to be re-entered and physicians can document only what has
changed and relevant items that have not changed since the patient’s last visit. The changes
implemented are a significant step in reducing administrative burdens that get in the way of patient
care and will allow physicians to spend more time with their patients, one of the key elements to a
meaningful patient-physician relationship. Considering the variation in patients, case complexity,
and specialty-specific needs, the AMA is not in favor of imposing a universal minimum time for
patient visits and supports these changes that enable physicians more flexibility determining the
appropriate amount of time to dedicate to their patients. The AMA is collaborating with the
University of California San Francisco to investigate changes in documentation and coding time,
perceived burden and physician burnout throughout the phases of the E/M coding changes. The outcomes of this research will help institutional leaders and physicians identify additional opportunities to reduce physician administrative burden and increase time spent with patients. This research will also prioritize and inform advocacy efforts with federal (e.g., CMS) and state regulators, commercial plans and EHR vendors to further address issues such as coding, documentation, and burden reduction on behalf of physicians, their practices and patients.

The AMA during the COVID-19 pandemic has advocated for the expansion of and reimbursement for telehealth so that patients can experience continuity of care and so physicians are adequately compensated for their time providing remote patient care. The AMA’s Digital Health Implementation Playbook series offers comprehensive step-by-step guides to implementing telehealth in practice. Each Playbook offers key steps, best practices, and resources to support implementation. The AMA continues to publish new guidelines and resources, as well information about the latest updates on telehealth expansion amid COVID-19.

The AMA offers and continues to develop education modules that teach strategies and tactics to help physicians save time on clerical and basic clinical tasks so that they have more time for relationship-building and medical decision making with patients. Many of AMA’s STEPS Forward™ modules address some aspect of organizational culture or practice efficiency to help physicians optimize their patient relationships, including several that aim to help practices save time, communicate more effectively, and improve patient and provider satisfaction.

The AMA’s ongoing work to reduce physician burnout strives to remove the obstacles and burdens that interfere with patient care or hinder communication with patients. This work includes the AMA Practice Transformation Initiative (PTI), which supports researchers in building evidence on effective interventions to reduce burnout and increase physician satisfaction within their health systems. Interventions implemented through the PTI include measures to enhance the roles of non-provider care team members to reduce administrative burden for physicians, and to gain efficiencies in physician time. Other interventions aim to help clinicians maximize their practice efficiency, promote self-care, and address sources of burnout and stressful workplace situations. The AMA also offers institutional assessments to help organizations measure burnout among their physician staff, implement improvements, and develop evidence-based support systems within their practices, reducing burnout and improving physicians’ ability to provide high-quality patient care. In addition, the AMA offers a guideline, “Collaborative communication strategies: Partner with patients,” to help clinicians communicate clearly and effectively with patients, particularly about treatment adherence which is one of the key elements of a successful patient-physician relationship.

CONCLUSION

Many factors contribute to the dynamics of a relationship between a patient and physician, including shared decision-making, online health and medical information, health literacy, trust, implicit bias, physical settings, communication, and external influences. These factors have been studied and written about at length. The evidence shows that patients and physicians both have better experiences when they feel they have adequate time for talking and making decisions about treatment together. Physicians have better experiences when they have assistance with documentation so they can spend more of their visit face-to-face with their patients rather than looking at the computer. Physicians are more satisfied with their patient relationships when patients trust them. Patients are more satisfied with their clinic visits and their physicians when they feel they have been listened to and allowed to talk about their concerns. Improving communication and
preventing implicit biases from influencing care decisions are ways both physicians and patients can ensure their relationships with one another are healthy, trusting, and productive.

Considering the volume and range of published literature about the barriers to patient-physician relationships identified in Resolution 703-A-19 and discussed in this report, it is not recommended that additional formal research be undertaken by the AMA. The AMA will continue to dedicate significant resources to helping physicians overcome these barriers to enhance and preserve their relationships with their patients.

RECOMMENDATION

The Board of Trustees recommends that Resolution 703-A-19 not be adopted and that this report be filed.

Fiscal note: None
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Physician Satisfaction, Patient Satisfaction, and Charting Efficiency: A Randomized
At the November 2020 Special Meeting, the House of Delegates (HOD) referred Resolution 710, “A Resolution to Amend the AMA’s Physician and Medical Staff Bill of Rights.” Resolution 710 was sponsored by the Medical Society of Virginia and instructed the AMA to amend Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” to add new text to the preamble as shown below:

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

Preamble

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

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

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

The AMA recognizes the responsibility to provide for the delivery of high quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization’s governing body, and relies on accountability and interdependence with government and public health agencies that regulate and administer to these organizations.
The AMA supports the right to advocate without fear of retaliation by the health care organization’s administrative or governing body including the right to refuse work in unsafe situations without retaliation.

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

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

Testimony overwhelmingly supported referral of Resolution 710, noting the complexity of issues raised by the proposed changes. In particular, testimony reflected that while the suggested additions were particularly timely during the COVID-19 pandemic, the enumeration and description of medical staff and physician rights and responsibilities should be considered carefully with an eye toward how these immediate needs might fit into a description of broader, longer-term concerns.

DISCUSSION

Resolution 710 ultimately sought to protect individual physicians and medical staffs collectively from retaliation or retribution when speaking out, either publicly or privately, about physician or patient care concerns. This issue has been particularly applicable during the COVID-19 pandemic as physicians across the country sought to address the lack of access to adequate personal protective equipment. Protecting physicians in and outside of their places of work and empowering them to advocate on behalf of their patients are long-standing tenets of AMA practice and policy, so their inclusion in an enumeration of medical staff and physician rights and responsibilities should be supported.

Resolution 710 affirms the right of physicians to advocate, both inside and outside of their organizations, for what they and their patients need. Individual physician and medical staff advocacy directed at an organization’s administration and governing body is encouraged and should be conducted freely, without fear of retaliation or retribution. Advocacy efforts oriented toward external decisionmakers should be informed by medical staff input and even be guided by it when appropriate. While conscientious physicians will take care to ensure internal and external advocacy efforts are conducted in a way that does not disadvantage care delivery or unnecessarily interfere with their organizations’ operations, physicians advocating either independently or collectively always should be protected from undue adverse consequences.

Accordingly, we support the content additions proposed by Resolution 710. But we note the importance of properly integrating these ideas into the existing policy. Much of the proposed verbiage is already included in the “rights and responsibilities” portion of the existing policy, with Resolution 710 proposing that it be repeated in the preamble. In order to preserve the expository role of the preamble, which is intended to address the theoretical underpinnings of medical staff and physician rights and responsibilities and explain why enumerating them is necessary, we instead recommend that the ideas set forth by Resolution 710 be incorporated into the rights and responsibilities articles themselves.
RECOMMENDATION

The Board of Trustees recommends that the following be adopted in lieu of Resolution 710-NOV-20 and that the remainder of the report be filed:

1. That AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” be amended by addition and deletion:

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

   Preamble

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

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

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

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

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

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:
a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
b. The right to advocate for its members and their patients without fear of retaliation by the health care organization’s administration or governing body, both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.
c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.
e. The right to be represented and heard, with or without vote, at all meetings of the health care organization’s governing body.
f. The right to engage the health care organization’s administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:
a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
d. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.
e. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
f. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
g. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.
IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization’s administration or governing body, including advocacy both in collaboration with and independent of the organization’s advocacy efforts with federal, state, and local government and other regulatory authorities.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.
g. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization’s advocacy efforts, without fear of retaliation by the medical staff or the health care organization’s administration or governing body.

(Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000
Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another ten years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.
RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

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<td>D-125.992</td>
<td>Opposition to Prescription Prior Approval</td>
<td>Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians. (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>D-165.985</td>
<td>Evolving Internet-Based Health Insurance Marts</td>
<td>Our AMA will continue to monitor the evolution of the Internet-based health benefits industry and report to the House of Delegates on important developments. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Rescind. Superseded by Policy H-165.839, which states: 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges: A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.</td>
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2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.

D-385.960  Appropriate Payments for Vaccine Price Increases  Our AMA will work with national specialty societies to educate physicians to include language in their health insurer contracts to provide for regular updating of vaccine prices and payment levels, which should include Retain. Still relevant.
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<td>D-390.958</td>
<td>The Impact of National Physician Payment Reductions on the National Unemployment Rate</td>
<td>Our AMA will expand its previous studies on the economic impact on the medical practice for the purpose of developing data on the negative economic impact on physician practice employees and communities of incremental SGR cuts and will include in future communications with the US Congress, other stakeholders, and the American people, data-driven information on the national economic impact, including the impact from potential loss of employment of medical practice employees and others, due to payment decreases for physician practices. (Res. 218, I-11)</td>
<td>Rescind. The SGR was repealed in 2015. Moreover, the AMA regularly conducts economic analyses that inform AMA advocacy on behalf of physician practices, including a COVID-19 Physician Practice Financial Impact Survey and Changes in Medicare Physician Spending During the COVID-19 Pandemic.</td>
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| D-400.991 | gCPT Modifiers | (1) Our AMA will continue to actively collect information, through existing processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data collection from other interested members of the Federation on the acceptance of CPT modifiers by third party payers.  
(2) Pertinent information collected by our AMA through existing methods and collected through the AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be shared with applicable state, county and national medical specialty societies in order to promote a greater understanding of third party payer payment policies related to CPT modifiers.  
(3) Our AMA use the available information to engage in discussions with payers.  
(4) Aggregate information collected through existing methods and collected through the AMA PSA Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be disseminated to state and federal regulators and legislators.  
(Sub. Res. 808, I-01; Modified: CMS Rep. 7, A-11) | Rescind. Superseded by Policy D-70.971 which states:  
(1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.  
(2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.  
(3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.  
(4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.  
(5) Our AMA will include in its model managed care contract, provisions that will require |
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<td>D-400.994</td>
<td>Conscious Sedation</td>
<td>Our AMA will support the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) as they review the coding and valuation issues related to procedures that are performed using moderate sedation/analgesia (i.e., “conscious sedation”). (Res. 107, A-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Rescind. Directive accomplished. New CPT codes for moderate sedation were implemented and RUC recommendations were adopted by CMS in 2017.</td>
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<td>D-435.996</td>
<td>Malpractice Insurance Rate Increases and Physician Reimbursement</td>
<td>Our AMA will: (1) call upon the CMS to use current data in calculating the malpractice insurance portion of the Resource-Based Relative Value Scale and that this calculation take into account inter-specialty and geographic variances; and (2) study the calculated malpractice insurance portion of the RBRVS to determine the effect increasing malpractice insurance costs have on physician reimbursement. (Res. 109, A-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>D-70.983</td>
<td>Inappropriate Bundling of Medical Services by Third Party Payers</td>
<td>Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices; (2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate</td>
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<td>H-100.964</td>
<td>Drug Issues in Health System Reform</td>
<td>bundling of services, rejection of CPT modifiers, and denial and delay of payment; (3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate; (4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician; (5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and. (6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA’s advocacy on this issue. (CMS Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain-in-part. The following subsections should be rescinded for the reasons provided below. Policy H-100.964 should otherwise be retained as still relevant.</td>
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The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package. (2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited. (3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices. (4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the |
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<td>substitution of FDA B-rated generic drug products.</td>
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<td>(5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.</td>
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<td>(6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.</td>
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<td>(7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information, and supports the physician’s role as the “learned intermediary” about prescription drugs.</td>
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<td>(7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.</td>
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<td>(8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance.</td>
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<td>(10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive “formulary” drug because economic</td>
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<td>incentives can interfere with pharmacist professional judgment.</td>
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<td>(11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.</td>
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<td>(12) supports CEJA’s opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA’s MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public disclosure of patient and reporter identities.</td>
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<td>(13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.</td>
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<td>(14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.</td>
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<td>(15) encourages the use of three compendia (AMA’s DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses.</td>
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<td>16</td>
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<td>(16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs.</td>
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<td>17</td>
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<td>(17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies.</td>
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<td>H-130.945</td>
<td>Overcrowding and Hospital EMS Diversion</td>
<td>It is the policy of the AMA: (1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds; (2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department; (3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups; (4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities; (5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and (6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions. Citation: (CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02; Reaffirmed in lieu of Res. 201, I-11)</td>
<td>Retain. Still relevant.</td>
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| H-155.974 | Excessive Regulatory Costs     | Our AMA will: (1) support actively seeking reduction in regulatory requirements such as record review, length-of-stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals,  
(2) vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated;  
(3) seek through appropriate legislative channels support for an Economic Impact Statement requirement for all legislation and regulation affecting the delivery of medical care and that the increased cost be reflected in the RBRVS value; and  
(4) advocate that all governmental health care cost containment activities must simultaneously evaluate and report the total costs associated with their activities, and that government, federal, state and local, join the medical profession and hospitals in their efforts to contain the cost of health care, by reducing the number of regulations, reports, and forms. (Res. 125, A-79; Reaffirmed: CLRPD Rep. B, I-89; Res. 54, I-90; Res. 147, I-90; Res. 135, A-92; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 25, I-01; Reaffirmed: BOT Rep. 7, A-11) | Retain. Still relevant. |
| H-165.862 | Evolving Internet-Based Health Insurance Marts | Our AMA endorses the concept and use of Internet-based health insurance marts and health benefits systems as mechanisms for employers and individuals to select and purchase health insurance. (CMS Rep. 5, A-01; Reaffirmed: CMS Rep. 7, A-11) | Rescind. Superseded by Policy H-165.839, which states: |
|         |                                | 1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:  
A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.  
B) Any benefits standards implemented for plans participating in the exchange |
and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. C) Physician and patient decisions should drive the treatment of individual patients. D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process. F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion
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<tr>
<td>H-180.948</td>
<td>Opposition to Incentives for Care in Non-Physician Clinics</td>
<td>Our AMA will communicate with large insurance companies that providing incentives to patients toward non-physician clinics outside the primary care physician relationship can lead to decisions made on limited information, duplication of testing and procedures, ultimately higher health care costs and a reduction in the quality of health care for the patients of America. (Res. 708, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-185.985</td>
<td>Internal Guidelines Used by Third Party Payers to Determine Coverage</td>
<td>Our AMA calls upon all third party payers and appropriate federal regulatory agencies to make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians. (Res. 126, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Rescind. Superseded by Policy H-185.984, which supports 24-hour-a-day access to patient coverage and benefits information.</td>
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<td>H-200.995</td>
<td>Federally Funded Clinic Programs</td>
<td>Our AMA supports the following policy statements regarding federally funded clinics: (1) Physician services should be available in underserved areas and should be provided in a manner which ensures continuity of patient care, integration with the existing health system, and retention of the health providers. (2) Physicians should be sensitive and responsive to indicators of need for additional health personnel or accessibility of health care. Through their component medical society, physicians should seek involvement in the designation process for Health Manpower Shortage Areas and</td>
<td>Retain. Still relevant.</td>
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Medically Underserved Areas. The medical community and local residents are in an excellent position to ascertain the need for additional health providers in the community, and to support appropriate decisions in that regard.

(3) Where need is clearly identified, through a federal designation process or other means, the local medical community should explore alternatives for responding appropriately to meet the need.

(4) Where physicians have responded appropriately to needs identified through the designation process, the component medical society should work with the local planning groups to remove the area’s designation, so that federal resources are not called on to duplicate services.

(5) Where identified needs cannot be met by the local medical community, and all local public and private financial assistance options are determined to be inadequate, federal assistance should be sought. In such cases, the local medical community should assume the responsibility of working with the agency applying for federal funds to facilitate the placement of health personnel with long range service potential.

(6) Where inappropriate designations were made leading to capacity which exceeds the need, the patient volume is likely to be low, and the unit costs excessive. In such situations, constructive consultation between the local medical community and the federally funded clinic program should explore options for a resolution of the problem. (Res. 125, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)

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<td>H-215.964</td>
<td>Patient Identification Wrist Bands</td>
<td>Our AMA (1) supports the concept of uniform patient identification wrist bands at all hospitals and other health care facilities where wrist bands are used; (2) encourages the adoption of uniquely colored patient identification wrist bands for specific patient information, such as, patient’s name, allergies and those with identified greater fall risk; and (3) will actively pursue national standardization of</td>
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<td>H-215.984</td>
<td>Duplicate Bureaucratic Regulations</td>
<td>Our AMA encourages the identification of duplicate regulatory activities and inspection in hospitals and nursing homes so that these matters may be brought to the attention of legislators, governors and regulatory agencies. It is AMA policy that such information be made available nationally via the AMA and the AHA in an attempt to eliminate duplicate bureaucratic bodies and unnecessary regulations. (Res. 53, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-220.930</td>
<td>Regulatory Standards Should be Evidence-Based</td>
<td>Our AMA will work through its representatives on the Joint Commission and with other deeming authorities and the Centers for Medicare &amp; Medicaid Services to: (1) ensure that clinical standards imposed on health care institutions and providers be evidence-based with significant efficacy and value, as demonstrated by best available evidence; and (2) require that appropriate citations(s) from the peer reviewed scientific literature be</td>
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<td>H-220.950</td>
<td>Medical Staff Involvement in Hospital Compliance With Accrediting Organization Standards Plans of Action to Correct Deficiencies</td>
<td>Our AMA: (1) adopts the policy that a hospital medical staff must be appropriately involved in a surveyed organization’s development of a plan of action to correct a deficiency and that such involvement be consistent with existing medical staff bylaws, rules and regulations; (2) encourages hospital medical staffs to amend their bylaws, if necessary, to establish processes to ensure appropriate medical staff input into the development of a plan of action to correct a deficiency; and (3) urges accrediting organizations to work to ensure that these principles are part of their accreditation standards. (Res. 810, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-220.953</td>
<td>Quality Improvement Requirements for Leadership Structures of Health Care Organizations</td>
<td>Our AMA supports the following concepts for incorporation in The Joint Commission’s accreditation programs for health care organizations: (1) establish accreditation programs with greater emphasis on the assessment of the effect that actions and decisions of the administrative and governing bodies of health care organizations have on the quality of patient care; (2) establish the requirement that management efforts must be made in concert with those of physicians, nurses and other health care professionals pursuant to the needs of the patients served by these professionals and the prevailing standards of practice; (3) establish the requirement of assessing major processes in the health care organization with the goal of continuous improvement rather than intensely focusing on individual persons or services; (4) establish the requirement that risk management processes be established that will emphasize prevention of problems rather than policies that call for taking action only after a problem has arisen; (5) establish accountability of the management and governance elements.</td>
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<td><strong>of a health care organization to its professional staff of physicians and nurses; and</strong> (6) require that the bylaws of the governing body provide a process through which the medical staff could appeal any decision made by the administration and/or the governing body which has an adverse effect on the quality of care rendered to patients, require that medical staff bylaws provide a process by which the need for such an appeal is identified, and provide a process for making the appeal. (Res. 822, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)</td>
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<tr>
<td>H-220.995</td>
<td>Hospital Guidelines Impact Statement</td>
<td>Our AMA recommends that when guidelines, rules and specific recommendations to hospitals and other medical facilities are originated by accreditation, certification or regulatory agencies, they include a proof of impact statement to include (1) actual or estimated costs of implementation (as a total cost or cost per bed). Included in the costs should be estimates of volunteer medical staff time required to implement the policy; (2) a brief statement of the expected benefit, goal or improvement in health care or reduction in health care costs; (3) a brief outline of the data tending to prove that the guidelines and rules will actually and significantly improve patient care, not have an adverse impact, and will accomplish the intended goal stated in the benefit statement; and (4) cost estimates of implementation and ongoing compliance, for small, medium, and large hospitals, and/or other health care facilities. (Res. 37, A-79; Reaffirmed: CLRDPD Rep. B, I-89; Reaffirmed in lieu of Res. 816, I-93; Amended: Sub. Res. 805, I-01; Modified: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-225.952</td>
<td>The Physician’s Right to Exercise Independent Judgement in All Organized Medical Staff Affairs</td>
<td>Our AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent</td>
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<td>H-225.972</td>
<td>AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs</td>
<td>It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible. (Res. 808, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-235.974</td>
<td>Autonomy of the Hospital Medical Staff</td>
<td>Our AMA (1) believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel policies and programs; (2) believes hospital medical staffs should develop personnel policies and programs for members of the hospital medical staff and incorporate these policies in the medical staff bylaws or rules and regulations; and (3) understands that there are physicians who are not members of the medical staff but who are employees of the hospital and their participation in hospital programs should be dictated by their employment agreements. (Res. 832, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-240.997</td>
<td>Patient Signatures for Medicare Payment</td>
<td>Our AMA endorses a proposal to permit all physicians to use the patient signature on hospital records in completing any claim form accepted by</td>
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<td>H-25.989</td>
<td>Long-Term Care Prescribing of Atypical Antipsychotic Medications</td>
<td>Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with “black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare.” (Res. 819, I-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-285.920</td>
<td>Criteria for Level of Care Status</td>
<td>(1) Our AMA support the development and use of level of care guidelines that meet the following criteria: (a) Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions; (b) Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances; (c) Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment; (d) Level of care guidelines should be developed under the direction of actively practicing physicians; (e) Level of care guidelines should be developed based on individual patient severity of illness and intensity of service;</td>
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<td><em>(f)</em> Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus; <em>(g)</em> Level of care guidelines should be reviewed and updated; and <em>(h)</em> Level of care guidelines should allow for a timely appeal process. <em>(2)</em> It is the policy of the AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines. <em>(CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11)</em></td>
<td>Retain. Still relevant.</td>
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<td>H-285.921</td>
<td>Managed Behavioral Health Organizations (MBHOs)</td>
<td>It is the policy of our AMA that, when requested, Managed Behavioral Health Organizations (MBHOs) should share their written disease management protocols with primary care and other treating physicians. When a patient is receiving treatment for mental illness and/or chemical dependency through an MBHO, with the patient’s permission and in accordance with relevant legal requirements, the primary care physician should be notified immediately; and, if requested, be kept apprised of the patient’s treatment (including all medications prescribed) and progress, so that the primary care and other treating physicians can coordinate the patient’s health care needs in optimal fashion. <em>(Res. 702, I-01; Reaffirmed: CMS Rep. 7, A-11)</em></td>
<td>Retain. Still relevant.</td>
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<td>H-290.981</td>
<td>Out-of-State Medicaid Patients</td>
<td>The AMA encourages the CMS to propose regulations that prohibit state Medicaid programs from requiring physicians and other providers to be credentialed in the patient’s state of residency, as long as the physician or provider is credentialed where the care is rendered. <em>(Res. 136, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmation A-11)</em></td>
<td>Retain. Still relevant.</td>
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<td>H-330.954</td>
<td>Mandatory Transmission of</td>
<td>Our AMA opposes the policy of local Medicare carriers of mandating that physicians choose between electronic</td>
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<td>Electronic Claims</td>
<td>remittance advice or standard paper remittance report until all secondary insurers accept the electronic remittance advice explanation of benefits in its present format. (Res. 815, A-93; Appended: Res. 107, I-00; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)</td>
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<td>H-340.997</td>
<td>Medicare Preauthorization Review</td>
<td>Our AMA opposes the mandating of blanket hospital preadmission review for all patients or for specific categories of patients by government or hospital edict, and supports the prerogative of physician-directed peer review organizations to implement focused preadmission review on a voluntary basis. (CMS Rep. G, A-84; Reaffirmed by CLRPD Rep. 3-I-94; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11)</td>
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| H-345.976 | Medicaid Coverage of Adults in Psychiatric Hospitals | 1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders.  
2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes.  
3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services. (CMS Rep. 3, A-11) | Retain. Still relevant. |
<p>| H-35.992  | Reimbursement for Allied Health Personnel   | Our AMA believes that (1) reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel; and (2) such personnel should be under the supervision of practicing physicians. (BOT Rep. A, NCCMC Rec. 41, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. H, A-93; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11) | Retain. Still relevant. |
| H-380.995 | Insurance Carrier Terminology              | Our AMA urges individual physicians to consider including in their patient information materials an explanation as to why the amount billed may in some cases be more than the insurance benefit paid. (CMS Rep. F, I-81; CLRPD Rep. F, I-91; Reaffirmed: Rescind. Superseded by Policy H-390.865, which calls for a universal EOB to be issued to both the patient and the physician that includes an explanation of billed, covered and patient responsibility amounts. |                  |</p>
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<td>H-385.916</td>
<td>Reimbursement for Office-Based Surgery Facility Fees</td>
<td>Our AMA urges third party payers to include facility fee payments for procedures using more than local anesthesia in accredited office-based surgical facilities. (Res. 716, A-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-385.917</td>
<td>Interpreter Services and Payment Responsibilities</td>
<td>Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services. (CMS Rep. 5, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-385.925</td>
<td>Selective Revenue Taxation of Physicians and Other Health Care Providers</td>
<td>Our AMA: (1) strongly opposes the imposition of a selective revenue tax on physicians and other health care providers; (2) will continue to work with state medical societies on issues relating to physician and other provider taxes, providing assistance and information as appropriate; (3) strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform; and (4) believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs. (Sub. Res. 258, A-92; Reaffirmed: Res. 134, A-93; Res. 207, I-93; Reaffirmation A-99; Reaffirmation A-00; Appended Res. 132, A-01; Reaffirmation A-05; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: CMS Rep. 6, I-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-385.932</td>
<td>Contact Capitation Contracts</td>
<td>Our AMA strongly encourages all physicians contemplating entering into contact capitation agreements to exercise extreme caution, with attention to business skills and competencies needed to successfully practice under contact capitation arrangements and potentially uncontrollable market forces that may impact upon ones</td>
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<td>H-385.940</td>
<td>CPT Codes for Evening and Night Services</td>
<td>Our AMA will continue its efforts to advocate for the fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services and unusual travel. (Sub. Res. 821, A-98; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-385.967</td>
<td>Incentives and Penalties to Encourage Third Party Payers to Make Prompt Payment of Health Insurance Claims</td>
<td>It is the policy of our AMA to investigate and document reports of problems with delays in payments by third party payers, including the federal government, and to seek legislation or regulations that assure prompt payment by all third party payers. (Res. 113, I-91; Reaffirmed: Res. 138, A-98; Reaffirmation I-01; Reaffirmation I-04; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: Res. 216, A-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-385.968</td>
<td>Physician Fee Determination by Contractual Arrangements Between Third Party Payers and Hospital</td>
<td>Our AMA condemns the practice of negotiating or creating contractual arrangements between third party payers and hospitals limiting reimbursement to physicians unless those physicians have been involved in the negotiation process and have been given a good faith opportunity to participate. (Sub. Res. 248, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-385.970</td>
<td>Payment of Physicians' Services for Patients in Observational or Short Stay Units</td>
<td>Our AMA supports seeking reimbursement from all third party payers for physicians’ services to patients who are appropriately managed in short stay units. (Res. 182, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-390.889</td>
<td>Medicare Reimbursement of Telephone Consultations</td>
<td>It is the policy of the AMA to: (1) support and advocate with all payers the right of physicians to obtain</td>
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<td>H-390.895</td>
<td>Medicare Patient Surveys</td>
<td>It is the policy of the AMA to negotiate with CMS to rescind rules and regulations that inordinately withhold payment to physicians for services rendered to Medicare beneficiaries until the beneficiary completes a survey or questionnaire. (Res. 102, I-91; Reaffirmation A-01; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-45.986</td>
<td>Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft</td>
<td>Our AMA supports seeking appropriate action, including legislation if necessary, which would result in an exemption or exception to the exclusion of benefits clauses of insurance policies for all medical care providers and others when they are participating in medical aircraft flights, even though such flights might otherwise be considered as “non-scheduled.” (Sub. Res. 144, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Rescind. Superseded by Policy H-45.997, which supports legislation to provide immunity to physicians providing care during an in-flight medical emergency.</td>
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<td>H-450.961</td>
<td>Health Plan “Report Cards”</td>
<td>The AMA: (1) supports the development and appropriate use of health plan performance standards; (2) The AMA urges all organizations that are developing, or planning to develop, health plan performance measures to include actively practicing physicians, physician organizations, and consumers in the development, evaluation and refinement of such measures; (3) The AMA urges all organizations that are developing health plan performance measures to work toward greater uniformity both in the content of such measures and in the formulas used for calculating performance results; (4) The AMA encourages national medical specialty societies and state medical associations to participate in the development, evaluation, and refinement of health plan performance measures; (5) The AMA advocates that individual health plans, government entities, private sector accreditation organizations and others that develop performance measures for use in programs to evaluate the performance of health plans adhere to the following principles: (a) Health plan performance measures shall be developed for a variety of users, including health care purchasers, physicians and other health care providers, and the public.</td>
<td>Retain-in-part. The text of the policy remains relevant and should be retained. To better reflect the content of the policy, the title should be amended by addition and deletion as follows: Health Plan “Report Cards” Health Plan Performance Measures</td>
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(b) The involvement of actively practicing physicians and physician organizations in the development, evaluation, refinement, and use of health plan performance measures shall be essential.
(c) Health plan performance measures shall include an appropriate mix of process-oriented and outcomes-oriented measures.
(d) Health plan performance measures shall be representative of the full range of services typically provided by health plans, including preventive services.
(e) The limitations of data sources used in health plan performance measures shall be clearly identified and acknowledged.
(f) Valid health plan performance data collection and analysis methodologies, including establishment of statistically significant sample sizes for areas being measured, shall be developed.
(g) Performance data used to compare performance among health plans shall be adjusted for severity of illness, differences in case-mix, and other variables such as age, sex, and occupation and socioeconomic status.
(h) Health plan performance data that are self-reported by health plans shall be verified through external audits.
(i) The methods and measures used to evaluate health plan performance shall be disclosed to health plans, physicians and other health care providers, and the public.
(j) Health plans being evaluated shall be provided with an adequate opportunity to review and respond to proposed health plan performance data interpretations and disclosures prior to their publication or release.
(k) Effective safeguards to protect against the unauthorized use or disclosure of health plan performance data shall be developed.

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<tr>
<td>H-450.975</td>
<td>Definition of Quality</td>
<td>Our AMA adopts the following statement defining patient care quality: Quality of care is defined as the degree Retain. Still relevant.</td>
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<td>H-450.976</td>
<td>Corrective Action and Exclusive Contracts</td>
<td>It is the policy of the AMA that exclusive contracts should never be used as a mechanism to solve quality assurance problems in lieu of appropriate peer review processes. (Res. 3, A-91; Modified: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-465.984</td>
<td>Access to Physician Services in Rural Health Clinics</td>
<td>Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that truly do not have appropriate access to physician services. (Sub. Res. 717, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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<td>H-465.997</td>
<td>Access to and Quality of Rural Health Care</td>
<td>(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community’s problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued. (CMS Rep. G, A-87; Modified: Sunset Report, I-97)</td>
<td>Retain. Still relevant.</td>
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<td>H-478.989</td>
<td>Biometric Technologies Used to Enhance Security</td>
<td>Our AMA encourages the use of biometric technologies where feasible, such as, but not limited to, fingerprint and palm scanners in hospitals and clinics (1) for patient identification to improve patient safety while reducing health insurance fraud and (2) for providers to streamline and secure user authentication processes and better protect patient privacy. (Res. 816, I-11)</td>
<td>Retain. Still relevant</td>
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<td>H-478.996</td>
<td>Medical Care Online</td>
<td>It is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology. (CMS Rep. 4, A-01; Reaffirmed: CMS Rep. 7, A-11)</td>
<td>Retain. Still relevant.</td>
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| H-70.917  | Ensuring CPT Usage of the Term Physician is Consistent with AMA Policy | 1. Our AMA will ensure that CPT employ the term “physician” consistent with our AMA’s policy in all internal and external communications, publications and products.  
2. As a condition for licensure of CPT intellectual property by outside entities, references to the term “physicians” within CPT must remain consistent with our AMA’s policy, and the AMA will take appropriate enforcement action against violators.  
3. Our AMA will ensure that the CPT code set continues to be applicable and relevant to physicians and qualified healthcare professionals who may report the professional services described therein. (Res. 602, I-11) | Retain. Still relevant. |
| H-70.974  | CPT Coding System                                                   | 1. The AMA supports the use of CPT by all third-party payers and urges them to implement yearly changes to CPT on a timely basis.  
2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient’s insurance. (Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11) | Retain. Still relevant. |
Subject: Universal Basic Income Pilot Studies  
(Resolution 236-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates referred Resolution 236, which was sponsored by the Medical Student Section and asks that the American Medical Association (AMA) support federal, state, local, and/or private Universal Basic Income pilot studies in the United States that intend to measure health outcomes and access to care for participants.

This report provides background on Universal Basic Income (UBI) proposals, outlines potential funding mechanisms for a UBI program, provides numerous examples of past and current UBI pilot programs and, where available, any resulting outcomes, details relevant AMA policy, and provides recommendations consistent with ongoing AMA advocacy efforts.

BACKGROUND

Some economists and policymakers argue that, although there was strong 3.4 percent growth in gross domestic product (GDP) in 2019 and low rates of unemployment, those numbers conceal the fact that many families are struggling financially. Wage growth remains stagnant, and nearly 1 in 10 employed adults work as contractors with limited job security and therefore employment benefits such as health insurance and long-term financial security. Moreover, the novel coronavirus (COVID-19) pandemic is severely exacerbating these health and economic issues. There have been more than 48 million jobless claims in the US since March. At the time this report was written, about 31.8 million people are receiving unemployment benefits, which equates to about 1 in 5 individuals in the workforce. Simultaneously, the US continues to set record numbers of COVID-19 cases with cases trending upward in 39 states. In light of the pandemic, the International Monetary Fund projects that growth in the US will fall 8 percent in 2020 and overall worldwide output will fall 4.9 percent.

UBI is one method that is being suggested as having the potential to address current income inequality and to mitigate the loss of jobs caused by technological advances and COVID-19. UBI is an economic support mechanism typically intended to reach all or a large portion of the population. It is particularly noteworthy and contrasted with current US welfare programs in that receipt of UBI comes with no or minimal conditions. According to the International Monetary Fund, in formulating a UBI plan, policymakers generally grapple with three primary considerations: who is eligible, the generosity of the UBI transfers, and the fiscal cost. Some UBI proposals are universal while others are targeted to lower-income populations. Additionally, policymakers must weigh the incentives and disincentives of the generosity of transfers. For example, they must determine how UBI will affect decisions to enter the workforce and the number of hours worked. Finally, and perhaps most importantly, policymakers must determine the fiscal cost of implementing UBI to governments in an environment of limited financial resources.
Proponents of UBI claim that it would help break the poverty cycle and dependency on welfare programs. They claim UBI will give the disadvantaged the time and money to seek higher education and needed job training. Others claim that UBI would disincentivize work. However, decreased working hours has not been established in UBI trials to date.

Advocates mention that UBI could replace the current complicated safety net. The US has a patchwork benefits system with programs including but not limited to:

- Supplemental Nutrition Assistance Program: Provides nutrition benefits to supplement the food budget of families in need so they can purchase healthy food.
- Temporary Assistance for Needy Families: A time-limited program that assists families with children when the parents or other responsible relatives cannot provide for the family’s basic needs.
- Children’s Health Insurance Program (CHIP): Provides health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP also covers pregnant women.
- Section 8: Housing choice voucher program assisting low-income families, the elderly, and the disabled, to afford safe and sanitary housing in the private market.
- Earned Income Tax Credit: A refundable tax credit to low- and moderate-income individuals, particularly those with children.
- Special Supplemental Nutrition Program for Women, Infants, and Children: Provides federal grants to states for supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and to infants and children up to age five who are at nutritional risk.
- Supplemental Security Income: Program providing cash benefits to meet the needs of elderly, blind, and disabled individuals who otherwise have challenges paying for food and shelter.

Every year, the US spends nearly $1 trillion across dozens of state and federal programs amounting to significant administrative oversight across multiple agencies. However, some critics of the programs state that the complex network of resources is a consequence of having different programs intentionally target different populations with varying needs and that the purpose of each program is distinct. Critics of UBI state that it amounts to redistribution but does not necessarily advance mobility or represent an investment in human capital. Rather, they believe, society should focus its collective efforts on reforming current safety net programs to better meet their intended goals.

**FUNDING**

Regardless of where one stands on UBI, how to pay for it is the primary challenge. Some estimates put the annual price for a US program in the trillions. Presumably, such a high cost would have to be funded through some type of taxation.

Some UBI advocates claim that such a high cost would be offset by savings as fewer people require welfare, food stamps, and other social programs. Moreover, advocates argue, UBI could be funded through savings from averting prisons, emergency care, and homelessness, based on the evidence that high health care spending in the US is a direct result of low social safety net spending. In fact, the significant literature on social determinants of health (SDOH) establishes a direct link between social factors and health status, and some evidence points to a link between social spending and health outcomes. However, it remains unclear exactly how much low spending on
SDOH impacts health spending and therefore how much overall spending could be reduced in a UBI program.

Former 2020 presidential candidate and current New York City mayoral candidate Andrew Yang has run on a platform of a guaranteed income. Yang’s proposal, called the Freedom Dividend, suggested giving $1,000 per month to all US citizens over the age of 18 unconditionally. Yang proposed funding his UBI proposal through four sources. First, he proposed streamlining and consolidating several welfare programs. Second, he suggested implementing a Value Added Tax of ten percent to generate revenue. Third, he stated that UBI would put money into the hands of American consumers and would thereby generate economic growth. And fourth, he proposed taxing top earners and pollution through such actions as a financial transactions tax and a carbon fee.

UBI PILOT PROGRAMS AND RESULTS

Manitoba Basic Annual Income Experiment (Mincome)

In 1975, the Canadian government began the Manitoba Basic Annual Income Experiment (Mincome), which lasted three years. The results of this experiment were published in 2011. Unlike most UBI pilots, Mincome allowed researchers to compare the health of those receiving UBI to the health of similar people not receiving UBI. The experiment involved 1,300 urban and rural families with incomes below $16,000 in Canadian dollars for a family of four. Families with higher incomes still received the UBI but at a reduced rate. Therefore, working was still rewarded, and the results of the pilot show that the majority of Mincome participants kept working. Importantly, families receiving the UBI had fewer hospitalizations, accidents, and injuries. Additionally, mental health hospitalizations fell dramatically in the population receiving UBI. Further, the high school completion rate for 16- to 18-year-old boys increased, and adolescent girls were less likely to give birth before the age of 25. The experiment was terminated after three years when Canada’s governing party changed midway through the proposed duration of the pilot. To date, Mincome remains one of the few UBI experiments measuring any health outcome related data.

Finland’s Basic Income Experiment

In 2017, Finland launched a UBI experiment involving a guaranteed tax-free income of about $590 per month to 2,000 randomly selected unemployed citizens. The trial experiment lasted nearly two years. As researchers explore the effects of the experiment, one general finding is that happiness and overall sense of wellbeing improved. Participants also stated that the income gave them a sense of autonomy and allowed them to return to meaningful activities. Regarding employment, the results are mixed. Employment went up slightly in the second year of the trial but not significantly. Participants stated that there were still no jobs available in the areas in which they were trained. Others noted that, due to the basic income, they were more prepared to take on lower paying jobs to enable them to reenter the workforce.

Ontario Basic Income Pilot

In March 2017, the government of Ontario, Canada began the Ontario Basic Income Pilot. The pilot was undertaken in three sites in Ontario with 4,000 low-income individuals participating with an additional 2,000 people participating in the comparison group. The participants were eligible to receive up to $16,989 per year for a single person, less 50 percent of any earned income or up to $24,027 per year for a couple, less 50 percent of any earned income. The pilot measured, among other markers, food security, stress and anxiety, mental health, housing stability, and health and
health care usage. Additionally, participants receiving support through social assistance needed to withdraw from those programs to participate and receive the UBI. In 2019, Ontario terminated the pilot earlier than planned two months after a change in the control of the province’s government from the Liberal Party to the Progressive Conservatives Party. The new government stated that winding down the pilot will enable participants to transition back to more proven support systems without putting an undue burden on taxpayers.

Stockton Economic Empowerment Demonstration

In February 2019, the city of Stockton, California began giving 125 city residents a guaranteed income of $500/month for 18 months. The monthly income was unconditional, and it was intended to test UBI as a solution to poverty and inequality. Though the program was scheduled to end in June 2020, it was renewed until January 2021 due to the COVID-19 pandemic. The 125 residents participated in individual onboarding appointments, which included informed consent and benefits counseling. According to the Stockton Economic Empowerment Demonstration (SEED), the purpose of the benefits counseling was to ensure that the participants were aware of any risks associated with the UBI disbursements possibly impacting their health insurance or other benefits such as food stamps or Supplemental Security Income. One of the primary outcomes that the SEED researchers planned to measure was the effect of the UBI on the participants’ functioning and well-being. One of the early program results observed was that most recipients spent their money on groceries and utility bills. In the early phase of the program, food spending made up about 30 percent to 40 percent of the spending each month. However, after the pandemic started, the share of food spend increased to almost 50 percent. After initial results were released, a group of mayors announced the formation of the Guaranteed Income Coalition, which is committed to investigating how to successfully build and launch UBI projects in their cities.

In March 2021, SEED released the results from the first year of the experiment. A primary finding is that the individuals who received the monthly UBI payment secured full-time employment at more than twice the rate of those in the control group. Additionally, within a year, the proportion of recipients receiving the cash payments who had a full-time job went from 28 percent to 40 percent. Meanwhile, the control group saw a 5 percent increase in full-time employment. Another positive finding is that those receiving cash payments reported being less anxious and depressed compared to the control group. As far as how the group spent the money, of the money tracked, recipients spent more on necessities like food (37 percent), home goods and clothes (22 percent), utilities (11 percent), and car costs (10 percent). The recipients spent less than 1 percent of the UBI payment on alcohol or cigarettes. Although the study’s sample size is small, the early results indicate that UBI payments give recipients stability and enhance health.

OpenResearch

Another UBI pilot being undertaken is by OpenResearch, a non-profit research lab. The study, which started in 2020, recruited about 3,000 people across two states. It randomly assigned 1,000 of those individuals to receive $1,000 per month for three years while using the other 2,000 individuals as the control group. Importantly, the pilot will measure health outcomes including health markers (e.g., body mass index, hypertension), healthy behaviors, health insurance coverage, food security, housing quality and stability, physician and mental health care utilization, crime victimization, and mental health.
RELEVANT AMA POLICY

The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to provide leadership in addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency. Policy H-280.945 calls for better integration of health care and social services and supports. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

The AMA also has strong policy supporting Medicaid. Policy H-290.986 states that the Medicaid program is a safety net for the nation’s most vulnerable populations. Moreover, the AMA is committed to expanding Medicaid coverage. In particular, Policy D-290.979 directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. Finally, Policy D-290.985 encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services.

DISCUSSION

There are risks to replacing targeted social safety net programs, which protect the most vulnerable, with a UBI program. The AMA strongly supports these existing evidence-based safety net programs. Of note, AMA Ethics Opinion 11.1.1 states that health care is a fundamental human good and the Council believes physicians have a responsibility to work to ensure access to care. The Council advises caution regarding support for any proposal that may have the effect of jeopardizing access to care.

The AMA continues to advocate for Medicaid funding and other safety net program funding. Medicaid and other safety net programs increase vital access to care for patients, reduce the number of uninsured individuals, and improve the lives of working Americans. The Council believes the AMA should continue its efforts to improve upon and expand Medicaid and other programs that improve the health of patients. Therefore, the Council recommends reaffirming the AMA’s comprehensive policy on addressing health disparities, the role of Medicaid as a vital safety net program, the AMA’s enduring commitment to expanding Medicaid eligibility, and sufficient funding for the program.

An evidence-based method to analyze UBI is currently unavailable. Models have been population-based and generally do not meet minimum standards for randomized control studies. They have also been subject to political influence and change. Experiments are key to understanding how and if UBI would work on a large scale. Consequently, there is a void of data on how a sustained UBI program would operate and the far-reaching effects the program would have once implemented. The Council does not believe that there are adequate data to actively support UBI pilots at this time. However, the Council recognizes that UBI may be one of myriad solutions to help address growing inequity and health care disparities. Therefore, the Council recommends that the AMA
actively monitor UBI pilots moving forward, especially pilots that intend to measure the health outcomes and access to care of its participants.

The Council understands that the concept of UBI is evolving rapidly, particularly in light of the COVID-19 pandemic. The pandemic is catalyzing support for UBI not only in the US but also worldwide. Since February 2020, governments all over the world, including the US, have started distributing direct cash payments among large portions of their populations in order to mitigate the loss of jobs and financial disruption of the pandemic. A report from the United Nations recently stated that temporary basic income payments could stem the spread of the pandemic by enabling workers, particularly those living below the poverty line, to stay at home. Additionally, Spain started a UBI program offering monthly payments up to $1,145 to its poorest families in 850,000 households. The program is the largest test of UBI seen thus far. The program is seen as a way to not only soften the impact of the COVID-19 pandemic but also to become a structural instrument of stability in the country. Also, in March 2021, Congress passed, and the president signed into law the third pandemic aid package that once again includes direct payments to millions of Americans. Importantly, the law, the American Rescue Plan, substantially expands the Child Tax Credit and supplements the earnings of families receiving the credit. Under the law, most Americans will receive $3,000 a year for each child ages 6-17, and $3,600 per year for each child under 6. The provision lasts one year and will be sent via direct deposit on a “periodic” basis. This provision represents a major expansion of the child tax credit, and the proposed “periodic” payments mirror a UBI payment.

As the COVID-19 pandemic and its economic fallout continue, the US and society must consider the appropriate responses to not only the pandemic but also deepened and newly exposed financial inequities. The AMA is committed to following and analyzing the relevant research to confront these issues and propose solutions.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation’s most vulnerable populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services. (Reaffirm HOD Policy)

5. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care. (Directive to Take Action)

Fiscal Note: Less than $500.
REFERENCES


Subject: Promoting Accountability in Prior Authorization

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

At the 2019 Annual Meeting, the House of Delegates adopted Policy D-320.983, which asks that
the American Medical Association (AMA) study the frequency by which health plans and
utilization review entities are using peer-to-peer (P2P) review prior authorization (PA) processes,
and the extent to which these processes reflect AMA policies, including H-285.987, “Guidelines
for Qualifications of Managed Care Medical Directors,” H-285.939, “Managed Care Medical
Director Liability,” H-320.968, “Approaches to Increase Payer Accountability,” and the AMA
Code of Medical Ethics Policy 10.1.1, “Ethical Obligations of Medical Directors,” with a report
back to the House of Delegates.

This report provides background on PA, an overview of the P2P PA process, outlines the
significant AMA advocacy efforts on PA and utilization management (UM) review, and proposes
recommendations to strengthen AMA policy on PA and, in particular, P2P reviews.

BACKGROUND

Health plans employ PA, step therapy, and other forms of UM to control access to certain
treatments and reduce health care expenses. The medical literature clearly establishes the time and
cost burdens associated with UM requirements on physician practices. UM often involves manual,
time-consuming processes that can divert valuable and scarce physician resources away from direct
patient care. More importantly, PA and other UM methods interfere with patients receiving timely
and optimal treatment selected in consultation with their physicians. At the very least, UM
requirements can delay access to needed care. In some cases, the barriers to care imposed by UM
may lead to patients receiving less effective therapy, no treatment at all, or even potentially harmful
therapies.

PEER-TO-PEER REVIEWS

P2P conversations refer to discussions between a physician and an insurance company physician
employee. The discussion generally occurs after an initial PA denial that typically involves
questions of medical necessity or treatment requests that are considered investigational. However,
numerous physicians have stated that some insurers are starting to require P2Ps for first-line PAs.
The rationale behind P2P is to provide a more transparent PA process that is collaborative and
appropriately follows relevant clinical guidelines. However, for many treating physicians, P2P
review simply represents another time-consuming and potentially detrimental use of UM by
insurance companies. Peer reviewers can be unqualified to assess the need for services for an
individual patient for whom they have minimal information and have never evaluated or spoken
with. These issues are exacerbated if physicians are required to participate in P2P for first-line PAs.
RELEVANT AMA ADVOCACY

PA and other UM programs are a high-priority advocacy issue for the AMA. Several current AMA initiatives address the concerns raised in Policy D-320.983 and strengthen the AMA’s ability to effectively advocate on UM issues:

1. **State Legislative Activity:** In response to the numerous concerns raised by AMA members and the Federation of Medicine, the AMA’s Advocacy Resource Center works closely with state and specialty medical societies to address PA and other UM-related issues through state legislation. The AMA’s model bill on PA, the “Ensuring Transparency in Prior Authorization Act,” addresses a variety of concerns related to UM programs, including response timeliness, duration of authorizations, public reporting of UM program results, retroactive denials, and electronic PA. Additionally, the bill states that UM staff have experience treating patients with the medical condition or disease for which the health care service is requested. At the time of writing, there were nearly 40 bills related to PA and step therapy in the state legislatures, several of which are broad reform efforts based on the AMA model bill, as well as several directed at reducing UM requirements for individuals with HIV/AIDS, cancer, substance use disorder and other chronic diseases and conditions. Additionally, as part of the state policymakers’ responses to COVID-19, commercial plans and Medicaid in many states were required (or urged) to reduce certain UM requirements to ensure safe access to care during state stay-at-home orders and other restrictions.

2. **Prior Authorization and Utilization Management Reform Principles:** To improve access to care and reduce practice burdens, the AMA convened a workgroup of state and specialty medical societies, national provider associations, and patient representatives to create a set of best practices related to PA and other UM requirements. The workgroup identified the most common provider and patient complaints associated with UM programs and developed the Prior Authorization and Utilization Management Reform Principles to address these priority concerns. These 21 principles seek to improve PA and UM programs by addressing the following 5 broad categories of concern:

   a. Clinical validity
   b. Continuity of care
   c. Transparency and fairness
   d. Timely access and administrative efficiency
   e. Alternatives and exemptions

These “best practice” principles have served as the foundation for an extensive, multi-pronged advocacy campaign to reform and improve UM programs. Workgroup members directly advocate with health plans, benefit managers, and other UM entities to voluntarily adopt these principles; urge accreditation organizations, such as the National Committee for Quality Assurance and the Utilization Review Accreditation Commission, to include these concepts in criteria for utilization review programs; introduce bills based on these principles to state legislatures; encourage technological standards organizations to support improved UM processes; and launch a media campaign to raise awareness of the principles and requested reforms.

Additionally, two of the PA principles specifically reference the qualifications that health plan reviewers should possess. Principle 3 states that utilization review entities should offer an appeals system for their UM programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/sub-
specialty for discussion of medical necessity issues. Principle 16 states that, should a provider
determine the need for an expedited appeal, a decision on such an appeal should be
communicated by the utilization review entity to the provider and patient within 24 hours.
Moreover, providers and patients should be notified of decisions on all other appeals within ten
calendar days. And all appeal decisions should be made by a provider who is not only of the
same specialty and subspecialty, whenever possible, as the prescribing/order physician, but
also, the reviewing provider must not have been involved in the initial adverse determination.²

PA reform principles initiated meaningful discussions with the health insurance industry about
reducing PA burdens. These discussions led to the development of the Consensus Statement on
Improving the Prior Authorization Process—created by the AMA, American Hospital
Association, America’s Health Insurance Plans, American Pharmacists Association, BlueCross
BlueShield Association and Medical Group Management Association. The AMA continues to
advocate for insurers to operationalize the concepts outlined in the Consensus Statement in
their PA programs.³

4. Prior Authorization Research: The lack of alignment between physician and health plan
interests on PA and other UM programs creates significant challenges in achieving meaningful
reform on this issue. Recognizing the key role that credible evidence plays in successful
advocacy on this topic, the AMA is engaged in research to gather data regarding the impact of
PA on patients and physician practices, including an annual physician survey assessing the
burdens associated with UM programs.

PA Physician Survey – In conjunction with a market research partner, the AMA
fielded a web-based survey of 1000 practicing physicians in December 2019. The
survey sample comprised 40 percent primary care and 60 percent specialty physicians
and only included physicians who provide at least 20 hours of patient care during a
typical week and routinely complete PAs in their practice. Along with gathering data
on the impact of PA on both patient access to timely care and practice burdens, the
survey also assessed physicians’ perception of the frequency of P2P review
requirements and the qualifications of insurer “peers.”

One survey question asked physicians: “How often are you involved in a peer-to-peer
review during the prior authorization process?”

- Never – 6%
- Rarely – 30%
- Sometimes – 45%
- Often – 15%
- Always – 3%
- Don’t know – 1%

Another survey question asked physicians: “How has the frequency of peer-to-peer
reviews during the prior authorization process changed over the last five years?”

- Increased significantly or increased somewhat – 60%
- No change – 35%
- Decreased somewhat or decreased significantly – 5%
An additional survey question asked physicians: “When completing a peer-to-peer review during the prior authorization process, how often does the health plan’s ‘peer’ have the appropriate qualifications to assess and make a determination regarding the prior authorization request?”

- Always – 2%
- Often – 13%
- Sometimes – 41%
- Rarely – 28%
- Never – 4%
- Don’t know – 11%

Note: Percentages do not sum to 100 percent due to rounding.

DISCUSSION

The Council recognizes the value and importance of the AMA’s current multi-pronged advocacy efforts related to PA and applauds the House of Delegates for highlighting the issue of P2P PA and its effect on physicians and most importantly patients. To continue its effective advocacy efforts regarding PA, the Council recommends reaffirming several AMA policies and recommends a number of new policies specifically related to P2P PA. First, the Council recommends reaffirming Policy H-320.939, which states that the AMA will continue its widespread PA advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff; and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

Additionally, the Council recommends reaffirming Policies H-320.948 and H-320.961, which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. Further, the Council recommends reaffirming Policy H-320.949, which states that UM criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions, and Policies H-285.998 and H-320.945, which further underscore the importance of a clinical basis for health plans’ coverage decisions and policies.

While physicians have the freedom to choose their method of making a living, physicians employed by insurance companies must not have their ethical obligations discharged. Insurance companies know that many patients and physicians do not appeal PA decisions, and even fewer seek an external review. However, when an external review is sought, nearly one-third of external reviews of insurer denials are overturned. These overturned denials demonstrate that insurers’ processes for determining medical necessity often do not reflect current clinical standards of care. It is imperative to patient safety and quality of care that physicians make utilization review decisions in good faith and follow evidence-based guidelines in their work for insurers. Therefore, the Council recommends reaffirming Policy H-285.939, which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services.
Furthermore, the Council recommends addressing the timeframe for PA decisions for P2P discussions. Physicians generally receive the PA decision at the end of the P2P discussion. However, insurers have suggested that plans should have two business days after the P2P to make a decision. A recent operating rule for electronic PA has this longer specification. Specifically, it states that once a health plan receives a complete PA request, including any P2P medical reviews conducted, the health plan must return an approval or denial to such request within two business days. Further delaying the PA determination harms all patients and has a disproportionately negative effect on vulnerable populations. Therefore, the Council recommends requiring that PA decisions be made at the end of the P2P review discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. The Council believes such mitigating circumstances include instances wherein a physician involved in the P2P discussion requests additional time to read relevant medical literature. Importantly, the Council notes that such an extension shall not be permitted where the PA request is urgent.

As highlighted in Policy D-320.983, care must be taken to ensure that plan reviewers are, in fact, physician peers with the appropriate experience treating the condition in question and from the same specialty or subspecialty. The AMA already has strong policy stating that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review (e.g., Policy H-320.968). Nevertheless, the Council believes that policy should be strengthened to ensure that not only is the reviewing physician of the same specialty and licensed to practice in the jurisdiction, but also has the expertise to treat the medical condition or disease under review according to up-to-date evidence-based guidelines and has knowledge of novel treatments.

Moreover, as directed by Policy D-320.983, the Council highlights Ethics Opinion 10.1 regarding ethical guidance for physicians in nonclinical roles. Ethics Opinion 10.1 states that physicians earn and maintain the trust of their patients and the public by upholding norms of fidelity to patients, on which the physician’s professional identity rests, and that, despite not directly providing care to patients, physicians employed by insurers have committed themselves to the values and norms of medicine. Accordingly, the Council recommends that physicians employed by insurance companies must follow current evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.

The Council notes that the AMA’s efforts to reduce PA burdens are particularly important during public health emergencies, such as the novel coronavirus (COVID-19) pandemic. Recognizing the enormous strain placed on physicians and the entire US health care system and, more importantly, the impact that delayed care has on patients during the COVID-19 crisis, the AMA and other organizations have successfully advocated for many commercial health plans to temporarily suspend or otherwise adjust PA requirements. Meanwhile, legislators and regulators have reduced PA in both the commercial and Medicaid markets via legislation, executive orders, and waivers. While the AMA strongly supports relaxation in PA requirements during the COVID-19 emergency, there is considerable variation in the adjustments being made across the commercial health insurer market and corresponding effective dates, with some plans quickly reinstating regular PA processes only a few months into the pandemic. The AMA is tracking individual health plan COVID-19-related PA program updates to help physicians stay informed of these rapidly changing policies (see https://www.ama-assn.org/system/files/2020-04/prior-auth-policy-covid-19.pdf). To that end, the Council recommends that the AMA urge temporary suspension of all prior authorizations and calls for the extension of existing approvals during a declared public health emergency.

Finally, the Council notes that PA remains a top-of-mind issue for physicians and, as such, deserves substantial AMA attention and resources. As detailed in this report, the AMA prioritizes...
PA as one of its key advocacy issues and continues to collaborate with relevant stakeholders to address physician concerns on this topic. The AMA is committed to ensuring that tackling PA and UM issues will continue to be a leading priority for the AMA.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-320.939 which states that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and adoption of the Prior Authorization and Utilization Management Reform Principles, the Consensus Statement on Improving the Prior Authorization Process, AMA model legislation, the Prior Authorization Physician Survey and other PA research, and educational tools aimed at reducing administrative burdens for physicians and their staff, and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policies H-320.948 and H-320.961 which encourage sufficient clinical justification for any retrospective payment denial and prohibition of retrospective payment denial when treatment was previously authorized. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-320.949 which states that utilization management criteria should be based upon sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policies H-285.998 and H-320.945 which underscore the importance of a clinical basis for health plans’ coverage decisions and policies. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-285.939 which states that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services. (Reaffirm HOD Policy)

6. That our AMA advocate that peer-to-peer (P2P) PA determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion. (New HOD Policy)

7. That our AMA advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments. (New HOD Policy)

8. That our AMA advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable. (New HOD Policy)
9. That our AMA continue to advocate for a reduction in the overall volume of health plans’ PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency. (New HOD Policy)

10. That our AMA rescind Policy D-320.983, which directed the AMA to conduct the study herein. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES


5 CAQH CORE Prior Authorization & Referrals (278) Infrastructure Rule Version PA.2.0. CAQH CORE. Available at: https://www.caqh.org/sites/default/files/core/phase-iv/452_278-infrastructure-rule.pdf
At the 2019 Interim Meeting, the House of Delegates referred Resolution 818, which was sponsored by the Organized Medical Staff Section. Resolution 818-I-19 asked the American Medical Association (AMA) to: (1) study the impact of “auto accept” policies (i.e., unconditional acceptance for the care of a patient) on public health, as well as their compliance with the Emergency Medical Treatment and Labor Act (EMTALA) in order to protect the safety of our patients; and (2) advocate that if a medical center adopts an auto accept policy, it must have been ratified, as well as overseen and/or crafted, by the independent medical staff. Reference Committee J from the 2019 Interim Meeting noted that the resolution simultaneously called for study and new policy, and it emphasized the importance of first studying the issue of auto accept policies. Accordingly, this report explores patient transfer issues, with consideration of potential clinical and financial impacts on patients, and legal, accreditation, and medical staff bylaws implications for physicians and medical centers.

BACKGROUND

Optimal patient health and well-being should be the principal goals of patient transfer, but disagreements can arise in pursuing those goals. Some physicians have observed that medical centers where they practice can automatically accept the transfer of patients with emergent and/or serious conditions, and they have voiced concern that accepting transfer patients without adequate input from the medical staff could jeopardize patient care. The term “auto accept policies” encompasses a variety of medical center policies that address how patients may be “automatically” received at their institutions. For example, one large public health system has implemented an auto accept policy whereby critical care nurses answer phone calls from transferring physicians and accept patient transfers instantaneously—transfer requests are not denied.1 As part of this system, physicians are paid to be on call and to receive patients from the region. Another medical center will automatically accept any acute critical transfer, with a specially educated triage registered nurse gathering clinical and basic demographic information, locating an accepting physician, and arranging for a bed in the appropriate level of care that will be ready when the patient arrives.2 As a third example, another medical center has a pilot program to automatically accept into their Emergency Department (ED) stable patients from other medical centers who need specific services.3 These varied auto accept policies highlight the challenges that are inherent in transferring patients among medical centers and the critical role that physicians must play in these processes.

Any time a patient is transferred from one facility to another, it is essential that both transferring and receiving facilities ensure that there is an accepting physician who is capable of taking responsibility for the care of the transferred patient, and medical centers receiving a transferred patient must affirmatively accept the patient. Under certain conditions, acceptance will be
mandatory. Nevertheless, medical center transfer policies, including auto accept policies, that fail to identify the appropriate physicians and their capabilities run the risk of suboptimal care for the patient and delays while the appropriate physicians and resources are identified. In addition, transfers of patients with emergent and/or serious conditions carry implications not only for individual patients, but also public health and legal implications for individual physicians and medical centers, so patient transfer policies must address all of these implications.

KEY CHALLENGES ARISING WITH PATIENT TRANSFERS

Interhospital transfer is an understudied area, with little known about institutional variations in information transfer and impacts on patient outcomes. A recent survey of 32 tertiary care centers in the United States studied communication and documentation practices during interhospital patient transfers and found that practices vary widely among tertiary care centers, and the level of transfer center involvement in oral and written handoff was inconsistent. Moreover, patients may be transferred from one medical center to another for a variety of reasons, including to receive specific expert medical services such as monitoring, tests, or procedures, or to accommodate patient or family preference. With a variety of specialists involved in the care of patients with emergent and/or serious conditions requiring transfer, communication and coordination are critical, but complicated. Often, the physicians who will be directly caring for a transferred patient want to be involved early in the transfer process to ensure that their specific questions are answered. In an attempt to address transfer challenges, some hospitals have established dedicated call centers, often staffed by senior-level nurses, to coordinate communication between accepting and receiving physicians. However, studies have found such call centers to be highly variable in their functionality and effectiveness.

Non-medical factors have been found to influence decisions regarding whether a stable patient will be transferred to another facility for inpatient care, but again, the impact on quality of care is unknown. An analysis of all-payer administrative data from a representative sample of community hospitals in the United States found that uninsured patients and women were significantly less likely to be transferred to another acute care hospital. The study authors were surprised to find the lower rate of transfer for uninsured patients, expecting that a hospital would seek to transfer uninsured patients as soon as they fulfilled their EMTALA obligations. Instead, the study authors suspected that the lower transfer rates for uninsured patients can be explained by an unwillingness of receiving hospitals to accept uninsured transfer patients. At the same time, the study authors emphasized that economic factors are unlikely to explain the lower transfer rates they found for women, and they expressed concern for the potential of implicit or explicit biases contributing to this disparity. Critically, though, it is unknown whether the differences in transfer patterns identified in this study led to differences in health outcomes.

Hospitals’ interfacility transfer agreements and protocols can impact patient care not only within inpatient departments, but in the ED as well. To the extent that inpatient beds are reserved for specific categories of patients, including interfacility transfer patients, challenges can arise when there are insufficient inpatient beds available to receive transfers from the medical center’s ED. Patients who stay in the ED for longer than the time required for a “timely transfer” to an inpatient bed are considered “boarders,” and challenges surrounding boarding patients in the ED are well-established. (Definitions of “timely transfer” vary, but experts often look for a period of less than two hours from the admission order.) Boarding can exacerbate health disparities, with Black, female, elderly, and psychiatric patients being more likely to board for longer periods of time. Moreover, patients with medically treated conditions are more likely to board than those with surgically treated conditions. With the ED being the dominant source of hospital admissions, it is critical for medical center transfer policies to promote optimal care for the patients who present
with emergent and/or serious conditions, both before and after their stabilization. The problems
associated with patient boarding are so severe, there is evidence that they increase in-hospital death
rates substantially. Reflecting these problems, The Joint Commission (TJC) imposes
requirements that hospitals address boarding for purposes of accreditation. Importantly,
reservation of inpatient beds for interfacility transfer patients is just one factor contributing to the
complex challenge of ED boarding, and solving the broader issue of ED boarding is beyond the
scope of this report.

When contemplating the transfer of a stable patient who is not receiving care in an ED, in addition
to the critical clinical implications of the transfer, patient financial impacts must also be
considered. Prior to transferring a patient to a new medical center, it is important to consider
whether the new facility is in-network under the patient’s health plan. If the intended transfer
facility is out-of-network (OON), the patient and/or family will need to be prepared for the
financial implications of receiving OON care. Additionally, if the patient is receiving, or intends to
receive, care that requires prior authorization (PA), it is important to recognize that site of service
can be an essential element of PA approval, so a service approved at an originating facility may
require reapproval for a new site of service. Transfer decisions should include a patient-centered
discussion between a patient and/or family and a referring physician that addresses the various
potential merits and risks of undergoing a transfer.

The novel coronavirus (COVID-19) pandemic has posed unprecedented challenges, including
managing patient transfers. Geographically localized surges in COVID-19 cases put extreme
pressure on local health care facilities, as hospitals strive to transfer COVID-19 patients to sites
where they can receive optimal care and/or transfer non-COVID-19 patients out of their facility to
protect uninfected patients and free up resources to care for more COVID-19 patients. State and
local emergency medical planners have taken a variety of approaches in rising to meet the
pandemic’s challenges, and the Centers for Disease Control and Prevention (CDC) has issued
guidance around patient safety and relief for health care facility operations. The CDC emphasizes
the importance of communication between health care professionals at both the transferring and
receiving facilities with accurate clinical descriptions of patients and clear acceptance by receiving
facilities.

Balancing the complex considerations surrounding patient transfers, the American College of
Emergency Physicians (ACEP) has published guidelines on Appropriate Interfacility Patient
Transfer, and AMA policy (Policies H-130.982 and H-130.961) expressly supports these
guidelines. Key elements of the ACEP guidelines specify, “The medical facility’s policies and
procedures and/or medical staff bylaws must define who is responsible for accepting and
transferring patients on behalf of the hospital . . . Agreement to accept the patient in transfer should
be obtained from a physician or responsible individual at the receiving hospital in advance of the
transfer. When a patient requires a higher level of care other than that provided or available at the
transferring facility, a receiving facility with the capability and capacity to provide a higher level of
care may not refuse any request for transfer. When transfer of patients is part of a regional plan to
provide optimal care at a specialized medical facility, written transfer protocols and interfacility
agreements should be in place.” These guidelines, developed by subject matter experts and
supported by the AMA, help to ensure that high quality patient care drives interfacility patient
transfers, with physician input into the decision-making process.

EXTERNAL FACTORS SHAPING PATIENT TRANSFER POLICIES

Medical centers’ ability to implement transfer policies such as the auto accept policies described in
Resolution 818-I-19 is influenced by a number of external factors, including Medicare Conditions
of Participation (COPs), accreditation standards, medical staff governing documents, and in certain
cases, state and/or federal law. Medicare COPs govern patient transfer in the context of discharge
planning, requiring that hospitals transfer or refer patients to appropriate facilities, agencies, or
outpatient services, as needed, for follow-up or ancillary care. Moreover, Medicare COPs make
it clear that the medical staff “is responsible for the quality of medical care provided to patients by
the hospital,” and TJC provides an accreditation framework to guide medical center and
physician collaboration. As outlined by TJC, “The organized medical staff oversees the quality of
patient care, treatment, and services provided by practitioners privileged through the medical staff
process.” Additionally, for a medical center’s “governing body to effectively fulfill its
accountability for the safety and quality of care, it must work collaboratively with the medical staff
leaders toward that goal.” While accreditation standards do not have the force of law, TJC’s long
history of hospital accreditation and its recognition by federal and private payers have made its
standards nationally accepted practices. Additionally, medical staff documents including bylaws,
rules and regulations, and policies govern the relationship between medical centers and their
medical staff. The bylaws describe the rights, responsibilities, and accountabilities of the medical
staff and specify how the organized medical staff works with and is accountable to the governing
body. Medical staff rules and regulations usually address patient care issues across the organization
and typically contain provisions about patient transfers.

As the sponsors of Resolution 818-I-19 indicate, EMTALA provides a legal framework for many
interhospital transfers, with specific mandates for both facilities and physicians. EMTALA was
established as federal law in 1986, and many states have related laws and regulations that impose
additional duties on hospitals and physicians. EMTALA was designed to prevent hospitals from
transferring uninsured or Medicaid patients to public hospitals without minimally providing a
medical screening examination to ensure the patients were stable for transfer. Additionally, under
EMTALA, hospitals with specialized capabilities must accept patient transfers from hospitals that
lack the capability to treat unstable emergency medical conditions, and EMTALA transfer
obligations apply, even under the extraordinary circumstances posed by COVID-19. However,
EMTALA does not apply to the transfer of stable patients. Importantly, both hospitals and
physicians can be penalized for EMTALA violations, with penalties including termination of the
hospital or physician’s Medicare provider agreement and fines of up to $104,826 per violation.
With both the hospital and the physician individually liable under EMTALA, it is critical that both
work together to ensure that patient transfers further the shared goal of optimal patient care.

RELEVANT AMA POLICY

AMA policy directly responds to the resolves of referred Resolution 818-I-19. First, a
comprehensive array of policy guides collaboration between medical centers and medical staff.
Policy H-225.957 sets forth principles for strengthening the physician-hospital relationship,
emphasizing the interdependence between the organized medical staff and the hospital governing
body, while highlighting the medical staff’s role in quality-of-care issues. Similarly, Policy
H-225.971 provides a strong framework for how hospitals and medical staff ought to collaborate
and articulates the primary role of the medical staff on matters of quality of care and patient safety.
In addition, Policy H-225.942 provides a set of physician and medical staff member bill of rights,
which include the right to be well-informed and share in the decision-making of the health care
organization’s operational and strategic planning. Finally, Policy H-225.961 states that in crafting
medical staff development plans, hospitals/health systems should incorporate the principles that the
medical staff and its elected leaders must be involved in the hospital/health system’s leadership
function, including in developing operational plans, service design, resource allocation, and
organizational policies. The policy further insists that the medical staff must ensure that quality
patient care is not harmed by economic motivations.
Long-standing policy also guides the transfer of patients among medical centers. Policy H-130.982 provides principles to guide interfacility transfers of unstable emergency patients, detailing the critical roles of both the transferring and receiving physicians and endorsing ACEP’s Appropriate Interfacility Patient Transfer guidelines. Similarly, Policy H-130.961 also endorses the ACEP guidelines, encouraging county medical societies and local hospitals to review and utilize the ACEP guidelines as they develop local transfer arrangements. In addition, Policy H-130.965 supports working with the American Hospital Association (AHA) to develop model agreements for appropriate patient transfer.

Finally, AMA policy and advocacy strive to protect patients and physicians facing burdens from health plan OON restrictions and PA requirements. Policy H-285.904 sets forth principles related to unanticipated OON care, and Policy H-320.939 details the AMA’s position on PA and utilization management (UM) reform.

In addition to AMA policy, AMA ethics opinions also guide physicians and medical centers as they refine patient transfer policies. Code of Medical Ethics Opinion 9.5.1 guides the relationship between an organized medical staff and hospital and establishes that the core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care. Additionally, Code of Medical Ethics Opinion 9.4.2 provides a series of steps physicians should take if they become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards.

DISCUSSION

The Council thanks the sponsors of Resolution 818-I-19 for highlighting the critical intersection of medical center transfer policies with quality of care, public health, legal/regulatory, and medical staff concerns. Existing AMA policy lays the groundwork to protect patients and physicians in the context of patient transfers, and this policy can be expanded. First, the Council recommends amending Policy H-130.982, changing the title of the policy and broadening the language used, so that this long-standing policy guiding the transfer of emergency patients would apply to protect all transferred patients. Similarly, the Council recommends building upon the strong policy that establishes a physician and medical staff member bill of rights and outlines the rights and responsibilities of organized medical staff. Policy H-225.942 emphasizes the importance of physicians’ treatment decisions remaining insulated from commercial or other motivations that could threaten high-quality patient care and the medical staff’s responsibility to participate in the health care organization’s operational and strategic planning to safeguard the interests of patients, the community, the health care organization, and the medical staff and its members. The policy also outlines medical staff rights, including the right to be well-informed and share in the decision-making of the health care organization’s operational and strategic planning, including involvement in decisions to grant exclusive contracts, or close medical staff departments. The Council recommends amending Policy H-225.942 to articulate the medical staff’s right to be well-informed and share in the decision-making regarding transferring patients into, out of, or within the health care organization. Additionally, the Council recommends amending Policy H-130.965 to support working with both the AHA and other interested parties to develop model agreements for appropriate patient transfer.

Finally, recognizing the significant patient, physician, and medical center time and talent involved in obtaining PA approval, the Council believes that when circumstances (such as the site of service) change, the PA process should support revisions to pending or existing approvals rather than require re-initiation of the PA request. In articulating the AMA’s position on PA and UM
reform, Policy H-320.939 emphasizes that the AMA will continue its widespread PA advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care. Building upon this strong advocacy position, the Council recommends amending Policy H-320.939 by adding a new section four stating that health plans should minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending PA requests.

The Council also recommends reaffirming several policies that address key concerns raised by Resolution 818-I-19. Speaking to physician and medical staff roles in decision-making regarding patient transfers, Policy H-225.957 provides principles for strengthening the physician-hospital relationship. Policy H-225.957 emphasizes that the primary responsibility for the quality of care rendered and for patient safety is vested with the organized medical staff and sets forth parameters for collaboration and dispute resolution between the medical staff and hospital governing body. In addition, Policy H-225.971 details the roles that medical staff and hospital governing bodies and management each and collectively play in quality of care and credentialing and reaffirms TJC standard that medical staffs have “overall responsibility for the quality of the professional services provided by individuals with clinical privileges.” Moreover, the policy states that hospital administrative personnel performing quality assurance and other quality activities related to patient care should report to and be accountable to the medical staff committee responsible for quality improvement activities. Reaffirming these policies underscores the AMA’s longstanding and continuing commitment to productive collaboration between physicians and medical centers in developing patient transfer practices that are focused on providing high-quality patient care. Finally, the Council recommends reaffirming Policy H-285.904, which sets forth principles to protect patients receiving unanticipated OON care. Policy H-285.904 states that patients must not be financially penalized for receiving unanticipated care from an OON provider; insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties; and patients who are seeking emergency care should be protected under the “prudent layperson” legal standard, without regard to PA or retrospective denial for services after emergency care is rendered.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 818-I-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-130.982 by addition and deletion as follows:

   H-130.982 Interfacility Patient Transfers of Emergency Patients
   Our AMA: (1) supports the following principles for the interfacility patient transfers of emergency patients: (a) all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility patient transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician’s judgment it is in the patient’s best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility patient transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies physician
organizations to develop, in conjunction with their local hospitals, protocols and
interhospital transfer agreements addressing the issue of economically motivated transfers
of emergency patients in their communities. At a minimum, these protocols and
agreements should address the condition of the patients transferred, the responsibilities of
the transferring and accepting physicians and facilities, and the designation of appropriate
referral facilities. The American College of Emergency Physicians’ Appropriate
Interfacility Patient Transfer should be reviewed in the development of such community
protocols and agreements; and (3) urges state medical associations to encourage and
provide assistance to physician organizations that are their county medical societies as they
developing such protocols and interhospital agreements with their local hospitals. (Modify
Current HOD Policy)

2. That our AMA amend subsection II(d) of Policy H-225.942 by addition and deletion as
follows:

d. The right to be well informed and share in the decision-making of the health care
organization’s operational and strategic planning, including involvement in decisions to
grant exclusive contracts, or close medical staff departments, or to transfer patients into,
out of, or within the health care organization. (Modify Current HOD Policy)

3. That our AMA amend Policy H-130.965 by addition as follows:

Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the
basis of economics; (2) supports working with the American Hospital Association (AHA)
and other interested parties to develop model agreements for appropriate patient transfer;
and (3) supports continued work by the AMA and the AHA on the problem of providing
adequate financing for the care of these patients transferred. (Modify Current HOD Policy)

4. That our AMA amend Policy H-320.939 by addition of a fourth section as follows:

4. Our AMA advocates for health plans to minimize the burden on patients, physicians, and
medical centers when updates must be made to previously approved and/or pending prior
authorization requests. (Modify Current HOD Policy)

5. That our AMA reaffirm Policy H-225.957, which provides principles for strengthening the
physician-hospital relationship. Policy H-225.957 sets forth parameters for collaboration
and dispute resolution between the medical staff and the hospital governing body, and it
establishes that the primary responsibility for the quality of care rendered and for patient
safety is vested with the organized medical staff. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-225.971, which details the roles that medical staff and
hospital governing bodies and management each and collectively play in quality of care
and credentialing. Policy H-225.971 states that hospital administrative personnel
performing quality assurance and other quality activities related to patient care should
report to and be accountable to the medical staff committee responsible for quality
improvement activities. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-285.904, which sets forth principles related to
unanticipated out-of-network care. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


Appendix: Policies Recommended for Amendment or Reaffirmation

H-130.965 Refusal of Appropriate Patient Transfers
Our AMA (1) opposes the refusal by an institution to accept patient transfers solely on the basis of economics; (2) supports working with the American Hospital Association to develop model agreements for appropriate patient transfer; and (3) supports continued work by the AMA and the AHA on the problem of providing adequate financing for the care of these patients transferred.

H-130.982 Transfer of Emergency Patients
Our AMA: (1) supports the following principles for the transfer of emergency patients: (a) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed medical care to all emergency patients, regardless of their ability to pay; (b) an interfacility transfer of an unstabilized emergency patient should be undertaken only for appropriate medical purposes, i.e., when in the physician’s judgment it is in the patient’s best interest to receive needed medical service care at the receiving facility rather than the transferring facility; and (c) all interfacility transfers of emergency patients should be subject to the sound medical judgment and consent of both the transferring and receiving physicians to assure the safety and appropriateness of each proposed transfer; (2) urges county medical societies to develop, in conjunction with their local hospitals, protocols and interhospital transfer agreements addressing the issue of economically motivated transfers of emergency patients in their communities. At a minimum, these protocols and agreements should address the condition of the patients transferred, the responsibilities of the transferring and accepting physicians and facilities, and the designation of appropriate referral facilities. The American College of Emergency Physicians’ Appropriate Interfacility Patient Transfer should be reviewed in the development of such community protocols and agreements; and (3) urges state medical associations to encourage and provide assistance to their county medical societies as they develop such protocols and interhospital agreements with their local hospitals.

H-225.942 Physician and Medical Staff Member Bill of Rights
Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

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

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients’ best interest. Only within the confines of the principles and processes of self-governance can
physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care. From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

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

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

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

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

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization’s administration or governing body.

d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.


H-225.957 Principles for Strengthening the Physician-Hospital Relationship

The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.

2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.

3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.

4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.

5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self-govern, as that authority is set forth in the governing documents of the organized medical staff. The organized
medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.

6. The organized medical staff has inherent rights of self-governance, which include but are not limited to:

a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.

b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.

e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.

f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.

g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.

h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality-of-care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.

i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.

j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
m) Establishing in medical staff bylaws, regulations and policies and procedures.
n) Enforcing the organized medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.

8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.

9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital’s governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.


**H-225.971 Credentialing and the Quality-of-Care**

It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have “overall responsibility for the quality of the professional services provided by individuals with clinical privileges”; (3) that each hospital’s quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff’s overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and
credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital.


H-285.904 Out-of-Network Care
1. Our AMA adopts the following principles related to unanticipated out-of-network care:
   A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
   B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
   C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
   D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
   E. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
   F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
   G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
   H. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g., the Gould Criteria) are not accounted for within a minimum coverage standard.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.


H-320.939 Prior Authorization and Utilization Management Reform
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA
research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.

3. Our AMA supports efforts to track and quantify the impact of health plans’ prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

Similar to retail health clinics, urgent care centers (UCC) are proliferating and quickly changing the health care landscape. The rise in the number of UCCs is partially driven by the public’s desire and expectation of prompt, available, and convenient care. The Council noted that American Medical Association (AMA) policy is largely silent on UCCs and the extent UCCs should play a role in meeting the health care needs of patients.

This report, initiated by the Council, provides background on UCCs, notes the various types of ownership models, outlines the extent of physician oversight and physician employment in the centers, summarizes relevant policy, and proposes new recommendations that expand upon the current body of policy on stand-alone health care clinics.

BACKGROUND

UCCs are free-standing same-day clinics focused on caring for patients who need expedient medical care but who are not experiencing a life-threatening emergency. In 2019, there were more than 9,600 UCCs in the US, representing a 9.6 percent jump in the number of centers since 2018. They provide unscheduled, episodic care to patients. These centers usually provide services such as treating earaches, fever or flu-like symptoms, and minor burns or cuts. Some centers also have X-ray capabilities but generally have limited laboratory capabilities. Overall, the scope of services offered across UCCs varies. The most common diagnosis at UCCs is an upper respiratory infection. Additionally, the number of stand-alone care settings such as UCCs and retail health clinics continues to grow each year as patients look for and expect timely care and convenience. These settings are usually open daily, evenings, and weekends making them an attractive alternative to primary care physician offices for unplanned visits.

Proponents of UCCs emphasize their role in ensuring access to care for vulnerable populations and patients living in rural areas. However, only about 10 percent of clinics are in rural areas while 75 percent are in suburban areas, and 15 percent are in urban areas. Moreover, the payer mix of UCCs indicates that 55 percent of their patients are covered by private health insurance and 22 percent by either Medicare or Medicaid, 10 percent are paid with cash, and 7 percent are paid via workers’ compensation. UCCs usually require upfront payment for services from uninsured patients creating a barrier to care for these patients.

In addition to requiring up-front payment, UCCs are in stark contrast with emergency departments (ED) because they do not have state or federal Emergency Medical Treatment and Labor Act obligations to see, treat, or stabilize patients without regard for the patient’s ability to pay.
URGENT CARE CENTER USE COMPARED TO EMERGENCY DEPARTMENT USE

In addition to convenience, proponents of UCCs state that the centers generate health care system cost-savings. UCCs may be classified as cost-effective if they are used as a substitute for an avoidable ED visit. However, it is estimated that only 3.9 percent of ED visits are considered non-urgent. An additional 24 percent of visits are classified as semi-urgent. Therefore, it seems that the utility of UCCs does not lie in their ability to provide substitutive care.

UCCs also have the potential to divert patients away from their usual source of care or patients might utilize UCCs as their usual source of care. Both situations have the potential to disrupt the patient-physician relationship. There are also worries, in an attempt to save money, insurers are encouraging customers to go to free-standing clinics for care, thereby exacerbating fragmentation. Further, UCCs have the potential to be used as additive, rather than substitutive, care, with a corresponding increase to the cost to the health care system. Accordingly, although UCCs have a role to play in the health care system, it is critical that this role is clearly defined and put into practice to avoid increased health care costs and care fragmentation.

URGENT CARE CENTER OWNERSHIP

Initially, when UCCs started to emerge in the early 2000s, they generally were opened by physicians, physician practices, and medical groups. However, more recently, the proliferation of UCCs has been driven by well-capitalized health systems and investor-owned companies. In 2008, 54 percent of UCCs were owned by physicians. Now, less than 40 percent are owned by physicians. Moreover, while hospitals owned less than 25 percent of UCCs in 2008, hospital ownership grew to 37 percent in 2014. At times, because of a UCC’s connection to a hospital, it is effectively treated less as a separate extension of that hospital.

UCC developers and health systems have also started partnering with private equity firms and payers. For example, UnitedHealth Group (UHG) and its Optum medical care services unit purchased MedExpress, a brand of UCCs, in 2015. Over the past five years, MedExpress UCC growth is up 70 percent, with more than 250 UCCs. According to UHG, its significant portfolio of clinics and UCCs will increasingly be “wired together” throughout the country.

PHYSICIAN OVERSIGHT

According to the Urgent Care Center Association of America, about 80 percent of UCCs employ a combination of physicians, physician assistants, and nurse practitioners. The remaining 20 percent of centers employ only physicians. UCCs appear to be largely physician-led, with 94 percent of facilities employing at least one full-time physician. Of the physicians practicing in UCCs, about 48 percent are family medicine physicians, 30 percent are emergency medicine physicians, and 8 percent are internal medicine physicians. Physician employment at UCCs tends to attract physicians wishing to work part-time hours and those looking to transition into retirement.

Staffing in UCCs contrasts with that in retail health clinics, which rely more heavily on nurse practitioners and physician assistants to provide the majority of care.

RELEVANT AMA POLICY

UCCs are consistent with long-standing AMA policy on pluralism (Policies H-165.920, H-160.975, H-165.944, and H-165.920). Most notably, the AMA supports free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the
number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations, or promotion (Policy H-165.985).

AMA Policy H-160.921, established with Council on Medical Service Reports 7-A-06, 5-A-07 and 7-A-17, outlines principles for retail health clinics. The policy proposes that an individual, company, or other entity establishing or operating a retail health clinic must have a well-defined and limited scope of clinical services; use standardized medical protocols derived from evidence-based practice guidelines; establish arrangements by which their health care practitioners have direct access to and supervision by MDs/DOs; establish protocols for ensuring continuity of care with practicing physicians within the local community; establish a referral system with physician practices or other facilities for appropriate treatment if the patient’s conditions or symptoms are beyond the scope of services provided by the clinic; inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated; establish appropriate sanitation and hygienic guidelines and facilities to ensure the safety of patients; use electronic health records (EHRs) as a means of communicating patient information and facilitating continuity of care; and encourage patients to establish care with a primary care physician to ensure continuity of care. Additionally, Policy H-160.921 states that health insurers and other third-party payers should be prohibited from waiving or lowering copayments only for patients that receive services at retail health clinics.

Council on Medical Service Report 7-A-17 further articulated AMA retail clinic policy (i.e., Policy H-160.921) by supporting that a retail health clinic must help patients who do not have a primary care physician or usual source of care to identify one in the community; must use EHRs to transfer a patient’s medical records to his or her primary care physician and to other health care providers, with the patient’s consent; must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information; should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made; should use local physicians as medical directors or supervisors; clinics should neither expand their scope of services beyond minor acute illnesses nor expand their scope of services to include infusions or injections of biologics; and should have a well-defined and limited scope of services, provide a list of services provided by the clinic, provide the qualifications of the on-site health care providers prior to services being rendered, and include in any marketing materials the qualifications of the onsite health care providers. Additionally, Policy H-160.921 supports that the AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed the spending for services that a patient receives at a retail health clinic if the physician could not reasonably control or influence that spending.

The AMA also has established policy that addresses the patient-physician relationship, physician extenders, and continuity of care. The AMA encourages policy development and advocacy in preserving the patient-physician relationship (Policies H-100.971 and H-140.920). The AMA has extensive policy on guidelines for the integrated practice of physicians with physician assistants and nurse practitioners (Policies H-160.950, H-135.975, and H-360.987). Policy H-160.947 encourages physicians to be available for consultation with physician assistants and nurse practitioners at all times, either in person, by phone, or by other means. Policy H-425.997 encourages the development of policies and mechanisms that assure continuity and coordination of care for patients. Finally, the AMA believes that full and clear information regarding benefits and provisions of every health care system should be available to the consumer (Policy H-165.985).

The AMA has extensive policy related to the health care team. Several policies reinforce the concept of physicians bearing the ultimate responsibility for care and advocate that allied health
professionals such as nurse practitioners and physician assistants function under the supervision of a physician (e.g., Policies H-35.970, H-45.973, H-35.989). Policy H-160.912 advocates that all members of a physician-led team be enabled to perform medical interventions that they are capable of performing according to their education, training and licensure, and the discretion of the physician team leader. Policy H-160.906 defines “physician-led” in the context of team-based health care as the consistent use by a physician of the leadership, knowledge, skill, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of those skills.

LEGISLATIVE ACTIVITY

Early in the emergence of UCCs, state regulation largely focused on defining “urgent care,” articulating services included within the definition, and accreditation standards. More recently, as the number of UCCs has increased, states are starting to pursue a more active role in urgent care regulatory oversight. For example, some states give state health agencies the authority to license UCCs.13

AMA ACTIVITY

With respect to scope of practice issues, the AMA has established the Scope of Practice Partnership with members of the Federation as a means of using legislative, regulatory, and judicial advocacy to oppose the expansion of scope of practice laws for allied health professionals that threaten the health and safety of patients.

DISCUSSION

The Council believes that UCCs can play a role in meeting the health care goals of high quality, efficient care. Nonetheless, striking a patient-centered balance between the use of UCCs and traditional physician visits, including the ED, requires coordination between the various health care settings. Coordination leads to better outcomes and protects against duplicative care. The Council believes that UCCs can serve as a health care access point when a patient’s usual source of care is unavailable. Therefore, in its recommendations, the Council emphasizes that the design and use of UCCs, just like retail clinics, should serve as a complement to, rather than a substitute for, the primary care physician or usual source of care. Accordingly, the Council recommends a set of principles to guide the use of UCCs similar to those on retail health clinics (Policy H-160.921).

The Council recommends that a UCC must help patients who do not have a primary care physician or usual source of care to identify one in the community. Given that it is critical that UCCs take responsibility for ensuring continuity of care, the Council further recommends that UCCs must transfer a patient’s medical records to his or her primary care physician or other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving provider is capable of receiving it. Additionally, the Council recommends that UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information.

Moreover, it has been shown that policies that support patient-centered medical home activities in UCCs can help protect against fragmentation of care.14 Accordingly, the Council recommends that UCCs work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made. The Council also notes the importance of the patient-centered medical home (PCMH) and the fact that many physicians are expanding
hours and scheduling to provide patients with enhanced access to care. To underscore the
effectiveness of PCMHs and physicians’ continued commitment to provide more comprehensive
access to care, the Council recommends reaffirming Policy H-385.940 advocating for fair and
equitable payment of services described by Current Procedural Terminology codes, including those
that already exist for off-hours services. Physicians spend a significant amount of off-hours time
messaging and otherwise communicating with patients, and they should be incentivized and
supported to continue doing so.

Additionally, the Council is pleased that the vast majority of UCCs are physician-led, and
recommends emphasizing the importance of physician-led care by not only reaffirming Policy
D-35.985 advocating for the physician-led team, but also recommending that UCCs use local
physicians as medical directors or supervisors. Similarly, the Council recommends reaffirming
Policy H-385.926 supporting physicians’ choice of practice and method of earning a living.

As previously stated, UCC capabilities range significantly. As such, the Council believes it is
imperative that each center have a well-defined and limited scope of clinical services, provide a list
of services provided by the center, provide the qualifications of the on-site providers prior to
services being rendered, the degree of physician supervision of non-physician providers, and
include in any marketing materials the qualifications of the onsite health care providers. Moreover,
the Council believes that a physician should not be attributed to the spending for services that a
patient receives at a UCC if the physician could not reasonably control or influence that spending.

The Council believes that UCCs can serve as a convenient way for patients to receive medical care
that does not require life-saving interventions. However, it is critical that patients understand the
limits of UCCs and not confuse them for an ED. Therefore, the Council recommends that UCCs
be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements,
or as a way to describe the type of care provided. Further, the Council wholeheartedly supports
patient education on the role of alternative sources of care such as UCCs. Patients should be
notified if physicians are providing off-hours care and told what to do in urgent situations when
their physician may be unavailable. Moreover, patients should be informed of the differences
between a UCC and an ED. Additionally, the Council is interested in the volume of patient
transfers to an ED after a UCC visit and will monitor this issue.

When health care is provided episodically, opportunities to develop or nurture the patient-physician
relationship may be missed. Therefore, it is vital to ensure that there is care coordination between
the UCC and a patient’s usual source of care. Emphasizing the patient-physician relationship is
critical to achieving the quadruple aim. To that end, the Council’s recommendations aim to ensure
that UCCs can be a modern component of patient-centered care.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy D-35.985 supporting the
   physician-led health care team. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-385.926 supporting physicians’ choice of practice and
   method of earning a living. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy H-440.877 stating that if a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted to the patient’s primary care physician and the administrator of the vaccine should enter the information into an immunization registry, when one exists. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.940 advocating for fair and equitable payment of services described by Current Procedural Terminology (CPT) codes, including those for off-hour services. (Reaffirm HOD Policy)

5. That our AMA supports that any individual, company, or other entity that establishes and/or operates urgent care centers (UCCs) adhere to the following principles:
   a. UCCs must help patients who do not have a primary care physician or usual source of care to identify one in the community;
   b. UCCs must transfer a patient’s medical records to his or her primary care physician and to other health care providers, with the patient’s consent, including offering transfer in an electronic format if the receiving physician is capable of receiving it;
   c. UCCs must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
   d. UCCs should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
   e. UCCs should use local physicians as medical directors or supervisors;
   f. UCCs should have a well-defined scope of clinical services, communicate the scope of services to the patient prior to evaluation, provide a list of services provided by the center, provide the qualifications of the on-site health care providers prior to services being rendered, describe the degree of physician supervision of any non-physician practitioners, and include in any marketing materials the qualifications of the on-site health care providers; and
   g. UCCs should be prohibited from using the word “emergency” or “ED” in their name, any of their advertisements, or to describe the type of care provided. (New HOD Policy)

6. That our AMA work with interested stakeholders to improve attribution methods such that a physician is not attributed to spending for services that a patient receives at an UCC if the physician could not reasonably control or influence that spending. (New HOD Policy)

7. That our AMA support patient education including notifying patients if their physicians are providing off-hours care, informing patients what to do in urgent situations when their physician may be unavailable, informing patients of the differences between an urgent care center and an emergency department, and asking for their patients to notify their physician or usual source of care before seeking UCC services. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES

1 Cheryl Alkon, What’s Behind the Growth of Urgent Care Center Clinics?, Medical Economics. Available at: https://www.medicaleconomics.com/view/whats-behind-growth-urgent-care-clinics
6 National Hospital Ambulatory Medical Care Survey: 2017 Emergency Department Summary Tables. Available at: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2017_ed_web_tables-508.pdf
10 Convenient Care: Growth and Staffing Trends in Urgent Care and Retail Medicine. Merritt Hawkins. Available at: https://www.ihaconnect.org/About-IHA/Files/Merritt%20Hawkins/mhwhitepaperconvenientcarePDF.pdf
Subject: Addressing Payment and Delivery in Rural Hospitals

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

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

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

BACKGROUND

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

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

From 2018 to 2020, 50 rural hospitals closed, a more than 30 percent increase in the number of closures compared to the 3 years prior.⁶ The closure of hospitals was generally preceded by
financial losses caused by a combination of decreasing rural population and inadequate payments from health insurers. There are more than 2,000 rural hospitals across the country, and more than 800 (40 percent) of them are estimated to be at risk of closing. Most of the hospitals at risk of closing are small rural hospitals serving isolated rural communities.

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

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

IMPACT OF PAYER MIX

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

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

Most small rural hospitals lose money on Medicaid patients, but in some states, small rural hospitals also receive cost-based payments for Medicaid patients, and some states provide special subsidies to offset losses on Medicaid and uninsured patients.
For many small rural hospitals, the leading cause of negative margins is insufficient payment from private health insurance plans and MA plans. Many private health insurance plans pay less than the cost to deliver essential services in small rural hospitals, whereas private plan payments at most large hospitals are higher than the cost of delivering services. Although most hospitals lose money on Medicaid and care to the uninsured, larger hospitals can use profits on privately insured patients to cover those losses. In contrast, many small rural hospitals cannot cover losses on Medicaid and uninsured patients because the payments from private payers do not generate significant profits or may not even cover the costs of providing services to the privately insured patients.

COST OF DELIVERING SERVICES IN RURAL HOSPITALS AND CLINICS

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

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

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

QUALITY MEASUREMENT CHALLENGES IN RURAL HOSPITALES

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

Rural hospital volume varies significantly for several reasons including the population of the community, the age and health status of the population, the availability of other primary care options, and the accessibility of the hospital. Many currently used quality measures are not applicable to numerous types of patients and aspects of care, and many focus on a specific condition or service. Accordingly, many rural hospitals cannot achieve a meaningful sample size because they do not have enough patients with that specific condition. Moreover, rural hospitals
often face challenges reporting quality measurement data due to limited staff, time, and infrastructure.

The typical value-based payment system of bonuses and penalties often penalizes rural providers and hospitals. Again, the small patient panels inherent in rural care mean that providers can easily be penalized for random variation over which they have no control.19

RISK ADJUSTMENT CHALLENGES IN RURAL HOSPITALS

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

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

RELEVANT AMA POLICY

The AMA has significant policy on rural health. Policy H-465.994 supports the AMA’s continued and intensified efforts to develop and implement proposals for improving rural health care. AMA policy specific to rural hospitals includes Policy H-165.888 stating that any national legislation for health system reform should include sufficient and continuing financial support for rural hospitals. Policy H-465.990 encourages legislation to reduce the financial constraints on small rural hospitals to improve access to care. Policy H-465.999 asks for a more realistic and humanitarian approach toward certification of small, rural hospitals. Policy H-465.979 recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities. Policy D-465.999 calls on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; oppose the elimination of the state-designated CAH “necessary provider” designation; and pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.

Policy H-385.913 discusses payment and delivery reform in the context of the shift away from volume to value. The policy states that alternative payment models (APMs) must provide flexibility to physicians to deliver the care their patients need. Policy H-385.913 also calls for
APMs to be feasible for physicians in every specialty and for practices of every size to participate in. Importantly, Policy D-385.952 directs the AMA to continue encouraging the development and implementation of APMs that provide services to improve the health of vulnerable and high-risk populations, including those in rural areas.

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

DISCUSSION

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

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

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

The Council notes that taking these steps to ensure adequate and reliable payment for rural hospitals is critical to addressing the barriers to procedural service lines. A small patient population 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
hospital. The Council believes that addressing payment issues for rural hospitals will help give
those hospitals the flexibility to offer more complex services. In turn, those services will boost
financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately
increase patient access to care.

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

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

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

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy D-290.979 directing our
   AMA to support state efforts to expand Medicaid eligibility as authorized by the
   Affordable Care Act. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.976 stating that Medicaid payments to medical
   providers be at least 100 percent of Medicare payment rates. (Reaffirm HOD Policy)

3. That our AMA support that public and private payers take the following actions to ensure
   payment to rural hospitals is adequate and appropriate:
   a. Create a capacity payment to support the minimum fixed costs of essential services,
      including surge capacity, regardless of volume;
   b. Provide adequate service-based payments to cover the costs of services delivered in
      small communities;
   c. Pay for physician standby and on-call time to enable very small rural hospitals to
      deliver quality services in a timely manner;
   d. Use only relevant quality measures for rural hospitals and set minimum volume
      thresholds for measures to ensure statistical reliability;
   e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be
      assessed due to low statistical reliability; and
   f. Create voluntary monthly payments for primary care that would give physicians the
      flexibility to deliver services in the most effective manner with an expectation that
      some services will be provided via telehealth or telephone. (New HOD Policy)

4. That our AMA encourages transparency among rural hospitals regarding their costs and
   quality outcomes. (New HOD Policy)
5. That our AMA support better coordination of care between rural hospitals and networks of
   providers where services are not able to be appropriately provided at a particular rural
   hospital. (New HOD Policy)

6. That our AMA encourage employers and rural residents to choose health plans that
   adequately and appropriately reimburse rural hospitals and physicians. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES

2 Rural and Urban Health. Georgetown University Health Policy Institute. Available at: https://hpi.georgetown.edu/rural/
4 Medicaid Works for People in Rural Communities. Center on Budget and Policy Priorities. Available at: https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities
6 Supra note 3.
9 Supra note 7.
10 Id.
13 Supra note 10.
16 Id.
17 Id.
18 Id.
19 Id.
20 Supra note 7.
21 Supra note 14.
Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

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

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

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

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

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

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

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

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

Received: 04/23/21

AUTHOR’S STATEMENT OF PRIORITY

New York ranked this as vitally important – it has to do with physician health and well-being which has been sorely tested during the last year. Physicians are under enormous stress each and every day, and the COVID pandemic added immeasurably to that stress. The incidence of physician suicide increased during the last year – a clear indication of the added stress of COVID. Working without the necessary and proper equipment during the pandemic and watching colleagues die of COVID while doing their job has all added to the burden of being a physician. Physicians have few protections for their wellbeing and good health. Many feel that physicians should be “super-heroes” unaffected by the stress of providing health care in today’s very different environment. Adding physician burnout as an RSI subject to OSHA oversight would go a long way toward ensuring physicians work situation is monitored to ensure that they do not burnout.
Whereas, More than 70 percent of consumers search for health information online, according to Pew Research Center, and 77 percent of consumers say they use online reviews as the first step in finding a new physician*; and

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

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

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

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

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

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

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

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

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

Fiscal Note: Minimal - less than $1,000

* 2015 survey of 1,438 patients by Software Advice, a software research and advisory firm.
AUTHOR’S STATEMENT OF PRIORITY

The issue of inaccurate and defamatory information posted on the internet, social media and other post sites has been heavily discussed by media during the last year. The damage that those posts and reviews can do has been made abundantly clear – causing some on the receiving end to go so far as suicide. It is clear that negative reviews which may be unfounded and which physicians are given no opportunity to refute can cause lasting damage, not only to a physician’s practice and livelihood but to his/her mental health. The potential for patient harm exists as well, since some patients may believe erroneous information, doing damage to their own health care. Social media outlets may be reluctant to remove negative posts, but online review organizations should be held to a higher standard. AMA has policy but it is six years old and does not specify the right to due process. It requires action so that physicians are given the rights and due process everyone deserves. This is in many ways an issue of patient and physician well-being and should not be ignored during these especially stressful times.

RELEVANT AMA POLICY:

Anonymous Cyberspace Evaluations of Physicians D-478.980
Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.
Citation: (BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14)
WHEREAS, Employed physician contracts contain clauses to the effect that the physician maintains privileges ONLY if the physician remains employed by the hospital/health system; and

WHEREAS, An employed physician due to circumstances beyond the physician’s control could be dismissed and upon that dismissal, lose all privileges despite having been credentialed according to hospital/health system bylaws; and

WHEREAS, Hospital medical staff bylaws ensure rights and due process for all members of the medical staff; therefore be it

RESOLVED, That our American Medical Association advocate in support of all employed physicians receiving all rights and due process protections afforded all other members of the medical staff. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 04/23/21

AUTHOR’S STATEMENT OF PRIORITY

This resolution is a High priority for all employed physicians, which many have found are actually the majority of US physicians.

While the Independent Medical Staff physicians’ hospital privileges are protected by due process enshrined in their by-laws, employed physicians hospital privileges remain in effect ONLY as long as they remain in their employment. This means that should the physician be dismissed, that means that that physician’s privileges are no longer in effect, since the usual due process afforded by the staff by-laws are superseded by the employment contract. For example, a physician who complained “too much” about the lack of appropriate PPE during the pandemic could not only lose his/her job but would have to begin at square one should that physician wish to regain privileges – those bylaws would no longer be in effect.

It has been suggested by other delegates to the AMA HOD, that not only was this resolution extremely important, but it did not go far enough. The phrase “seek regulation/legislation” was suggested as an addition to ensure that all employed physicians retain the same rights and process afforded the members of the hospital medical staff within their bylaws.
RELEVANT AMA POLICY

Fair Process for Employed Physicians H-435.942
1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity.
2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.
Citation: Res. 007, I-16

AMA Principles for Physician Employment H-225.950
1. Addressing Conflicts of Interest
   a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
   b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
   c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
   d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
   (i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
   (ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
   e) Assuming a title or position that may remove a physician from direct patient-physician relationships—such as medical director, vice president for medical affairs, etc.—does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.
   Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.
2. Advocacy for Patients and the Profession
   a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
   b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.
3. Contracting
   a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
   b) Physicians should never be coerced into employment with hospitals, health care systems, medical
groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise
their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians—not lay administrators—should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:

i. The agreement is for the provision of services on an exclusive basis; and

ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and

iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.


Physician and Medical Staff Member Bill of Rights H-225.942

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

Preamble

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

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients. Medical staff self-governance is vital in protecting the ability of physicians to act in their patients’ best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

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

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

a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organizations governing body.

b. The responsibility to provide leadership and work collaboratively with the health care organizations administration and governing body to continuously improve patient care and outcomes.

c. The responsibility to participate in the health care organization’s operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.

d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.

e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.

f. The responsibility to make appropriate recommendations to the health care organization’s governing body regarding membership, privileging, patient care, and peer review.

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

a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

b. The right to advocate for its members and their patients without fear of retaliation by the health care organizations administration or governing body.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

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

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

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:
a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organizations administration or governing body.
d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.
f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19
Whereas, The US Centers for Medicare and Medicaid Services (CMS) has been publishing mortality data of hospitalized patients since 2008; and

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

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

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

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

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

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

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

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

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

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

RESOLVED, That our AMA collaborate with CMS and other stakeholders to eliminate the use of claims data for measuring physician and hospital quality. (Directive to Take Action)
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
Whereas, Prior authorization is a recognized factor in the delay of patient care; and

Whereas, Each insurance company, pharmacy benefit manager and retail pharmacy all have different prior authorization processes which create undue stress and time to complete these processes on physician practices; and

Whereas, Denials from insurance companies, pharmacy benefit managers, and retail pharmacies do not inform the prescribing physician at the time of the denial of alternative but similar medications which are on the patients formulary; therefore be it

RESOLVED, That our American Medical Association promote that all medication denials from insurance companies, pharmacy benefit managers or retail pharmacies provide the approved formulary alternatives in the same class of medications or the step edit requirements at the time of the denial to the prescribing physician (Directive to Take Action); and be it further

RESOLVED, That at the time of denial by insurance companies, pharmacy benefit managers, or retail pharmacies, that our AMA advocate they be required to inform the patient of the lowest cash or discount card price for that medication. (Directive to Take Action)

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

Received: 05/11/21
AUTHOR’S STATEMENT OF PRIORITY

The resolution is timely and should be discussed at the A2021 for the following reasons:

1. Physician burnout, which is at an all-time high during the Covid-19 pandemic, is due in part by the increasingly onerous prior authorization process. The resolution is an attempt to simplify the process for physician practices by forcing the denying pharmacy benefit manager, insurance company, or retail pharmacy to immediately at the time of medication denial to provide the prescriber with formulary alternatives and not force the provider to submit a prior authorization to determine the alternative medications which are on the formulary.

2. Patients deserve to know at the time of purchase of medications that the cash or discount cash price may be lower than the copay required by their insurance. If a medication is denied by insurance, the patient should be provided the cash or discount card price so they may determine if their purchase should not be subject to further insurance company delay due to the prior authorization process.

3. The resolution demands transparency in the prior authorization process to both the patient and physician which is not currently the case. Further delay in consideration of the resolution will cost patients dollars and practices in time and money they both can ill afford.
Whereas, There are Medicare guidelines for most treatments for patients including, but not limited to criteria for admissions, diagnostic testing, medications, and procedures; and

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

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

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

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

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

RESOLVED, That our AMA advocate against applying proprietary criteria to determine eligibility of Medicare patients for procedures and admissions when the criteria are at odds with the 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 plans.¹


Subject: Financial Incentives for Patients to Switch Treatments

Referred to: Reference Committee G

Whereas, All patients should have access to the medications they and their provider feel are most appropriate; and

Whereas, Biologic drugs are highly effective and have the potential to reduce long-term disability; however, they are not without certain risks. All classes of biologics used in autoimmune diseases may cause serious adverse events. The decision to choose one biologic over another requires careful clinical evaluation and consideration by a physician and patient. Factors such as an individual patient's age, gender, diagnosis, medications, specific organ manifestations, antibody status, disease severity, comorbid conditions, and ability to tolerate the route of administration strongly influence the specific biologic choice; and

Whereas, Due to these highly individual characteristics among patients, the journey to finding an effective treatment is often long and challenging. The complex medical decision making, and subsequent risks associated with these medications, fall on the physician and the patient, so these decisions should not be curtailed by a health plan's coverage policies; and

Whereas, In March of 2021, Cigna notified patients that they could be eligible for a $500 pre-paid medical debit card if they agree to stop taking Cosentyx (secukinumab) and switch to a payer-preferred alternative medication; and

Whereas, Incentivizing patients who are stable on an effective therapy to abandon treatment for non-medical reasons needlessly puts them at risk for significant long-term consequences including irreversible damage and disability. Patients who are switched to another treatment may experience serious disease flares, as even drugs with similar mechanisms of action have widely variable patient to patient effectiveness; and

Whereas, Using money to persuade patients to make a choice against their own health raises ethical concerns and is highly irresponsible, especially when so many have suffered financially due to the ongoing pandemic and may be swayed by financial incentive to make a decision contrary to their health interests; and

Whereas, This initiative jeopardizes patients' health, interferes with medical decision making, and undermines the doctor-patient relationship by possibly obliging physicians to counsel patients to forgo the $500 payment in order to safeguard their health; and

Whereas, This program will disproportionately affect patients of lower socio-economic status, who may have less ability to refuse such a payment despite their health interests; and
Whereas, Other large national insurers are contemplating adopting or expanding similar policies financially incentivizing patients to switch treatments, and these policies could quickly become common across multiple disease states if not checked; and

Whereas, It is of the highest urgency during this time of economic uncertainty and public health emergency that payers avoid policies that would take advantage of financial instability and jeopardize patient health; therefore be it

RESOLVED, That our American Medical Association oppose the practice of insurance companies providing financial incentives for patients to switch treatments (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that would ban insurer policies that provide patients financial incentives to switch treatments, and will oppose legislation that would make these practices legal (Directive to Take Action); and be it further

RESOLVED, That our AMA engage with state regulators urging review of the legality of such policies providing financial incentives to patients who switch to preferred drugs. (Directive to Take Action)

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

Received: 05/12/21

AUTHOR’S STATEMENT OF PRIORITY

Especially during the PHE, ensuring patients stay on their medication is urgent and of the highest priority. However, new tactics by insurance companies to financially incentivize patients who are stable on effective therapy to abandon that treatment for non-medical reasons needlessly put patients at risk.

This year, Cigna notified patients they could receive $500 debit cards if they agreed to stop taking a non-preferred medication and switch to the payer-preferred alternative. There are indications this policy is planned to be expanded and other large payers including UHC have signaled desires to adopt or expand this type of program. Additionally, at least one piece of state legislation proposed this year would explicitly make these policies legal. Without action in opposition these tactics are likely to proliferate, affecting many physicians and patients.

Payer policies should not interfere with complex medical decisions about treatments. Using monetary incentives to persuade patients to make choices against their own health is particularly irresponsible when so many have suffered financially due to the COVID-19 pandemic, especially patients of lower socio-economic status who may have less ability to refuse a payment despite health interests.

It is of the highest priority during this time of economic uncertainty and public health emergency that payers do not take advantage of financial instability and jeopardize patient health. It is urgent that we have policy in opposition and take action protecting patients’ health, medical decision making, and the physician-patient relationship.
RELEVANT AMA POLICY

Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920
1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
   a. Collaborate with the physician community in the development and implementation of patient incentives.
   b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
   c. Provide treating physicians with access to patients’ FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
   d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
   e. Provide referring and/or primary care physicians with the full record of the service encounter.
   f. Never interfere with a patient-physician relationship (e.g., by proactively suggesting health care items or services that may or may not become part of a future care plan).
   g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
   a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
   b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
   c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
   d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician’s quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
   e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
   f. Provide meaningful transparency of prices and vendors.
   g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
   h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
   i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.

6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
   a. Patient outcomes/the quality of care provided with shopped services;
   b. Patient utilization of shopped services;
   c. Patient satisfaction with care for shopped services;
   d. Patient choice of health care provider;
   e. Impact on physician administrative burden; and
   f. Overall/systemic impact on health care costs and care fragmentation.

CMS Rep. 2, I-19

**E-9.6.3 Incentives to Patients for Referrals**

Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice.

Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.

AMA Principles of Medical Ethics: I,II,VIII
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708  
(JUN-21)

Introduced by: Georgia

Subject: Medicare Advantage Record Requests

Referred to: Reference Committee G

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

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

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

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

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

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

Received: 05/12/21

AUTHOR'S STATEMENT OF PRIORITY

The COVID-19 pandemic has created substantial financial issues for physician practices due to reductions in elective procedures and challenges maintaining appropriate staffing. Requests from Medicare Advantage plans for medical records have been a consistent issue that requires extensive staff time and may be costly for the practice to complete. Limiting these requests will help already stressed practices as they recover after the pandemic subsides. Finding solutions to the financial pressures facing practices right now cannot wait if the health care system in the United States is to adequately recover from the pandemic. The AMA’s current policy does not include a specific maximum amount of records that plans should be authorized to request. Due to the national nature of Medicare Advantage plans, the AMA is in the best position to advocate for these changes and advocating for the relief of administrative burdens is an important component of promoting the art and science of medicine.
RELEVANT AMA POLICY

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