REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 05-JUN-21

Subject: Medical Center Patient Transfer Policies (Resolution 818-I-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

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.[4] 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.[5] 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.[6] 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.[7] 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.[8] 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.[9] However, studies have found such call centers to be highly variable in their functionality and effectiveness.[10]

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.[11] 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.[12] 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.[13] (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.[14] Moreover, patients with medically treated conditions are more likely to board than those with surgically treated conditions.[15] With the ED being the dominant source of hospital admissions,[16] 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.[17] Reflecting these problems, The Joint Commission (TJC) imposes requirements that hospitals address boarding for purposes of accreditation.[18] 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,[19] 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.[20]

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.[21] 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.[22] 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."[23] 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.[24] Moreover, Medicare COPs make clear that the medical staff "is responsible for the quality of medical care provided to patients by the hospital,"[25] 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."[26] 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."[27] 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.[28] 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.[29]

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.[30] 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.[31] 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.[32] 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.[33] 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.[34]

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.

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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. (Sub. Res. 155, I-89Reaffirmed: Sunset Report and Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed: CMS Rep. 01, A-20)

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 interhopsital agreements with their local hospitals.
(CMS Rep. H, A-86Reaffirmed: BOT Rep. BB, A-90Reaffirmed: CMS Rep. F, I-92Reaffirmation A-00Reaffirmed: CMS Rep. 6, A-10Modified: CMS Rep. 01, A-20)

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

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) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
n) Establishing in 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.
(Res. 828, I-07Reaffirmed in lieu of Res. 730, A-09Modified: Res. 820, I-09Reaffirmed: Res. 725, A-10Reaffirmation A-12Reaffirmed: CMS Rep. 6, I-13)

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.
(BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13)

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.
Res. 108, A-17 Reaffirmation: A-18 Appended: Res. 104, A-18 Reaffirmed in lieu of: Res. 225, I-18 Reaffirmation: A-19 Reaffirmed: Res. 210, A-19

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.
CMS Rep. 08, A-17 Reaffirmation: I-17 Reaffirmed: Res. 711, A-18 Appended: Res. 812, I-18 Reaffirmed in lieu of: Res. 713, A-19 Reaffirmed: CMS Rep. 05, A-19 Reaffirmed: Res. 811, I-19