

## Reference Committee G

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*\* contained in the Handbook Addendum*

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-22

Subject: Addressing Inflammatory and Untruthful Online Ratings  
(Resolution 702-Jun-21)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee G

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### 1 INTRODUCTION

2  
3 At the June 2021 Special Meeting of the House of Delegates Resolution 702-Jun-21, “Addressing  
4 Inflammatory and Untruthful Online Ratings,” was introduced by the New York Delegation and  
5 referred for report back. This resolution asks the American Medical Association (AMA) to take  
6 action that would urge online review organizations to create internal mechanisms ensuring due  
7 process to physicians before the publication of negative reviews.

8  
9 This report discusses the concerns associated with online ratings of physicians and their practices,  
10 AMA’s efforts to support physicians in managing their online reputations, and the various legal and  
11 privacy implications that physicians may face when responding to patient ratings and reviews. Also  
12 included in this report are recommendations for physicians to follow when considering addressing  
13 or responding to patient ratings, based on available resources. Finally, this report makes  
14 recommendations for AMA policy and the development of resources that can further support  
15 physicians in managing their practice’s online reputation.

16  
17 It should be noted that, in considering what constitutes “online reviews” for the purposes of this  
18 report, not all reviews posted about physicians are created by patients, and there is no known  
19 process to screen reviewers to verify patient status. For example, some negative or false reviews  
20 could be posted by disgruntled former employees, ex-spouses or ex-partners, and even competitors  
21 or individuals who have personal disagreements with a physician. In addition, some physicians  
22 have experienced incidents in which vaccine skeptics, who were not patients, posted negative and  
23 false reviews simply on the basis of disagreement with the physician about vaccines. There is  
24 currently no formal redress for this problem and few rating sites will remove these false posts.

### 25 26 BACKGROUND

27  
28 Online rating platforms are an indelible presence on the internet, offering consumers increased  
29 transparency into the products and services in which they invest. Health care services are no  
30 exception. Numerous websites provide patients with information about their clinicians, including  
31 locations, specialties, clinical interests, insurance accepted, and oftentimes reviews from other  
32 patients or members of the public. Recent data shows that little more than one-third (37%) of  
33 patients use online reviews as their first step in searching for a new physician and 60% of patients  
34 have selected a physician based on positive reviews.<sup>1</sup> Incongruously, other research shows a higher  
35 percentage of patients (70%) use online reviews in selecting a physician.<sup>2</sup> Google My Business is a  
36 popular source of online reviews for many businesses, including health care practices and  
37 physicians. In addition, a 2017 study showed the online review site used most frequently was

Yelp.com, followed by Healthgrades.com, and then by the health system, hospital, or group practice website. Nearly 70% of respondents in this study had never used an online review site for health care services. More of those that *did* use one of these sites did so to learn more about a physician or hospital rather than to post a comment.<sup>3</sup> In addition, 83% of patients say they *trust* online ratings and reviews of physicians<sup>1</sup>, despite other research showing online ratings of physicians do not predict objective measures of quality of care or clinical performance.<sup>4</sup> Moreover, a 2018 Brookings article shows patients prefer online reviews to government ratings, such as the ratings provided by the Centers for Medicare and Medicaid Services (CMS), when choosing a doctor.<sup>5</sup>

In the information age, when social media and online reputations have such a large role in consumer decision-making, it is clear online review sites are not going away. Physicians, patients, and the sites that provide the forum for online reviews must coexist in a balanced way that provides patients and consumers the transparency to which they are accustomed, but also allows physicians the ability to respond to reviews and address concerns safely and professionally.

#### AMA POLICY

The AMA recognizes the threat that negative and inflammatory reviews can pose to a physician's and practice's reputation. AMA policy encourages the adoption of guidelines and standards governing the public release and accurate use of physician data and directs the AMA to identify and offer tools to physicians that allow them to manage their online profile and presence (Policy D-478.980, "Anonymous Cyberspace Evaluations of Physicians").

AMA policy also 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. (Policy D-478.980, "Anonymous Cyberspace Evaluations of Physicians").

In addition, policy supports legislation that would require that websites purporting to offer evaluations of physicians state prominently on their websites 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 (Policy D-478.980, "Anonymous Cyberspace Evaluations of Physicians").

The AMA *Code of Medical Ethics* Opinion E-2.3.2 includes guidance for physicians in maintaining and protecting their online presence.

1. Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
2. When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.
3. When using the internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the internet, content is likely there permanently. Thus, physicians should routinely monitor their own internet presence to

- 1 ensure that the personal and professional information on their own sites and, to the extent
- 2 possible, content posted about them by others, is accurate and appropriate.
- 3 4. If they interact with patients on the internet, physicians must maintain appropriate
- 4 boundaries of the patient-physician relationship in accordance with professional ethics
- 5 guidance just as they would in any other context.
- 6 5. To maintain appropriate professional boundaries physicians should consider separating
- 7 personal and professional content online.
- 8 6. When physicians see content posted by colleagues that appears unprofessional they have a
- 9 responsibility to bring that content to the attention of the individual, so that he or she can
- 10 remove it and/or take other appropriate actions. If the behavior significantly violates
- 11 professional norms and the individual does not take appropriate action to resolve the
- 12 situation, the physician should report the matter to appropriate authorities.
- 13 7. Physicians must recognize that actions online and content posted may negatively affect
- 14 their reputations among patients and colleagues, may have consequences for their medical
- 15 careers (particularly for physicians-in-training and medical students) and can undermine
- 16 public trust in the medical profession.

## 17 18 DISCUSSION

19  
20 Because patients often put their trust in online reviews in choosing a physician, physicians have a  
21 meaningful stake in ensuring online reviews of them and their practice are truthful and positive.  
22 Survey data show the majority of physician reviews are positive, and that negative reviews are less  
23 frequent.<sup>2</sup> This survey also demonstrated that patients largely disregard negative reviews, and more  
24 than a third of patients will ignore a review if the physician responded to the concern (Software  
25 Advice 2020). Evidence shows the majority of negative reviews are not associated with clinical  
26 factors, but more commonly describe experiences such as long wait times, poor parking, or lack of  
27 physician attention.<sup>6</sup> It has also been reported that negative reviews may be more frequent for  
28 physicians on probation<sup>7</sup>, those with larger patient panels and busier practices, and those who bill  
29 for more services.<sup>8</sup> For many physicians, inflammatory, false, or extremely negative reviews can be  
30 damaging, inflicting moral injury and threatening their practice. For example, there are instances in  
31 which one patient or reviewer will go to multiple rating sites to criticize or disparage a physician  
32 and will do so repeatedly over time, sometimes from different IP addresses, flooding the sites with  
33 negative comments and creating a false impression that the doctor has many negative reviews. This  
34 could prevent new patients from seeking care at that practice or from that physician.

35  
36 Health care quality reporting has grown in importance, and information about patient experiences  
37 and satisfaction is available in many forms. Unlike other businesses that may respond to online  
38 reviews however they deem appropriate, physicians are limited in how they can communicate with  
39 a patient in a public forum.

### 40 41 *Privacy concerns*

42  
43 There are concerns that negative, inflammatory, or untruthful patient reviews, although they may  
44 be the exception, can adversely and sometimes seriously affect a physician, their practice, or their  
45 career. Physicians may feel compelled to respond to negative online reviews to dispel false  
46 information or address the patients' concerns. There are limitations, however, to the ways  
47 physicians can respond to patients' online reviews since acknowledgement of a patient's visit  
48 might risk violating patient privacy protected by the Health Insurance Portability and  
49 Accountability Act (HIPAA). It is important to note that HIPAA does not explicitly prohibit  
50 physicians from responding to online reviews; physicians are free to respond to contribute to an  
51 online review forum, but they must maintain the privacy of the patient's protected health

1 information, even if the patient has already revealed personal information. While a patient is free to  
2 share any information about their visit in an online forum, physicians are prohibited from  
3 disclosing any patient information. Examples of this include defending a treatment decision or  
4 acknowledging that the reviewer was a patient. Violations of HIPAA may be reported by patients  
5 to the federal agency overseeing enforcement, the Department of Health and Human Services  
6 Office for Civil Rights (OCR), which responds to such reports with a range of actions from  
7 investigation and corrective action plans to significant financial penalties. Additionally, physicians  
8 may face legal or financial consequences under state law if the physician practices in a state  
9 granting individuals a private right of action for privacy violations.

#### 10 11 *Additional legal considerations*

12  
13 In addition to privacy concerns, the wrong type of physician response to a patient's online review  
14 can have far more serious consequences for a physician's practice than the review itself. If a  
15 reviewer's comments are so damaging or untrue that they subsequently affect the physician's  
16 ability to safely practice medicine, interfere with the physician's other patient relationships, result  
17 in loss of business, or threaten the safety of the physician or other practice employees, the  
18 physician may choose to seek legal action against the reviewer. Pursuing legal action against a  
19 patient or their family for defamation may come with further reputational damage and will present  
20 considerable costs, which should be considered when deciding how to manage such a situation. On  
21 the other hand, if a patient or other reviewer is spreading misinformation or disinformation about  
22 the physician or practice, action by the physician and legal team may help mitigate the issue and  
23 decrease the risk of further reputational damage and thus should be considered.

#### 24 25 *Solutions*

26  
27 Resolution 702-Jun-21 proposes that online review site organizations should provide physicians  
28 due process before publishing negative reviews and that the AMA should take action to encourage  
29 the development of these mechanisms.

30  
31 First, physicians should be aware that online review sites have little to no incentive to develop such  
32 mechanisms. One of their primary objectives is to facilitate free speech and provide a forum for  
33 honest patient feedback. These sites are protected by law in a way that precludes them from  
34 liability for what is posted on their site by users. Under Section 230 of the Communications  
35 Decency Act of 1996, online websites with patient reviews are protected from most litigation. This  
36 section of the Act is a key part of U.S. law that protects freedom of expression and innovation on  
37 the internet. Section 230 says that "No provider or user of an interactive computer service shall be  
38 treated as the publisher or speaker of any information provided by another information content  
39 provider" (47 U.S.C. § 230).<sup>9</sup> Essentially, online intermediaries that host or republish speech (e.g.,  
40 patient reviews) are protected against a range of laws that might otherwise be used to hold them  
41 legally responsible for what others say and do.<sup>10</sup> It should be noted, however that most, if not all,  
42 online review sites have openly published community review guidelines or standards. Physicians  
43 and practices do have the option to contact the review sites directly to dispute false or  
44 inflammatory reviews, especially if they believe the reviews violate the site's community  
45 standards.

46  
47 Second, the AMA does not have the authority to dictate due process for private companies.  
48 Encouraging physicians to attempt to filter negative reviews from public view could be perceived  
49 as a pressure tactic to censor patients or throttle their ability to speak freely. The AMA's  
50 Government Affairs staff has contemplated seeking legislative action to address this concern at the  
51 federal level, however, it has determined that the political environment would not be favorable to

1 achieving this legislative change and opening up federal health information privacy laws could  
2 have the unintended consequence of imposing additional requirements on physician practices,  
3 reducing patient data confidentiality protections, and limiting the ways physicians can exchange  
4 protected health information.

5  
6 It is ultimately the onus of the organization, practice, and physician to protect their reputations,  
7 both on and off the internet. Organizational policies, particularly for hospitals and larger practices,  
8 can help provide guidance and guardrails for employees. There is an abundance of online resources  
9 that recommend best practices and can help physicians and organizations learn how to navigate  
10 their online reputations, including how to handle negative or inflammatory patient reviews. The  
11 American Hospital Association and Medical Group Management Association, for example, both  
12 offer online guidance on managing online and social media presence.<sup>11, 12</sup>

13  
14 It may be tempting to try to prevent negative reviews by prohibiting patients, via signed agreement,  
15 from writing negative reviews about the physician or practice in exchange for the practice's  
16 compliance with the HIPAA Privacy Rule. This is not an appropriate mechanism to prevent  
17 negative commentary and could result in complaints against the practice or physician, or  
18 investigation by the OCR. In addition, the Consumer Review Fairness Act prohibits sellers from  
19 offering contracts with provisions that prohibit or restrict individuals from reviewing the seller's  
20 goods, services, or conduct.<sup>13</sup>

21  
22 In considering online review sites as a potentially valuable platform that can help generate or  
23 expand business, physicians may find ways to maximize overall reviews to minimize the weight  
24 and effects of the few negative comments such as by asking patients who are openly happy with the  
25 care they have received to post reviews. It is important to note that extreme points of view,  
26 provided by a minority of patients, should not be viewed as a singular barometer of a physician's  
27 practice. However, there may be times that criticism may help physicians find ways to improve  
28 care and satisfaction for all their patients. Even if patient reviews shed more light on subjective  
29 measures of satisfaction than objective treatment outcomes, the information can still be relevant  
30 and valuable to both future patients and the practice. For example, patient reviews can provide  
31 direct insight into their patients' communication preferences and priorities as a recipient of health  
32 care services. Negative reviews can sometimes be interpreted constructively, and physicians can  
33 consider whether changing certain aspects of their practices might be in their best professional  
34 interests, as well as their patients' best interests.

35  
36 The AMA has historically been mindful of the problems online patient reviews can pose for  
37 physicians. In 2011 the AMA established a partnership with Reputation.com through its member  
38 value program, which provided physicians and practices access to a service that helps manage  
39 online reputations. Participation in this program by AMA members was extremely low, so the  
40 partnership with Reputation.com was discontinued.

41  
42 The AMA recently submitted comments to the OCR in response to a Notice of Proposed  
43 Rulemaking (NPRM) explaining physicians' concerns about their lack of ability to respond to  
44 online complaints and inflammatory reviews without violating patient privacy. The AMA  
45 encouraged the OCR to develop a mechanism for physicians to respond to online patient  
46 complaints without violating HIPAA's privacy protections.<sup>14</sup> The AMA will continue to advocate  
47 for such a mechanism in future comments and requests to the OCR.

48  
49 In 2016 the AMA published an article<sup>15</sup> to guide physicians in how to respond to negative online  
50 reviews, and an earlier AMA article advised physicians on managing their online reputation.<sup>16</sup> The  
51 AMA is also currently developing a content page within its Debunking Regulatory Myths

1 collection to highlight and clarify the common misconceptions about responding to online patient  
2 reviews. This resource will include links to other published information on physician practice  
3 online reputation management and will be promoted through AMA communication channels to  
4 encourage engagement and attention to the issue.

## 5 6 CONCLUSION

7  
8 In this age of at-our-fingertips information and open forums for the free exchange of opinions, and  
9 with the increased attention to and regulation of care quality, it is undeniable that physicians will  
10 need to continue managing their online presence and reputation. It is clear that while online  
11 reviews can be helpful, they can also be devastating to a physician or practice. The AMA  
12 recognizes the damage a practice can sustain from false or inflammatory reviews, and in no way  
13 condones the allowance of such misinformation and disinformation to be propagated. While it may  
14 not be feasible, from a legal or policy perspective, to intervene *before* reviews are posted,  
15 thoughtfully and compliantly responding to patient reviews to reconcile issues is possible. This  
16 may include working with the website owners to rectify false reviews or reviews that otherwise  
17 violate the site's community guidelines. Whether and how that is achieved is up to each physician  
18 and their practice to carefully and intentionally manage.

## 19 20 RECOMMENDATION

21  
22 The Board of Trustees recommends that the following recommendation be adopted in lieu of  
23 Resolution 702-Jun-21 and the remainder of the report filed:

24  
25 That our American Medical Association\_(1) encourages physicians to take an active role in  
26 managing their online reputation in ways that can help them improve practice efficiency and  
27 patient care; (2) encourages physician practices and health care organizations to establish  
28 policies and procedures to address negative online complaints directly with patients that do not  
29 run afoul of federal and state privacy laws; and (3) will develop and publish educational  
30 material to help guide physicians and their practices in managing their online reputation,  
31 including recommendations for responding to negative patient reviews and clarification about  
32 how federal privacy laws apply to online reviews. (Directive to Take Action)

Fiscal Note: Less than \$1000

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## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-22

Subject: Council on Medical Service Sunset Review of 2012 House Policies

Presented by: Asa C. Lockhart, MD, Chair

Referred to: Reference Committee G

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1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of  
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is  
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for  
4 review and specifying the procedures to follow:  
5

- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A  
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to  
8 retain it. Any action of our AMA House that reaffirms or amends an existing policy position  
9 shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10  
10 years.  
11
- 12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the  
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of  
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall  
15 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been  
16 asked to review policies shall develop and submit a report to the House of Delegates  
17 identifying policies that are scheduled to sunset; (d) For each policy under review, the  
18 reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset  
19 the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like  
20 policy; (e) For each recommendation that it makes to retain a policy in any fashion, the  
21 reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall  
22 determine the best way for the House of Delegates to handle the sunset reports.  
23
- 24 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier  
25 than its 10-year horizon if it is no longer relevant, has been superseded by a more current  
26 policy, or has been accomplished.  
27
- 28 4. The AMA councils and the House of Delegates should conform to the following guidelines for  
29 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has  
30 been accomplished; or (c) when the policy or directive is part of an established AMA practice  
31 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA  
32 House of Delegates Reference Manual: Procedures, Policies and Practices.  
33
- 34 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.  
35
- 36 6. Sunset policies will be retained in the AMA historical archives.

## RECOMMENDATION

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

## APPENDIX – Recommended Actions

Policy #	Title	Text	Recommendation
D-165.957	State Options to Improve Coverage for the Poor	Our AMA (1) urges national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons; and (2) encourages state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage. (CMS Rep. 1, A-05; Reaffirmed in lieu of Res. 105, A-12)	<p>Rescind. Superseded by Policies <a href="#">D-165.942</a> and <a href="#">H-165.839</a>, which state:</p> <p>Empowering State Choice D-165.942</p> <p>Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.</p> <p>Health Insurance Exchange Authority and Operation H-165.839</p> <p>1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:</p> <p>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.</p> <p>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</p>

Policy #	Title	Text	Recommendation
			<p>patients and actively practicing physicians.</p> <p>C) Physician and patient decisions should drive the treatment of individual patients.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>

Policy #	Title	Text	Recommendation
			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-165.974	Achieving Health Care Coverage for All	Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy. (Res. 733, I-02; Modified: CCB/CLRPD Rep. 4, A-12)	Rescind. Superseded by Policy <a href="#">H-165.838</a> , which states: 1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and

Policy #	Title	Text	Recommendation
			<p>threaten seniors' access to care</p> <p>f. Implementation of medical liability reforms to reduce the cost of defensive medicine</p> <p>g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens</p> <p>2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.</p> <p>3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.</p> <p>4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.</p> <p>5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.</p> <p>6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to</p>

Policy #	Title	Text	Recommendation
			<p>privately contract, without penalty to patient or physician.</p> <p>7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.</p> <p>8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:</p> <p>a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services</p> <p>b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system</p> <p>c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted</p> <p>d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate</p>

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			<p>e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another</p> <p>f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest</p> <p>9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.</p> <p>10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.</p> <p>11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.</p> <p>12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.</p> <p>13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system</p>



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			should be part of any national health system reform.
D-185.985	Patient Access to Therapeutics	Our AMA will work with other interested parties to ensure that payment for prescription medications and durable medical equipment not be denied based solely on the use of a properly suffixed institutional Drug Enforcement Agency number or similar identifier. (Res. 121, A-12)	Retain. Still relevant.
D-260.995	Improvements to Reporting of Clinical Laboratory Results	<p>1. Our AMA will: (a) make its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees a high priority; and (b) become involved in and/or provide input into policies involving electronic transmission of clinical laboratory results.</p> <p>2. Our AMA will encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to urgently address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety.</p> <p>3. Our AMA will support the continued efforts of relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other like organizations whose members generate reports electronically to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results.</p> <p>4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization. (BOT Rep. 16, I-06; Modified: CMS Rep. 2, I-12)</p>	Retain-in-part. The following subsection was accomplished and should be rescinded. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization.
D-285.965	Small Businesses and Health Reform	Our AMA will: (1) advocate that stop-loss coverage of self-insured plans have minimum attachment points that are high enough to ensure the adequacy	Retain. Still relevant.

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		and financial security of health insurance coverage of enrollees, and be provided by stop-loss insurers that are legitimate and financially secure and solvent; and (2) encourage states to monitor the rate at which small employers self-insure, and the impact of such self-insurance on the viability and purchasing power on SHOP exchanges. (CMS Rep. 6, A-12)	
D-290.980	Medicare-Medicaid Dual Eligible Demonstration Program	<p>1. Our AMA will advocate that the Centers for Medicare &amp; Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the “State Demonstrations to Integrate Care for Dual Eligible Individuals” initiative.</p> <p>2. Because Medicare-Medicaid dual eligibles often have complex medical and social needs, our AMA will advocate to CMS and the states that established patient-provider relationships and current treatment plans will not be disrupted by the dual eligible Financial Alignment Initiative so as to preserve robust, patient-centered continuity of care.</p> <p>3. Our AMA will advocate to CMS and the states that the Medicare-Medicaid dual eligibles Financial Alignment Initiative should operate as a true demonstration program, and therefore it should not enroll a majority of dual eligibles in any state, and there must be a rigorous evaluation plan to be consistent with the design of a demonstration that can provide useful information to policymakers.</p> <p>4. Our AMA will advocate to CMS and states against automatically enrolling Medicare-Medicaid dual eligibles in a coordinated care program without their prior approval or consent.</p> <p>5. Our AMA will work with CMS and the states to ensure that the Medicare-Medicaid dual eligibles Financial Alignment Initiative demonstrates potential ways of achieving efficiencies in organizing the care of dual eligibles, and any savings from coordination of care to dual eligibles should arise from</p>	<p>Retain-in-part. The following subsection is out-of-date and should be rescinded. The Centers for Medicare &amp; Medicaid (CMS) has been implementing demonstration programs for dually eligible enrollees, including Financial Alignment Initiative demonstrations, since 2012.</p> <p>1. Our AMA will advocate that the Centers for Medicare &amp; Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the “State Demonstrations to Integrate Care for Dual Eligible Individuals” initiative.</p>

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		better health outcomes and efficiencies gained by reducing duplicative, unnecessary, or inappropriate care. The Initiative should not be employed as a policy lever simply to reduce provider payment rates, which could significantly harm beneficiary access. Res. 123, A-12	
D-290.986	Capitation of Medicaid Funding for Guam and Other US Territorial Possessions	The AMA will support: (1) Repeal of 42 USC 1308(f) and to allow Guam and other Territorial Possessions and Island Nations to participate in the Medicaid program on the same terms as the States, without capitation of matching funds; (2) Amending 42 USC 1396(d)(b)(2) by striking “50 per centum” and by inserting in lieu thereof: “determined in the same manner as such percentage is determined for the States under this subsection”; this will allow the Territories to participate in the Medicaid program on the same terms as the States; and (3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD. (BOT Action in response to referred for decision Res. 215, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmation A-12)	Retain-in-part. The following subsection is out-of-date and should be rescinded. (3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD.
D-330.918	Appropriateness of National Coverage Decisions	1. Our AMA will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care. 2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice. (Sub. Res. 120, A-11; Reaffirmed in lieu of Res. 125, A-12)	Retain. Still relevant.

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D-373.995	Shared Decision Making Resource Centers	Our AMA will advocate for full funding for section 3506 of the Affordable Care Act. (Res. 812, I-12)	Retain. Still relevant.
D-385.959	Billing Codes for Filling Out Forms	Our AMA will lobby the Centers for Medicare & Medicaid Services and other national payers to reimburse those physicians who utilize billing code 99080 for filling out various forms requested by patients. (Res. 803, I-12)	Retain. Still relevant.
D-390.956	MedPAC Recommendations from June 15, 2011	<p>1. Our AMA will oppose any policy that applies a payment reduction to professional component of diagnostic services where multiple imaging studies are interpreted by the same practitioner during the same session and will oppose any policy that reduces the physician work component of imaging and other diagnostic tests that are ordered and interpreted by the same practitioner.</p> <p>2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare &amp; Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS. (BOT action in response to referred for decision Res. 124, A-11; Appended: Res. 214, A-12)</p>	Retain-in-part. The following subsection is out-of-date and should be rescinded. 2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS.
D-410.992	Evidence-Based Utilization of Services	Our AMA supports physician-led, evidence based, efforts to improve appropriate utilization of medical services and will educate member physicians, hospitals, health care leaders and patients about the need for physician-led, evidence based, efforts to improve appropriate utilization of medical services. Res. 815, I-12	Rescind. Superseded by Policy <a href="#">H-285.931</a> . The Critical Role of Physicians in Health Plans and Integrated Delivery Systems H-285.931 Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS): (1) Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a

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			<p>council of advisors to the governing body or management;</p> <p>(b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes;</p> <p>(c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine;</p> <p>(d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and</p> <p>(e) have access to a due process system.</p> <p>(2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process.</p> <p>(3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols.</p> <p>(4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions.</p> <p>(5) Practicing physicians and patients of a health plan/IDS should have access to a</p>

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			<p>timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.</p> <p>(6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care.</p> <p>(7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data.</p> <p>(8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value.</p> <p>(9) Physician representatives/leaders must communicate key policies</p>

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			<p>and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative.</p> <p>(10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice. Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.</p>
D-410.993	Need to Include Assessment of Economic Impact in Practice Guidelines	Our AMA will continue to monitor the methodological guidance, data collection, and data synthesis applied to evaluating the economic impact of implementing guidelines into clinical practice. (BOT Rep. 13, A-12)	Retain. Still relevant.
H-35.996	Status and Utilization of New or Expanding Health Professionals in Hospitals	<p>(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff.</p>	Retain. Still relevant.

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		<p>Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role.</p> <p>(2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions. (BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmation A-12)</p>	
H-70.924	Litigation Center Cases to Combat Automatic Downcoding and/or Recoding	The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices. (BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4,	Retain. Still relevant.



<b>Policy #</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
H-70.925	CPT Editorial Panel Representation	(1) The CPT Editorial Panel shall be kept at a size compatible with its functioning as an efficient and effective editorial board and should not be subject to the requirement of formal slotted seats for individual specialty societies. (2) While the role of the CPT Advisory Committee as clinical and technical experts to the CPT Editorial Panel is important, necessary, and currently of satisfactory composition, the need to expand as the practice of medicine changes or the scope of the CPT code set changes should be regularly evaluated. (BOT Rep. 34,	Retain. Still relevant.
H-155.966	Controlling Cost of Medical Care	The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, house staff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general. (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12)	Retain. Still relevant.
H-155.998	Voluntary Health Care Cost Containment	(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical	Retain. Still relevant.

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		<p>tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care. (Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12)</p>	
H-160.913	Medicaid Patient-Centered Medical Home Models	<p>Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states. (CMS Rep. 3, A-12)</p>	Retain. Still relevant.
H-160.914	Support of Multilingual Assessment Tools for	<p>Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages. (Res. 703, A-12)</p>	Retain. Still relevant.

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	Medical Professionals		
H-165.832	Basic Health Program	<p>1. Our AMA supports the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care.</p> <p>2. Our AMA adopts the following principles for the establishment and operation of state Basic Health Programs:</p> <p>A. State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features.</p> <p>B. Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region.</p> <p>C. Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts.</p> <p>D. State BHPs should not require provider participation, including as a condition of licensure.</p> <p>E. Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment.</p> <p>F. State medical associations should be involved in the legislative and regulatory processes concerning state BHPs.</p> <p>G. State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process. (CMS Rep. 5, A-12)</p>	Retain. Still relevant.

Policy #	Title	Text	Recommendation
H-165.845	State Efforts to Expand Coverage to the Uninsured	<p>Our AMA supports the following principles to guide in the evaluation of state health system reform proposals:</p> <ol style="list-style-type: none"> <li>1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.</li> <li>2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.</li> <li>3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.</li> <li>4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.</li> <li>5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. (CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12)</li> </ol>	<p>Rescind. Superseded by Policy <a href="#">D-165.942</a>, which states:</p> <p>Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.</p>
H-165.904	Universal Health Coverage	<p>Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions</p>	Retain. Still relevant.

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		providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans. (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12)	
H-180.964	Health Care Coverage of Young Adults Under Their Parents' Family Policies	<p>Our AMA encourages the health insurance industry, employers and health plans to make available to young adults who do not have health insurance extended family health expense coverage to age 28 that conforms to the following characteristics: (1) The option to extend coverage under the parents' family policy or plan from the usual cut-off age to age 28 should be available for a specified initial enrollment period beyond the usual cut-off age under the plan.</p> <p>(2) Enrollment in the family coverage other than during this initial period should be available without a preexisting condition limitation to those individuals (to age 28) seeking the coverage because of loss of previous insurance protection within a specified time after loss of the previous protection, and should be available with a preexisting condition limitation to those seeking the coverage for other reasons at any time.</p> <p>(3) Status as a full-time student should not be a requirement for extension of or first-time enrollment in the parents' coverage.</p> <p>(4) To the extent that premiums for such a plan are higher, the extended coverage should be made available as a separate extra-cost rider. (CMS Rep. 1, I-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Retain. Still relevant.
H-180.978	Access to Affordable Health Care	Our AMA (1) through its coalition with business and industry and its state federation, supports giving priority	Rescind. Superseded by Policies <a href="#">H-165.846</a> and <a href="#">H-165.825</a> , which state:

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	Insurance through Deregulation of State Mandated Benefits	attention to a partial and rational deregulation of the insurance industry in order to expand access to affordable health care coverage; and (2) reaffirms its commitment to private health care insurance using pluralistic, free enterprise mechanisms rather than government mandated and controlled programs. (Res. 129, A-89; Reaffirmed: CLRPD Rep. 2, I-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: Res. 239, A-12)	Adequacy of Health Insurance Coverage Options H-165.846 1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. 2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children. 3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their

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			<p>associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.</p> <p>Ensuring Marketplace Competition and Health Plan Choice H-165.825 Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.</p>
H-190.988	Medicare Claims Processing Accuracy	Our AMA will: (1) continue efforts to assure that Medicare carriers accurately process claims; (2) continue to pursue legislation to require local physician input on the adequacy of carrier performance; (3) continue to pursue legislation to allow individual physicians to request and receive an	Rescind. No longer relevant.

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		administrative law hearing to challenge carrier performance of administrative and other policy requirements; and (4) take other appropriate actions that will result in penalties for carriers that process claims inaccurately. (BOT Rep. C, A-92; Reaffirmed: Res. 712, A-02; Reaffirmed:CMS Rep. 4, A-12)	
H-210.989	Medicare Physician Reimbursement for Home Health Visits	It is the policy of the AMA: (1) to urge Congress and CMS to adjust reimbursement for physician home visits so that the payment made to physicians is consistent with the services involved in treating patients at home; and (2) that physician reimbursement should appropriately reflect the relative differences in the training and skill of physicians and other home health care providers. (Res. 109, A-91; Reaffirmation A-97: Reaffirmation I-99; Reaffirmation A-02; Reaffirmed:CMS Rep. 4, A-12)	Retain. Still relevant.
H-215.982	Interpretive Services	Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained interpretive services. (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed:CMS Rep. 7, A-11; Modified: Res. 702, A-12)	Rescind. Superseded by Policy <a href="#">H-160.924</a> , which states: Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924 AMA policy is that: (1) further research is necessary on how the use of interpreters-- both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services



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			with the understanding, however, of these tools' limitations-- to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third-party payers and physicians shall not be required to participate in payment arrangements.
H-225.951	The Importance of Local Control of Hospitals	Our AMA will establish policy and advocate for local governing boards to continue to exist for individual hospitals within multi-hospital systems to ensure that community needs, the needs of local medical staff and patient care needs are met within those communities whenever possible. (Res. 719, A-12)	Retain. Still relevant.
H-225.964	Hospital Employed/Contracted Physicians Reimbursement	AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians. (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)	Retain. Still relevant.
H-225.973	Financial Arrangements Between	Our AMA: (1) opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time,	Retain. Still relevant.

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	Hospitals and Physicians	<p>skill, education and professional expertise of the physician;</p> <p>(2) opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges;</p> <p>(3) opposes financial arrangements between hospitals and physicians that (a) either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians, (b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request, or (c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals;</p> <p>(4) opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories; and</p> <p>(5) urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy. (CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended: CMS Rep. 2, I-02; Reaffirmed: CMS Rep. 4, A-12)</p>	
H-285.923	Elimination of Mental Health and Chemical Dependency Carve-Outs	Our AMA opposes and will work to eliminate mental health and chemical dependency carve-outs. (Sub. Res. 702, I-00; Reaffirmed: CMS 7, A-02; Reaffirmed: CMS Rep. 4, A-12)	<p>Rescind. Superseded by Policies <a href="#">H-185.974</a>, <a href="#">D-180.998</a>, <a href="#">H-95.914</a>, <a href="#">D-110.987</a>, and <a href="#">H-385.915</a> which state:</p> <p>Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974</p> <p>Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.</p>

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			<p>Insurance Parity for Mental Health and Psychiatry D-180.998 Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse.</p> <p>Opioid Mitigation H-95.914 Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.</p> <p>The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987 1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those</p>

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			<p>related to discriminatory benefit design and mental health and substance use disorder parity.</p> <p>5. Our AMA supports improved transparency of PBM operations, including disclosing:</p> <ul style="list-style-type: none"> <li>- Utilization information;</li> <li>- Rebate and discount information;</li> <li>- Financial incentive information;</li> <li>- Pharmacy and therapeutics (P&amp;T) committee information, including records describing why a medication is chosen for or removed in the P&amp;T committee's formulary, whether P&amp;T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;</li> <li>- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;</li> <li>- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and</li> <li>- Percentage of sole source contracts awarded annually.</li> </ul> <p>6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.</p> <p>Integrating Physical and Behavioral Health Care H-385.915 Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care</p>

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			<p>physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.</p>
H-285.956	Mental Health “Carve-Outs”	<p>Our AMA is opposed to mental health carve-outs. However, in order to protect the large number of patients currently covered by carve-out arrangements, the AMA advocates that all managed care plans that provide or arrange for behavioral health care adhere to the following principles, and that any public or private entities that evaluate such plans for the purposes of certification or accreditation utilize these principles in conducting their evaluations: (1) Plans should assist participating primary care physicians to recognize and diagnose the behavioral disorders commonly seen in primary care practice.</p> <p>(2) Plans should reimburse qualified participating physicians in primary care and other non-psychiatric physician specialties for the behavioral health services provided to plan enrollees.</p> <p>(3) Plans should utilize practice guidelines developed by physicians in the appropriate specialties, with local adaptation by plan physicians as</p>	<p>Rescind. Superseded by Policies <a href="#">H-185.974</a>, <a href="#">D-180.998</a>, <a href="#">H-95.914</a>, <a href="#">D-110.987</a>, and <a href="#">H-385.915</a> which state:</p> <p>Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974 Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.</p> <p>Insurance Parity for Mental Health and Psychiatry D-180.998 Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state</p>

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		<p>appropriate, to identify the clinical circumstances under which treatment by the primary care physician, direct referral to psychiatrists or other addiction medicine physicians, and referral back to the primary care physician for care of behavioral disorders is indicated, and should pay for all physician care provided in conformance with such guidelines. In the absence of such guidelines, direct referral by the primary care physician to the psychiatrist or other addiction medicine physician should be allowed when deemed necessary by the referring physician.</p> <p>(4) Plans should foster continuing and timely collaboration and communication between primary care physicians and psychiatrists in the care of patients with medical and psychiatric comorbidities.</p> <p>(5) Plans should encourage a disease management approach to care of behavioral health problems.</p> <p>(6) Participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual enrollees receiving behavioral health services, and should be afforded full due process in any resulting plan attempts at termination or restriction of contractual arrangements.</p> <p>(7) Plans using case managers and screeners to authorize access to behavioral health benefits should restrict performance of this function to appropriately trained and supervised health professionals who have the relevant and age group specific psychiatric or addiction medicine training, and not to lay individuals, and in order to protect the patient's privacy and confidentiality of patient medical records should elicit only the patient information necessary to confirm the need for behavioral health care.</p> <p>(8) Plans assuming risk for behavioral health care should consider "soft" capitation or other risk/reward-sharing mechanisms so as to reduce financial incentives for undertreatment.</p> <p>(9) Plans should conduct ongoing assessment of patient outcomes and</p>	<p>medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse.</p> <p>Opioid Mitigation H-95.914</p> <p>Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.</p> <p>The Impact of Pharmacy Benefit Managers on Patients and Physicians <a href="#">D-110.987</a></p> <ol style="list-style-type: none"> <li>1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.</li> <li>2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.</li> <li>3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.</li> <li>4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.</li> <li>5. Our AMA supports improved transparency of PBM operations, including disclosing: <ul style="list-style-type: none"> <li>- Utilization information;</li> </ul> </li> </ol>

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		<p>satisfaction, and should utilize findings to both modify and improve plan policies when indicated and improve practitioner performance through educational feedback. (CMS Rep. 2, A-96; Modified:CMS Rep. 6, I-00; Reaffirmed:CMS Rep. 9, A-01; Reaffirmed Res. 702, I-01; Reaffirmation A-02; Reaffirmed:CMS Rep. 4, A-12)</p>	<ul style="list-style-type: none"> <li>- Rebate and discount information;</li> <li>- Financial incentive information;</li> <li>- Pharmacy and therapeutics (P&amp;T) committee information, including records describing why a medication is chosen for or removed in the P&amp;T committee's formulary, whether P&amp;T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;</li> <li>- Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;</li> <li>- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and</li> <li>- Percentage of sole source contracts awarded annually.</li> </ul> <p>6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.</p> <p>Integrating Physical and Behavioral Health Care  <a href="#">H-385.915</a>  Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the</p>

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			<p>same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.</p>
H-285.979	Managed Care Insurance Company Credentialing	<p>The AMA: (1) supports the development and utilization by all health insurance plans and managed care organizations of both a uniform application form and a reapplication form;</p> <p>(2) will work with the centralized credentialing collection services established by state and county medical societies to implement the acceptance of uniform application and reapplication forms;</p> <p>(3) urges managed care organizations to recredential participating physicians no more frequently than every two years;</p> <p>(4) urges hospitals, managed care organizations and insurance companies to utilize state and county central credentialing services, where available, for purposes of credentialing plan physician applicants, and will identify all state and county central credentialing services and make this information available to all interested parties including hospital and managed care/physician credentialing committees;</p> <p>(5) supports state and county medical society initiatives to promulgate a uniform reappointment cycle for hospitals and managed care plans; and</p> <p>(6) opposes any legislative or regulatory initiative to mandate</p>	Retain. Still relevant.



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		accreditation for CVOs by the NCQA or any other agency until a fair, equitable, reasonable and appropriately inclusive process for such accreditation exists. (Sub. Res. 703, A-94; Amended in lieu of Res. 705, I-94; Amended by Res. 716, I-96; Reaffirmed: Res. 809, I-02; Reaffirmed:CMS Rep. 4, A-12)	
H-290.975	State and Federal Medicaid Physician Advisory Bodies	Our AMA supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients. (BOT Rep. 13, I-02; Modified:CMS Rep. 4, A-12)	Rescind. Superseded by Policy <a href="#">H-165.855</a> [8], which states: Medical Care for Patients with Low Incomes H-165.855 It is the policy of our AMA that: ... (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.
H-330.889	Strengthening Medicare for Current and Future Generations	1. It is the policy of our AMA that a Medicare defined contribution program should include the following: a. Enable beneficiaries to purchase coverage of their choice from among competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections. b. Preserve traditional Medicare as an option. c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with health savings accounts), as well as traditional Medicare. d. Require that competing private health insurance plans meet guaranteed issue and guaranteed renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraud, follow uniform marketing standards, meet plan solvency requirements, and cover at least the actuarial equivalent of the benefit package provided by traditional Medicare e. Apply risk-adjustment methodologies to ensure that affordable private health insurance coverage options are available for sicker beneficiaries and those with higher	Rescind. Superseded by Policy <a href="#">H-330.896</a> , which states: Strategies to Strengthen the Medicare Program H-330.896 Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental

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		<p>projected health care costs.</p> <p>f. Set the amount of the baseline defined contribution at the value of the government's contribution under traditional Medicare.</p> <p>g. Ensure that health insurance coverage is affordable for all beneficiaries by allowing for adjustments to the baseline defined contribution amount. In particular, individual defined contribution amounts should vary based on beneficiary age, income and health status. Lower income and sicker beneficiaries would receive larger defined contributions.</p> <p>h. Adjust baseline defined contribution amounts annually to ensure that health insurance coverage remains affordable for all beneficiaries. Annual adjustments should reflect changes in health care costs and the cost of obtaining health insurance.</p> <p>i. Include implementation time frames that ensure a phased-in approach.</p> <p>2. Our AMA will advocate that any efforts to strengthen the Medicare program ensure that mechanisms are in place for financing graduate medical education at a level that will provide workforce stability and an adequate supply of physicians to care for all Americans.</p> <p>3. Our AMA will continue to explore the effects of transitioning Medicare to a defined contribution program on cost and access to care. (CMS Rep. 5, I-12)</p>	<p>insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits</p>
H-330.890	Decoupling Social Security from Medicare	Our AMA supports abrogation of any connection between Medicare and Social Security benefits. (Res. 221, I-12)	Retain. Still relevant.
H-330.908	CMS Required Diabetic Supply Forms	Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity. (Sub. Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified: CMS Rep. 4, A-12)	Retain. Still relevant.

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H-335.970	Medicare Integrity Program	<p>Our AMA strongly urges CMS to adhere to the following principles during the implementation of the Medicare Integrity Program (MIP): (1) continue support for physician development of local medical review policy through strong Carrier Advisory Committees;</p> <p>(2) provide access to a Medical Director in each state;</p> <p>(3) provide a mechanism for close surveillance and monitoring of the performance of the MIP contractors to assure their accountability to questions and concerns raised by patients and physicians about coverage and other issues;</p> <p>(4) continue due process and appeals mechanisms for physicians; and</p> <p>(5) initiate a widespread and comprehensive effort to educate physicians about all aspects of the MIP. (CMS Rep. 4, A-97; Reaffirmed:CMS Rep. 1, A-99; Reaffirmation A-02; Reaffirmed:CMS Rep. 4, A-12)</p>	Rescind. Policy is out-of-date. Medicare Integrity Program is no longer active.
H-383.997	Hospital-Based Physician Contracting	<p>(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations.</p> <p>(b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations.</p> <p>(c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the specialty.</p> <p>(d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably.</p> <p>(e) The failure of physicians to reach an agreement with managed care</p>	<p>Retain-in-part. The publications listed in subsection 3 are out-of-print, making the subsection out-of-date. Subsection 3 should be rescinded.</p> <p>(3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled “Contracts: What You Need to Know,” to evaluate and respond to contract proposals.</p>

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		<p>organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination.</p> <p>(f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks.</p> <p>(g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments.</p> <p>(h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price.</p> <p>(i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting.</p> <p>(j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation.</p> <p>(k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians.</p> <p>(2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.</p> <p>(3) Our AMA encourages physicians to avail themselves of the contracting resources available <u>through</u> their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts:</p>	

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		What You Need to Know,” to evaluate and respond to contract proposals. (CMS Rep. 3, A-00; Reaffirmed: BOT Rep. 13, I-06; Reaffirmed: BOT Rep. 4, I-12)	
H-385.922	Payment Terminology	It is AMA policy to change the terminology used in compensating physicians from “reimbursement” to “payment.” (Res. 138, A-07; Reaffirmation A-12)	Retain. Still relevant.
H-385.958	Payment for Services Not Authorized by Health Plans	Our AMA advocates that all health plan contracts contain a provision to permit the direct billing of patients for medical services for which authorization was denied by a health plan, which the rendering physician, based upon reasonable evidence, determines to be essential for the welfare of the patient and for which prior patient consent was obtained. (Sub. Res. 705, I-93; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-385.961	Medicare Private Contracting	Our AMA will: (1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries’ freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective. (BOT Rep. OO, A-93; Reaffirmed: Sub. Res. 132, A-94; Appended: Res. 203, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 5, I-12)	Rescind. Superseded by Policy <a href="#">D-380-997</a> , which states: 1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient’s basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have

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			<p>been imposed by CMS or the private health insurance industry.</p> <p>2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.</p> <p>3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare</p>
H-385.984	Fee for Services When Fulfilling Third Party Payer Requirements	<p>The AMA believes that the attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be recompensed for his incurred administrative costs. (CMS Rep. J, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 3, I-12)</p>	<p>Rescind. Superseded by Policy <a href="#">H-285.943</a>, which states that the AMA (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers.</p>

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H-385.985	Denial of Payment for Medical Services Based Solely on Fiscal Considerations	Our AMA: (1) affirms that medical judgment as to the need for an assistant in any surgical procedure, or the need to provide any form of medical care, should be made by the physician based on what is best for the health and welfare of the patient and not on fiscal restraints or considerations; and (2) opposes any law, rule or regulation, or any decision by a third party carrier which denies payment for medical services due solely to fiscal considerations and which does not have as its primary purpose the health and safety of the patient. (Res. 12, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: BOT Rep. 32, A-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-390.845	Mandatory Physician Enrollment in Medicare	Our AMA supports every physician's ability to choose not to enroll in Medicare and will seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians. (Res. 223, I-12)	Retain. Still relevant.
H-390.846	Three-Day Payment Window Rule	Our AMA will: (1) work with the Centers for Medicare & Medicaid Services (CMS) to request a further delay in implementation of the 3-day Payment Window rule beyond the current delay of July 1, 2012; (2) thoroughly investigate all legislative and regulatory actions taken by Congress and CMS associated with the 3-Day Payment Window during this delay and determine whether additional legislative and/or regulatory actions are warranted to include overturning the current rule; and (3) work with other appropriate stakeholders to continue seeking a delay or modification of the three-day payment window rule; encourage CMS to clarify to whom and how this rule applies; and communicate the specifics about this rule to the physician community. (Res. 226, A-12)	Rescind. This policy was accomplished in 2012 and is out-of-date.
H-390.874	Repayment of Medicare Overpayments Made in Error	1. The AMA will request CMS to require Medicare carriers to be financially responsible for repayment to CMS of any overpayments made by the carrier to physicians where physicians could not reasonably be aware that the payments were overpayments or in	Rescind. Subsection 1 is superseded by <a href="#">Policy H-390.880</a> , and Subsection 2 is out-of-date. Interest Rates Charged and Paid by CMS H-390.880

Policy #	Title	Text	Recommendation
		<p>error and where the physicians relied on calculations by the carrier.</p> <p>2. Our AMA will: (A) communicate to the US Department of Health and Human Services (DHHS) its strong objection to the proposed plan to collect overpayment of Medicare services within 60 days of discovery, regardless of how this might affect the cash flow and the solvency of a medical practice; and (B) express to DHHS its strong objection to the proposed rule which would require practices or auditors to report any overpayments that were discovered within ten years of the date the funds were received instead of the current six-year requirement, due to the burden this would place on physicians' practices, which in essence is another unfunded mandate. (Res. 224, I-93; Reaffirmed:CMS Rep. 10, A-03; Appended: Res. 212, A-12)</p>	<p>1. (A) Our AMA will (1) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (2) seek to ensure that CMS's interest charges do not exceed legal limits; and (3) work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (B) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation.</p> <p>2. Our AMA supports amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.</p>
H-40.969	CHAMPUS Payment	<p>(1) The AMA urges the Department of Defense to raise to at least Medicare levels those CHAMPUS maximum allowable charges (CMACs) that are presently below Medicare allowable charges. (2) The AMA urges the Department of Defense to eliminate price controls and encourage competition under TRICARE through true pluralism in the health plan choices available to beneficiaries, consistent with AMA Policy H-165.890, which proposes advocating transformation of the current Medicare program through an invigorated marketplace. Consistent with Policy H-165.890, this approach should use a defined contribution by CHAMPUS, regardless of the health plan chosen. (3) Until TRICARE introduces a contracting approach that increases competition and sets physician payments through the marketplace, the AMA urges the Department of Defense to assure that all TRICARE programs pay physicians at a minimum of CMAC levels, consistent with Policy H-40.972. (BOT Rep. 1, I-96; Reaffirmed:CMS Rep. 8,</p>	<p>Rescind. Superseded by Policy <a href="#">D-40.991</a>, which states: Our AMA:</p> <p>1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution.</p> <p>2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program.</p> <p>3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to</p>



Policy #	Title	Text	Recommendation
		A-06; Reaffirmed:CMS Rep. 2, I-08; Reaffirmation A-12)	<p>recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services.</p> <p>4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians.</p> <p>5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines.</p> <p>6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey.</p> <p>7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including:</p> <p>(a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for</p>

Policy #	Title	Text	Recommendation
			<p>transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare.</p> <p>8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including:</p> <p>(a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and</p> <p>(b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.</p>
H-440.903	Public Health Care Benefits	Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants. (Res. 219, A-98; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)	<p>Retain-in-part. Update language from “legal” to “lawfully present,” as follows:</p> <p>Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all <u>legal lawfully present</u> immigrants.</p>
H-480.961	Teleconsultations and Medicare Reimbursement	Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various “fee splitting” or “fee sharing” reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed in lieu of Res. 806, I-12)	<p>Rescind. Superseded by Policies <a href="#">H-480.937</a> and <a href="#">H-480.946</a>.</p> <p>Addressing Equity in Telehealth H-480.937</p> <p>Our AMA:</p> <p>(1) recognizes access to broadband internet as a social determinant of health;</p> <p>(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for</p>

Policy #	Title	Text	Recommendation
			<p>historically marginalized and minoritized populations;</p> <p>(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;</p> <p>(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;</p> <p>(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;</p> <p>(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically</p>

Policy #	Title	Text	Recommendation
			<p>marginalized, minoritized and underserved populations;</p> <p>(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;</p> <p>(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and</p> <p>(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.</p> <p>Coverage of and Payment for Telemedicine H-480.946</p> <p>1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:</p> <p>a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:</p> <ul style="list-style-type: none"> <li>- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or</li> <li>- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or</li> <li>- Meeting standards of establishing a patient-physician relationship</li> </ul>

Policy #	Title	Text	Recommendation
			<p>included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.</p> <p>Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.</p> <p>b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.</p> <p>c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.</p> <p>d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.</p> <p>e) The delivery of telemedicine services must be consistent with state scope of practice laws.</p> <p>f) Patients receiving telemedicine services must have access to the licensure and board certification</p>

Policy #	Title	Text	Recommendation
			<p>qualifications of the health care practitioners who are providing the care in advance of their visit.</p> <p>g) The standards and scope of telemedicine services should be consistent with related in-person services.</p> <p>h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.</p> <p>i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.</p> <p>j) The patient's medical history must be collected as part of the provision of any telemedicine service.</p> <p>k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.</p> <p>l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.</p> <p>m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.</p>

Policy #	Title	Text	Recommendation
			<p>2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.</p> <p>3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.</p> <p>4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.</p> <p>5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.</p> <p>6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.</p> <p>7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.</p>

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-22

Subject: Prospective Payment Model Best Practices for Independent Private Practice  
(Resolution 122-J-21)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

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At the June 2021 Special Meeting, the House of Delegates referred Resolution 122, “Developing Best Practices for Prospective Payment Models,” which was sponsored by the Integrated Physician Practice Section. Resolution 122-J-21 asked the American Medical Association (AMA) to “study and identify best practices for financially viable models for prospective payment health insurance, including but not limited to appropriately attributing and allocating patients to physicians, elucidating best practices for systems with multiple payment contracts, and determining benchmarks for adequate infrastructure, capital investment, and models that accommodate variations in existing systems and practices” and to “use recommendations generated by its research to actively advocate for expanded use and access to prospective payment models.”

Testimony was generally supportive of the intent of Resolution 122-J-21. Testimony also cited longstanding AMA support for pluralism and noted that payment systems are complex and may affect various medical specialties differently. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report acknowledges a vast wealth of AMA policy outlining best practices for prospective payment models. In addition, physicians practicing in large integrated systems have those systems to provide guidance. Accordingly, while addressing practices that affect large integrated systems, the Council also focuses this report on the development of principles to guide physicians in non-integrated (independent) private practice wishing to enter into contractual agreements with other physician practices to form clinically integrated networks (CINs) for the purposes of engaging in prospective payment models.

### BACKGROUND

The move to value-based payment by both public and private payers has been advancing for more than a decade, driven by concerns with quality outcomes and accelerating health care costs. The AMA, in two qualitative studies conducted with the RAND Corporation, has examined the effects of these new payment models, often referred to as “Alternative Payment Models” or APMs, on physician practices and found that as recently as 2018, there remained significant barriers to the adoption of such models.<sup>1</sup> These barriers include:

- Lack of timely/accessible data for practices;
- Operational errors in payment models;
- Challenges related to interactions between payment models;
- Accelerated pace of change in payment models;
- Sudden or unexpected discontinuations of APMs; and
- Increasing complexity of payment models.



1 With the onset of the COVID-19 pandemic in 2020, adoption of value-based payment models  
2 slowed as the health care system managed the intense pressure of providing critical care for  
3 millions of severely ill patients. Most health care offices were forced to limit visits, many patients  
4 avoided and delayed seeking treatment, and many hospitals and outpatient facilities greatly reduced  
5 or canceled elective surgeries.<sup>2</sup> While all health care facilities and practices experienced serious  
6 financial disruption and many were forced to furlough or eliminate staff, suggestions have arisen  
7 that primary care practices who were in prospective payment models, such as per-member-per-  
8 month (PMPM), were able to manage the financial disruption more readily than those who were  
9 mostly dependent on fee-for-service (FFS) payments.<sup>3</sup>

10  
11 Appropriately funded prospective payment models offer one solution to provide potential stability  
12 and predictability of payment for some practices when demand for services decreases. Such models  
13 include capitation, global payments, PMPM payments and can provide physicians with more  
14 predictable financial resources to conduct care coordination activities that can improve outcomes,  
15 decrease more costly visits to hospitals, and reduce readmissions. Funding for these models should  
16 be sufficient to address the social determinants of health (SDOH) for the target population.

17  
18 Prospective payment models can take many forms. They can coexist with shared savings models  
19 and can be found among APMs. Numerous prospective payment models are being implemented  
20 currently, while others have been cancelled. In the Medicare program, Medicare Advantage plans  
21 receive capitation payments, and some pay their network physicians on a capitated basis, although  
22 many still pay on a per-service basis. For a listing of models in the traditional Medicare program,  
23 please visit the Centers for Medicare & Medicaid Services (CMS) sites for [approved Alternative](#)  
24 [Payment Models](#) and the [CMS Center for Medicare & Medicaid Innovation](#) (CMMI).<sup>5,6</sup>

## 25 26 CONSIDERATIONS FOR PROSPECTIVE PAYMENT MODELS

27  
28 Consistent with robust AMA policy, the AMA has been highly engaged with CMS, CMMI, and  
29 commercial health plans regarding physician concerns that payment reform models should enable  
30 rather than impede the provision of appropriate and necessary care. Longstanding AMA Policy  
31 H-385.926 supports the freedom of physicians to choose their method of earning a living, a concern  
32 raised during testimony on Resolution 122-J-21. For physicians exploring the opportunities to  
33 engage in prospective payment models, the following factors should be considered.

### 34 35 *Attribution*

36  
37 Current retrospective statistical attribution methodologies often fail to accurately assign to  
38 physicians the patients they cared for and the services they delivered. The purpose of attribution  
39 and corresponding performance measures should be to ensure that physicians are responsible only  
40 for the costs they can control and not for costs they cannot control. Physicians in private practice  
41 can be particularly impacted when inpatient and specialty care are inappropriately attributed to  
42 them. These are costs that such physicians might not be able to control.

43  
44 Attribution methods that rely solely on retrospective claims are problematic. Physicians providing  
45 telehealth services and fewer in-person visits need to use an additional payment code (i.e., modifier  
46 95) to have the patient attributed to them. Various attribution methods could provide mixed results  
47 for physicians regarding who is responsible for delivering efficient care. Any delay in providing  
48 physicians with lists of attributed patients in real-time stifles timely care coordination.  
49 Additionally, errors can occur where patients rarely or never seen by a physician are attributed to  
50 them, or conversely, patients to whom they have provided extensive services to are attributed to  
51 someone else. Adjudicating these attribution lists can be extremely time consuming, particularly

1 for private practices with limited staffing and resources. Furthermore, such inaccuracies may  
2 negatively affect a physician's payment rate especially if the corresponding quality and cost of care  
3 data associated with these patients are adverse.

#### 4 *Performance Targets*

5  
6 It is a priority that performance targets are clinically meaningful and parsimonious for physicians,  
7 including privately practicing physicians. Performance targets must be logically relevant for each  
8 specialty and evidence-based. Unachievable and irrelevant performance targets may discourage  
9 physicians from participating in evolving payment models and undermine the goals of value-based  
10 payment.  
11

#### 12 *Risk Adjustment*

13  
14 The resources needed to achieve appropriate patient outcomes during an episode of care depend  
15 heavily on the individual needs of each patient as well as their ability to access care and properly  
16 adhere to prescribed treatment plans. Many risk adjustment methods only explain a small amount  
17 of variation, and typically focus on variation in spending, not on patient factors. Risk adjustment  
18 generally relies on historical claims data, so it may not account for significant changes in the  
19 patient's health status that affect their current needs for services. Further exacerbating data  
20 deficiencies is that most risk adjustment systems give little or no consideration to the factors other  
21 than health status that can affect patient needs, such as functional limitations, access to health care  
22 services, and other SDOH.  
23

24  
25 An additional concern is that most risk adjustment methods do not adequately account for socio-  
26 demographic factors, such as community supports, on the cost and outcomes of care. Flawed risk  
27 adjustment methods have the unwanted effect of inappropriately penalizing the physicians and  
28 health systems caring for sicker patients and individuals with socio-demographic challenges while  
29 rewarding those who do not care for these patients. As an unintended consequence, it may be  
30 harder for higher-need patients to access care and for physicians caring for these patients to  
31 maintain a sustainable practice.  
32

#### 33 *Data and Health Information Technology*

34  
35 Costly health information technology (IT) continues to be one of the greatest drags on efficiency  
36 and satisfaction in the practice of medicine and a significant barrier to the development and  
37 implementation of care delivery and payment reform. Independently practicing physicians may  
38 lack IT systems sufficient to engage in a prospective payment model. Alternatively, any practice  
39 with a robust IT system still requires reliable data to reach their potential. Innovative payment  
40 models depend on access to high quality, real-time actionable data at the point of care. Physicians'  
41 ability to participate in new payment models often hinge on health IT systems that support and  
42 streamline participation. Without the appropriate tools, physicians will continue to struggle to track  
43 the metrics necessary to inform and improve care delivery. Physicians must have the guidance and  
44 technical assistance to meaningfully participate in prospective payment models and other APMs.  
45 Barriers to interoperability and access to patient data must be overcome if APMs are to enjoy  
46 widespread acceptance and participation.

## 1 *Telehealth*

2  
3 The COVID-19 pandemic accelerated uptake of telehealth. In 2020, physicians and health systems  
4 quickly deployed and expanded telehealth technology to diagnose, treat, and advise millions of  
5 patients. Before the pandemic, telehealth accounted for less than one percent of Medicare  
6 expenditures for physician services. It rose to as high as 16 percent during the spring of 2020 and  
7 then stabilized at between four and six percent for the remainder of that year. Medicare spent \$4.1  
8 billion on physician telehealth services in all of 2020 and \$2 billion in the first six months of 2021.<sup>4</sup>  
9

10 The adoption of telehealth illustrates how payment policy can serve as a catalyst to reform. The  
11 rapid expansion of telehealth services in response to the COVID-19 pandemic was possible after  
12 long-standing payment barriers were removed. Telehealth payment enables physicians to provide  
13 needed services to homebound and remote patients, as well as minimizing patient time away from  
14 work and other responsibilities.  
15

16 Increasingly, physicians and patients deploy telehealth services. AMA Physician Practice  
17 Benchmark Survey data show that, in 2020, 79 percent of physicians were in practices that used  
18 any type of telehealth and 70 percent were in one that used video conferencing with patients. Still,  
19 some patients lack the access to technology such as broadband, which is necessary to deploy  
20 advanced telehealth technologies and many lack the skills needed to receive care via telehealth.  
21 Similarly, many physicians and health systems lack the capital needed to purchase necessary  
22 services and equipment to provide secure telehealth services. Ultimately, these barriers  
23 disproportionately impact physicians in rural areas, safety net providers, and patients from  
24 historically marginalized and minoritized communities.  
25

## 26 **AMA POLICY**

27  
28 The AMA has a wealth of policy directly related to prospective payment models, including policy  
29 addressing persistent concerns with value-based payment and APMs (Policies D-385.963,  
30 H-385.913, H-385.908, and H-390.849), specific physician-led payment reforms (Policies  
31 D-390.953, H-390.844, H-450.931, H-450.961, and D-35.985), the importance of physician  
32 involvement in health IT (Policies D-478.972, D-478.995, D-478.996, H-450.933, and H-478.984),  
33 telehealth (Policies D-480.963, H-478.980, H-478.996, D-480.965, H-480.946,  
34 H-390.889, D-480.969, H-450.941, and Policy D-155.987), and improving risk adjustment (Policy  
35 H-385.907 and H-285.957).  
36

37 In addition, Policies H-165.844 and H-385.926 reiterate the AMA's long-standing commitment to  
38 pluralism and physician freedom of enterprise.  
39

## 40 **AMA ADVOCACY**

41  
42 The AMA continues to carefully examine APMs that are developed by CMS and provides  
43 feedback to the agency regarding needed modifications to enable physicians to deliver high-quality  
44 care. The AMA has also expressed concern if APMs could impose unreasonable requirements on  
45 physicians or require them to shoulder excessive financial risk. When the AMA identifies problems  
46 with an APM, it advocates for appropriate changes which have resulted in improvements in some  
47 current APMs. Examples of AMA advocacy to improve Medicare APMs include:  
48

- 49 • The AMA has testified to Congress about the importance of having physicians involved in  
50 designing APMs in order for the APMs to be successful.

- AMA regularly submits comments to CMS identifying problems with the APMs that CMS has developed, including recommendations for improvements.
- AMA submits comments to CMS each year describing ways to improve the overall regulations that define what qualifies as an APM and what physicians must do to meet the requirements of Medicare's Quality Payment Program.
- AMA has worked closely with national medical specialty societies and other national organizations, as well as state medical associations, to develop and recommend changes in public policy on APMs.

CMMI recently published its “[strategy refresh](#),” describing new objectives for CMMI based on its experience with APMs during its first 10 years.<sup>7</sup> A number of the policies outlined in the CMMI strategy are encouraging as they would implement recommendations made to CMMI leadership in a May 2021 [letter](#) from the AMA and many national specialty societies, as well as in several meetings.<sup>8</sup> These include CMMI plans to:

- Make APM parameters, requirements, and other critical details as transparent and easily understandable as possible for participants;
- Reduce administrative burdens from APM participation requirements;
- Make available and increase uptake of actionable data, learning collaboratives, and payment and regulatory flexibilities to participants, especially those treating the underserved;
- Improve testing and analysis of benchmarks and risk adjustment methods;
- Deepen and sustain outreach and solicitation of input from patient and physician groups;
- Explore model tests for specialty care payment models; and
- Identify ways to align or integrate episode payment models with accountable care models.

#### *AMA Physician Practice Benchmark Survey*

The AMA's Physician Practice Benchmark Survey has been conducted on a biennial basis starting in 2012. The 6<sup>th</sup> iteration of this nationally representative survey is planned for fall 2022. A primary focus of the survey is physician practice characteristics including employment status (whether a physician is an employee, an owner/partner, or an independent contractor), practice type (e.g., solo practice, single specialty practice, or multi-specialty practice), practice ownership (e.g., physician-owned or hospital/health system-owned), practice size (measured by number of physicians), and use of non-physician providers. A second focus of the survey is the payment methods in place between practices and payers. Methods asked about include FFS, pay-for-performance, bundled payments, shared savings, and capitation. Reports based on these topics are available on the [AMA website](#).<sup>9</sup> Relevant to Resolution 122-J-21, in 2020, an average of 6 percent of practice revenue was paid through capitation.

#### *Professional Satisfaction and Practice Sustainability*

The AMA's Professional Satisfaction and Practice Sustainability (PS2) unit continues to support effective development and implementation of sustainable physician payment models through research, development of tools and resources, and support of the spread of effective models through learning collaboratives and engagement with commercial health plans and large employers. An enhanced focus on sustainable physician-owned practices has been launched through its Private Practice Initiative, which offers resources such as its new series on [Payor Contracting](#) and forming [Clinically Integrated Networks](#).<sup>10,11</sup>

## DISCUSSION

The AMA has robust policy articulating best practices and principles for APMs, including prospective payment models (see Appendix). These policies guide continued AMA advocacy for the development and implementation of such models, including the necessary resources to make them successful. The Council recommends reaffirming policies that support a commitment to pluralism and the ability of physicians to choose their method of earning a living. The Council also recommends reaffirming policies that address the areas of concern highlighted by Resolution 122-J-21, as detailed in the Appendix regarding attribution, risk adjustment, physician involvement in contract negotiations, access to data reports, infrastructure, and capital investment (including for the delivery of telehealth), technical support and payment updates.

Consistent with Resolution 122-J-21, the Council recommends new policy to support increased inclusion of elements of prospective payment models for independent practices in the development of payment reform. The Council also recommends new principles to address the unique needs of independently practicing physicians wishing to address the challenges of contracting for prospective payments with other independent physicians. Principles should include the following:

- Compensation should incentivize the interdependence of the physician group members and foster collegiality between specialties.
- Attribution, performance targets and risk adjustment are likely to benefit from clinical data in addition to claims data.
- Any quality metrics should be clinically meaningful and developed with physician input.
- Models should strive to address community social determinants of health, with attention to patient attribution and contracted payers.
- Physicians should be leaders in their model's governance, which must be autonomous to monitor performance targets and price transparency, and to ensure that socio-demographic factors impacting overall patient health are addressed. In addition, model governance should address the purchase and leverage of high-quality health IT for better patient care and leverage group purchasing organizations to lower cost of telehealth technology.

The Council encourages the AMA and other entities, such as state and specialty medical societies, to continue to provide the guidance and infrastructure needed to allow physicians to join with other physicians.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 122-J-21, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles. (New HOD Policy)
2. That our AMA support the following principles to support physicians who choose to participate in prospective payment models:
  - a. The AMA, state medical associations, and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allow independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.

- 1 b. Prospective payment model compensation should incentivize specialty and primary  
2 care collegiality among independently practicing physicians.
- 3 c. Prospective payment models should take into consideration clinical data, where  
4 appropriate, in addition to claims data.
- 5 d. Governance within the model must be physician-led and autonomous.
- 6 e. Physician practices should be encouraged to work with field advisors on patient  
7 attributions and a balanced mix of payers.
- 8 f. Quality metrics used in the model should be clinically meaningful and developed with  
9 physician input.
- 10 g. Administrative burdens, such as those related to prior authorization, should be reduced  
11 for participating physicians.(New HOD Policy)
- 12
- 13 3. That our AMA reaffirm Policies H-165.844 and H-385.926, which support pluralism and the  
14 freedom of physician enterprise. (Reaffirm HOD Policy)
- 15
- 16 4. That our AMA reaffirm Policy H-385.907, which supports fair and accurate risk adjustment.  
17 (Reaffirm HOD Policy)
- 18
- 19 5. That our AMA reaffirm Policies H-385.913, D-478.972, D-478.995, H-478.984, H-478.980,  
20 D-480.965, H-480.946, D-480.969 and H-285.957, which collectively address the concerns  
21 raised in Resolution 122-I-21. (Reaffirm HOD Policy)
- 22

Fiscal Note: Less than \$500.

## REFERENCES

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**Council on Medical Service Report 2-A-22  
Prospective Payment Model Best Practices for Independent Private Practice  
Policy Appendix**

**Policy H-165.844 Educating the American People About Health System Reform**

Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Res. 717, I-07 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19)

**Policy H-285.957 Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts**

The AMA will work with interested medical organizations in urging state Medicaid programs and other third party payers to assure the inclusion of risk adjustment mechanisms in capitation rates paid to physicians providing care to chronically ill children and adults enrolled in managed care plans. (Sub. Res. 128, A-96 Reaffirmed: CMS Rep. 8, A-06 Modified: CMS Rep. 01, A-16)

**Policy H-385.907 Improving Risk Adjustment in Alternative Payment Models**

Our AMA supports:

- (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications;
- (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost;
- (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost;
- (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control;
- (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and
- (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19)

**Policy H-385.913 Physician-Focused Alternative Payment Models**

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).
2. Our AMA supports that the following goals be pursued as part of an APM:
  - A. Be designed by physicians or with significant input and involvement by physicians;
  - B. Provide flexibility to physicians to deliver the care their patients need;
  - C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
  - D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
  - E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
  - F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
  - G. Avoid placing physician practices at substantial financial risk;
  - H. Minimize administrative burdens on physician practices; and
  - I. Be feasible for physicians in every specialty and for practices of every size to participate in.



3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:
  - A. Identify leading health conditions or procedures in a practice;
  - B. Identify barriers in the current payment system;
  - C. Identify potential solutions to reduce spending through improved care;
  - D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
  - E. Define services to be covered under an APM;
  - F. Identify measures of the aspects of utilization and spending that physicians can control;
  - G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
  - H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
  - I. Identify mechanisms for ensuring adequacy of payment; and
  - J. Seek support from other physicians, physician groups, and patients.
4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:
  - A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
  - B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
  - C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
  - D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
  - E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.
5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. (CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 10, A-17 Reaffirmed: CMS Rep. 10, A-19 Reaffirmed: BOT Rep. 13, I-20)

**Policy H-385.926 Physician Choice of Practice**

Our AMA: (1) encourages the growth and development of the physician/patient contract;

(2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.);

(3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and

(4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.

(BOT Rep. QQ, I-91 Reaffirmed: BOT Rep. TT, I-92 Reaffirmed: Ref. Cmte. A, A-93 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed: CMS Rep. G, A-93 Reaffirmed: CMS Rep. E, A-93 Reaffirmed: Sub. Res. 701, A-93 Reaffirmation A-93 Reaffirmed: BOT Rep. 25, I-93 Reaffirmed: CMS Rep. 5, I-93 Reaffirmed: CMS Rep. 10, I-93 Reaffirmed: BOT Rep. 40, I-93 Reaffirmed: Sub. Res. 107,

I-93 Res. 124, I-93 Reaffirmed: Sub. Res. 127, A-94 Reaffirmed: BOT Rep. 46, A-94 Reaffirmed: Sub. Res. 132, A-94 Reaffirmed: BOT Rep. 16, I-94 Reaffirmed: CMS Rep. 8, A-95 Reaffirmed: Sub. Res. 109, A-95 Reaffirmed: Sub. Res. 125, A-95 Reaffirmed: Sub. Res. 109, I-95 Reaffirmation A-96 Reaffirmation I-96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-99 Appended by Res. 127, A-98 Reaffirmed: CMS Rep. 6, A-99 Reaffirmation A-00 Reaffirmation A-00 Sub. Res. 116, I-00 Reaffirmation & Reaffirmed: Res. 217, A-01 Reaffirmation A-04 Consolidated and Renumbered: CMS Rep. 7, I-05 Reaffirmation A-07 Reaffirmation A09 Reaffirmed: CMS Rep. 3, I-09 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation I-13 Reaffirmation A-15 Reaffirmed: CMS Rep. 5, I-15 Reaffirmed: CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 07, A-17 Reaffirmed: CMS Rep. 6, A-21)

#### **Policy D-478.972 EHR Interoperability**

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
- (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
- (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
- (4) will continue efforts to promote interoperability of EHRs and clinical registries;
- (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
- (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
- (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
- (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
- (9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Sub. Res. 212, I-15 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: Res. 221, I-16 Reaffirmed in lieu of: Res. 243, A-17 Reaffirmed: CMS Rep. 10, A-17 Appended: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Appended: Res. 202, A-18 Appended: Res. 226, I-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

#### **Policy H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities**

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Res. 208, I-18 Reaffirmed: CMS Rep. 7, A-21)

**Policy H-478.984 Prohibition of Clinical Data Blocking**

Our AMA will advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care. (Res. 222, I-16 Reaffirmed: CMS Rep. 10, A-17)

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians. (Res. 730, I-04 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 16, A-11 Modified: BOT Rep. 16, A-11 Modified: BOT Rep. 17, A-12 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed: BOT Rep. 24, A-13 Reaffirmed in lieu of Res. 724, A-13 Appended: Res. 720, A-13 Appended: Sub. Res. 721, A-13 Reaffirmed: CMS Rep. 4, I-13 Reaffirmation I-13 Appended: BOT Rep. 18, A-14 Appended: BOT Rep. 20, A-14 Reaffirmation A-14 Reaffirmed:

BOT Rep. 17, A-15 Reaffirmed in lieu of Res. 208, A-15 Reaffirmed in lieu of Res. 223, A-15 Reaffirmation I-15 Reaffirmed: CMS Rep. 07, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 227, A-17 Reaffirmed in lieu of: Res. 243, A-17 Modified: BOT Rep. 39, A-18 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 3, I-19)

**Policy D-478.996 Information Technology Standards and Costs**

1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. (Res. 717, A-04 Reaffirmation, A-05 Appended: Sub. Res. 707, A-06 Reaffirmation A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation I-08 Reaffirmation I-09 Reaffirmation A-10 Reaffirmation I-10 Reaffirmed: Res. 205, A-11 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed in lieu of Res. 724, A-13 Reaffirmation I-13 Reaffirmation A-14 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 204, I-17 Reaffirmation: I-17 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

**Policy D-480.965 Reimbursement for Telehealth**

Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. (Res. 122, A-19)

**Policy D-480.969 Insurance Coverage Parity for Telemedicine Service**

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.

2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.

3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16 Reaffirmed: CMS Rep. 1, I-19 Reaffirmed: CMS Rep. 7, A-21)

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-22

Subject: Poverty-Level Wages and Health  
(Resolution 203-N-21)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee G

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At the November 2021 Special Meeting, the House of Delegates referred Resolution 203, which was sponsored by the Medical Student Section. Resolution 203-N-21 asked the American Medical Association (AMA) to support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. Testimony at the November 2021 Special Meeting regarding the resolution was mixed, with significant testimony both supporting and opposing Resolution 203. Testimony placed Resolution 203 within the context of the AMA's advocacy regarding social determinants of health (SDOH). Testimony supporting Resolution 203 explained that a living wage is essential to promoting health and equity, while testimony in opposition indicated that increasing the federal minimum wage could cause some employers to reduce their number of employees, causing some low-wage workers to become jobless and their family incomes to fall. This report studies the impacts of poverty and minimum wage policies, highlights essential AMA policy, and presents new policy recommendations.

### BACKGROUND

In the United States (US), one in 10 people lives in poverty, and despite being employed with steady work, many cannot afford things they need to stay healthy. Healthy People 2030 set a goal of economic stability to "Help people earn steady incomes that allow them to meet their health needs."<sup>1</sup> According to Healthy People 2030, the SDOH are "conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risk."<sup>2</sup> The SDOH include education, housing, wealth, income, and employment, and they are impacted by larger, powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation.<sup>3</sup> The COVID-19 pandemic has created a concurrent public health and economic crisis that has exposed and exacerbated pervasive and severe access to care issues and social inequities. Not only has the pandemic disproportionately impacted minoritized and marginalized communities, but economic insecurity, housing insecurity, and food insecurity have disproportionately burdened communities of color and other underserved populations (e.g., people living in rural areas).

The large number of confounding variables makes it challenging to directly attribute changes in minimum wage policies to health outcomes, but there is widespread consensus that populations with low incomes have worse health outcomes.<sup>4</sup> This exacerbates health inequities because women and people of color (many of whom provide for families) are more likely to earn low wages. Black and Hispanic individuals and families specifically are disproportionately represented among minimum wage workers. In addition, studies have found that populations with high and rising income inequality are associated with lower life expectancy, higher rates of infant mortality,

obesity, mental illness, homicide, and other measures compared to populations with a more equitable income distribution.<sup>5</sup> A large body of research on wage, income, and health finds that policy interventions striving to increase the incomes of low-income populations will improve both economic measures (increasing income equality and economic security) and health measures (lower mortality rates, improve overall population health status, decrease health inequity, and lower overall health care costs).<sup>6</sup>

Many assume that low-wage workers are predominantly teenagers earning supplementary or optional income, but this is not accurate. Approximately 88 percent of minimum wage workers in the US are over 20 years old, and the average age is 35.<sup>7</sup> Based on 2019 data, approximately 48 percent of the people earning at or below the federal minimum wage have some college education, nearly 67 percent are female, and approximately 45 percent work full-time.<sup>8</sup> Most workers are in food service occupations (55 percent), and many others work in sales and related occupations (8.5 percent) or personal care and service roles (6.6 percent). Particularly relevant to physician practices, only 2.6 percent of minimum wage workers are characterized as having a “healthcare support” occupation, with another 4.6 percent generally characterized as holding “office and administrative” occupations.<sup>9</sup> Approximately 28 percent of low-wage workers have children, which places many children at risk of living in poverty.<sup>10</sup> Researchers have estimated that there would be 2,790 fewer low-birthweight births and 518 fewer postneonatal deaths annually if all states raised the minimum wage by one dollar. It is also critical to recognize the impact of racial, ethnic, and gender inequity. Although women make up 47 percent of the workforce overall, 64 percent of workers in frontline industries are women.<sup>11</sup> Moreover, while women of color make up 17 percent of the workforce overall, they are 26 percent of the frontline workforce. This inequity takes on heightened significance in light of these workers’ service amidst the COVID-19 pandemic.

The current federal minimum wage of \$7.25 per hour translates to an annual wage of \$15,080, if working 40 hours per week for all 52 weeks of the year.<sup>12</sup> Workers striving to support a family on the federal minimum wage qualify for federal poverty assistance. Currently, full-time work at the federal minimum wage rate is insufficient for a single parent to support even a single child above the federal poverty line, but in 1968, the federal minimum wage was sufficient to keep a family of three out of poverty. The federal minimum wage hit its peak in inflation-adjusted terms in 1968, and since then, increases have been too small to counter the decline in value due to inflation.<sup>13</sup> Although current low-wage workers tend to be older (offering more experience) and more educated than their 1968 counterparts, the reduced purchasing power of the federal minimum wage means that workers must work longer hours to achieve the standard of living that was considered the minimum half a century ago. The declining value of the minimum wage has been found to be the key driver of the growth of inequality between low-wage and middle-wage workers since the late 1970s. In contrast, a federal minimum wage of \$15 per hour has been predicted to raise family income for 14.4 million children, or nearly one-fifth of all US children.

## HISTORY AND CURRENT STATUS OF MINIMUM WAGE

The Fair Labor Standards Act (FLSA) was enacted in 1938 and is the federal law that establishes the minimum hourly wage that must be paid to all covered workers.<sup>14</sup> One of the goals of the FLSA and, specifically, the minimum wage, is to “correct and as rapidly as practicable to eliminate” labor conditions “detrimental to the maintenance of the minimum standard of living for health, efficiency, and general well-being of workers.”<sup>15</sup> However, determining what a “minimum standard of living” is, and what dollar amount is needed to support that, is a policy choice, and one that has been subject to voluminous debate. Moreover, the minimum wage is only one of many variables that influence a standard of living. The minimum wage rate has been raised 22 times, most recently in 2007 (P.L. 110-28), which increased the minimum wage to its current level of

1 \$7.25 per hour.<sup>16</sup> The FLSA was intended to both protect workers and stimulate the economy, and  
2 it covers approximately 139 million workers, or 85 percent of all wage and salary workers. Under  
3 the FLSA, if states enact minimum wage, overtime, or child labor laws that are more protective of  
4 employees than the FLSA, the state law applies. As of this writing, 30 states and the District of  
5 Columbia have minimum wage laws that set the minimum wage above the federal minimum. Two  
6 states have laws that would set minimum wages below the federal rate, and five states have no  
7 minimum wage requirement. The remaining 13 states have minimum wage rates equal to the  
8 federal rate.<sup>17</sup> Localities (cities and counties) can also choose to establish higher minimum wages.  
9 As of this writing, 45 localities have adopted minimum wages above their state minimum wage.<sup>18</sup>  
10 Accordingly, the federal minimum wage serves as the wage floor for approximately 39 percent of  
11 the labor force.<sup>19</sup> However, the number of hourly paid workers who are earning the federal  
12 minimum wage is relatively small and decreasing in recent years (down from 1.9 percent in 2019 to  
13 1.5 percent in 2020).<sup>20</sup> In 2020, 1.1 million workers earned the federal minimum wage.<sup>21</sup>

14  
15 Given the varying mechanisms that states may have in place to adjust their minimum wage, in any  
16 year, the number of states with minimum wage rates that exceed the federal minimum can vary.<sup>22</sup>  
17 Generally, a legislature can adjust minimum wage in one of two ways.<sup>23</sup> First, a legislature may  
18 choose specific dates by which a minimum wage will increase by a specific amount. Future  
19 legislative action is then needed to subsequently increase the minimum wage. This is the approach  
20 that the federal government took with P.L. 110-28, which raised the minimum wage from \$5.15 per  
21 hour in 2007 to \$7.25 per hour in 2009 through three phases. Twelve of the 30 states and District of  
22 Columbia that have minimum wage rates above the federal rate follow this approach, as well.  
23 When a minimum wage is set to a specific fixed amount, inflation will cause its value to erode over  
24 time. Accordingly, as the sponsors of Resolution 203-N-21 suggest, several states have taken a  
25 second approach to minimum wage, striving to maintain the value of the minimum wage over time  
26 by linking their minimum wage to some measure of inflation. Critically, though, choosing a  
27 measure of inflation and a point at which to begin indexing minimum wage to inflation is complex,  
28 with dramatically varying results. Of the 18 states and the District of Columbia that currently or are  
29 scheduled to index their state minimum wages to inflation, six different measures of inflation have  
30 been chosen. In addition to selecting an index, policy proposals to link a minimum wage to  
31 inflation must also consider the initial value (starting point for indexation), limits to the changes,  
32 triggers for change, and periodicity of change.<sup>24</sup> To illustrate the importance of these detailed  
33 decisions, if the federal minimum wage had been indexed to the Consumer Price Index for All  
34 Urban Consumers (CPI-U) at the time of its enactment in 1938, when minimum wage was \$0.25  
35 per hour, the federal minimum wage would have been \$4.23 per hour in 2016. In contrast, if the  
36 federal minimum wage were indexed to the CPI-U in 1968 when the rate was \$1.60 per hour, it  
37 would have been \$10.98 per hour in 2016. Congress has considered indexing the federal minimum  
38 wage several times but has not chosen to do so.<sup>25</sup> Indexation is used, however, for some federal  
39 programs, such as Social Security and Supplemental Nutrition Assistance (SNAP) benefits and in  
40 other federal wage regulations, such as the minimum wage for employees on certain federal  
41 contracts.

42  
43 There have been several recent initiatives aimed at increasing the federal minimum wage. In July  
44 2019, the House passed H.R. 582 which would increase the federal minimum wage to \$15 per hour  
45 by 2025, index the minimum wage to changes in the median hourly wage, and phase out  
46 subminimum wages for some individuals currently exempt from the minimum wage.<sup>26</sup> In January  
47 2021, the Raise the Wage Act of 2021 (H.R. 603) was introduced, which would incrementally raise  
48 the federal minimum wage to \$15 per hour by 2025.<sup>27</sup> In April 2021, President Biden issued an  
49 executive order that will require federal contractors to pay a \$15 per hour minimum wage for  
50 workers who are working on federal contracts.<sup>28</sup>

Increasing the federal minimum wage is popular among Americans – in a recent study, 80 percent of those polled believed that \$7.25 per hour is too low.<sup>29</sup> According to the Pew Research Center, 62 percent of Americans support raising the federal minimum wage to \$15 per hour.<sup>30</sup> Large employers including Amazon, Target, and Costco have voluntarily raised their minimum wages,<sup>31</sup> and a growing number of small and medium sized businesses have been committing to incrementally raising wages to \$15 per hour.<sup>32</sup> However, Amazon is a critical example of how increased wages alone may not always translate to improvements in health or quality of life for employees. Specifically, a recent study found that Amazon warehouse workers were not only injured more often than non-Amazon warehouse workers, they were also injured more severely, and they took longer to recover than others in the warehouse industry.<sup>33</sup>

## POLITICAL AND ECONOMIC DEBATE

Although the effects of the minimum wage have been well-studied, resulting in hundreds of academic and non-academic publications, there is no consensus on the causal relationship between changes in minimum wage and other economic outcomes.<sup>34</sup> The question, “Does a minimum wage cause unemployment?” has been described as, “one of the most studied questions in all of economics since at least 1912, when Massachusetts became the first state to create a minimum wage.”<sup>35</sup> Illustrating this lack of expert consensus, when a panel of experts in economics was asked if a \$15 federal minimum wage would increase unemployment, only five percent of the panel had a strong opinion and nearly 40 percent were uncertain.<sup>36</sup> For example, a Chicago Booth professor strongly agreed, an MIT professor disagreed, and a Harvard professor was uncertain. Economics research reflects this. For example, two recent studies of Seattle’s minimum wage suggested opposite effects.<sup>37</sup> Proponents argue that raising the minimum wage would increase worker productivity, reduce poverty and income inequality (which is partly due to structural racism and/or sexism), spur economic growth, promote education and self-improvement, and improve employee retention/reduce turnover costs.<sup>38</sup> In contrast, opponents argue that increasing the minimum wage would reduce private sector employment, increase labor costs, lead to small business and industry job loss, and increase outsourcing, unemployment, poverty, and cost of living.<sup>39</sup>

In addition to the often-cited minimum wage debate positions, several additional factors are noteworthy. For example, some argue that it is not an increase to the *federal* minimum wage that is most important, but rather local or regional adjustments. Given the vastly different costs of living across the US, a \$7.25 minimum wage affords significantly differing access to essential goods and services. For example, daily parking can cost approximately \$35 in Boston or \$1 in Cincinnati.<sup>40</sup> Monthly rent may average \$4,500 in San Francisco or \$870 in Rapid City, SD. Under a regional minimum wage theory, the minimum wage could account for differences in costs of living, set high enough to lift the maximum number of full-time workers out of poverty, but not so high as to increase automation, a reduction in workers’ hours, or off-shoring.<sup>41</sup> On the other hand, a federal mandate to increase minimum wages may be necessary to elevate the quality of life that minimum wage affords in areas of the country where systemic racism, sexism, and similar factors have contributed to low wages, and it may be necessary to avoid low-wage areas from being “trapped in a second-tier economy.”<sup>42</sup>

Related, wages may fail to adequately compensate workers for the skill and/or risk inherent in their work. A recent study highlighted that skills that are usually associated with managerial and knowledge work, such as critical thinking, active learning, problem-solving, time management, and decision-making, are also important elements of low-wage positions.<sup>43</sup> If undervalued skills were taken into account in determining wages, the average hourly wage was predicted to be \$16.52.<sup>44</sup> The undervaluing of low-wage workers takes on heightened relevance in the context of the COVID-19 pandemic. Throughout the COVID-19 pandemic, the US has relied upon essential



workers to perform jobs vital to the economy, under conditions that jeopardize health and safety for workers and their households. Yet, according to the Brookings Institution, essential workers comprised approximately half of all workers in occupations with a median wage of less than \$15 per hour, and workers of color are disproportionately impacted.<sup>45</sup> Wages for care workers (e.g., home health aides) are so low that nearly 20 percent of care workers live in poverty, and more than 40 percent rely on some form of public assistance.<sup>46</sup> Factoring public assistance into the minimum wage debate raises another important point: if minimum wage workers are earning so little that they must rely on taxpayer-funded benefits to survive, that is shifting the economic burden from the employers who benefit from employees' time and service to taxpayers. According to recent estimates, raising the federal minimum wage to \$15 per hour would reduce government expenditures on public assistance between \$13.4 and \$31 billion, and the majority of the workers who would benefit from the increased minimum wage are essential and frontline workers.<sup>47</sup>

#### ADDRESSING ADDITIONAL SDOH TO REDUCE HEALTH IMPACTS OF POVERTY

Income is a critical SDOH, but it is inherently intertwined with other essential SDOH. Affordable housing, transportation, nutritious food, and childcare, as well as educational and job opportunities can be more difficult for low-wage workers to obtain.<sup>48</sup> For example, as affordable housing becomes less accessible in many urban centers, homelessness (a well-established cause of poorer health outcomes) increases, and also causes low-wage workers to move farther from urban centers to access affordable housing. Extended commutes to work increase transportation costs, which decrease the portion of wages remaining to purchase other necessities, such as nutritious food and childcare. Moreover, low-wage work is often unpredictable and inconsistent, which causes many individuals to work multiple jobs, and gives them little control over their schedules. These erratic schedules can trap people in cycles of part-time work, limiting their ability to pursue educational or occupational opportunities, secure safe and affordable childcare, or attend to their health care needs. Accordingly, to increase the economic security of low-wage workers and families living in poverty, alongside minimum wage policy changes, additional changes to address non-occupational SDOH are required, and integrated public health programs can help. Research indicates that minimum wage increases are most successful in decreasing poverty and improving health when they are combined with other structural improvements that maintain or increase the purchasing power of wages.<sup>49</sup> Specifically, policy proposals should also consider public benefit programs, tax credits, job-creation policies,<sup>50</sup> employment programs, career counseling, and education to reduce poverty and improve health and wellbeing.<sup>51</sup> Policies that do not recognize the importance of these multiple SDOH may lead to missed opportunities to improve the economic resources of people in low-income households and advance health equity among the most historically disadvantaged low-wage earners.<sup>52</sup>

It is also essential to consider the unintended consequences incremental increases in minimum wage can have on low-wage workers. While increased wages have the potential to reduce workers' and their families' need for public assistance, minimal increases in wages could be sufficient to reduce or eliminate workers' eligibility for public assistance, but without providing enough in wages to purchase the same basket of goods and services otherwise secured with public assistance, a challenge known as the "benefit cliff." The benefit cliff can harm both employees struggling to meet their basic needs and employers struggling to hire and promote employees.<sup>53</sup> Consider the case of a recent widow with three children. She excelled in her position at a local grocery store, where she earned \$15 per hour, and relied on Medicaid and SNAP to help support her family.<sup>54</sup> She was offered a promotion to become a supervisor and earn \$18 per hour, but she had to decline the promotion because the increased income would have increased her Medicaid premiums, decreased her SNAP payments, and decreased her tax refund, impairing her ability to provide for her family. Public assistance programs are often rooted in federal statute and administered by federal, state,

1 and local agencies. To resolve the benefits cliff and optimally support low-wage workers and their  
2 employers, these intersecting programs must evolve in concert. Moreover, resolving the benefits  
3 cliff is essential to promote equity, as workers of color are disproportionately likely to work in low-  
4 wage jobs, and disproportionately likely to rely on public benefits, resulting in higher marginal tax  
5 rates, and making it more challenging for families of color living at or near the poverty level to  
6 climb the economic ladder. Policymakers striving to reduce poverty must assess how minimum  
7 wage policy interacts with other social policies and supports to ensure that new policies do not  
8 result in new harm to the low-income populations they want to serve.

## 9 10 AMA POLICY

11  
12 The AMA has extensive policy on health inequities and diversity, and the AMA continues to  
13 provide strong leadership striving to eliminate health care inequities. (Examples include Policies  
14 H-65.952, H-65.963, H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917,  
15 H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996,  
16 H-350.959). Related, Policy H-280.945 calls for better integration of health care and social services  
17 and supports. AMA policy also strongly supports Medicaid. (Examples include Policies H-290.986,  
18 D-290.979, D-290.985, and D-290.974). In addition, AMA policy emphasizes the importance of  
19 the SDOH and supports focus on the SDOH to improve overall health. (Key examples include  
20 Policies H-65.960, D-440.922, H-160.909, H-165.822, and D-440.916).

## 21 22 DISCUSSION

23  
24 It is essential that the AMA continue to be welcomed into conversations on all sides of policy  
25 debates as a trusted, evidence-based advocate for patients and the physicians who care for them.  
26 Accordingly, the Council recommends a set of principles that do not prejudge any minimum wage  
27 policy proposal, but instead clearly articulate essential variables that any minimum wage policy  
28 proposal should explicitly evaluate to ensure that proposals will translate into benefit, and not  
29 unanticipated harm, to individuals and communities. Consistent with AMA advocacy efforts, while  
30 the AMA is not opposed to the concept of indexing minimum wage to inflation, it wants to ensure  
31 that any such proposal has been well-designed to avoid unintended consequences and ensure that  
32 the proposal, once implemented, does not result in decreased access to health.

33  
34 First among the Council's recommended principles is a clear statement that poverty is detrimental  
35 to health. Next, the Council recognizes that the value of any set minimum wage will erode with the  
36 passage of time, but also recognizes that there are significant complexities and unintended  
37 consequences inherent in selecting an index for perpetual minimum wage adjustment. For this  
38 reason, the Council recommends a principle that broadly encourages federal, state, and/or local  
39 policies regarding minimum wage to include plans for adjusting the minimum wage level in the  
40 future and an explanation of how these adjustments can keep pace with inflation. In addition, the  
41 Council recommends building on Policies H-65.963 and H-65.960 to place those policies in the  
42 context of minimum wage debates. Accordingly, federal, state, and/or local policies regarding  
43 minimum wage should be consistent with the AMA's: (1) commitment to speak against policies  
44 that create greater health inequities and be a voice for our most vulnerable populations who will  
45 suffer the most under such policies, and (2) principle that the highest attainable standard of health,  
46 in all its dimensions, is a basic human right and that optimizing the SDOH is an ethical obligation  
47 of a civil society.

48  
49 The Council further appreciates that numerous variables impact the adequacy of a minimum wage  
50 for employees, as well as the potential burden on employers. Accordingly, the Council  
51 recommends that federal, state, and/or local policies regarding minimum wage should include an

1 explanation of how variations in geographical cost of living have been considered. Similarly,  
2 federal, state, and/or local policies regarding minimum wage should include an estimate of the  
3 policy's impact on factors including: unemployment and/or reduction in hours; first-time job  
4 seekers; qualification for public assistance (e.g., food, housing, transportation, childcare, health  
5 care, etc.); working conditions; health equity, with specific focus on gender and minoritized and  
6 marginalized communities; income equity; local small business viability, including independent  
7 physician practices; and educational and/or training opportunities.

8  
9 Finally, the Council emphasizes the importance of viewing income as among the many essential  
10 SDOH and the importance of coordinated public health systems to support advances in all SDOH.  
11 Accordingly, the Council recommends reaffirming Policy D-440.922, which supports programs  
12 and initiatives that strengthen public health systems to address health inequities and the SDOH and  
13 Policy H-165.822, which encourages coverage pilots to test the impacts of addressing certain non-  
14 medical, yet critical health needs, for which sufficient data and evidence are not available, on  
15 health outcomes and health care costs.

## 16 17 RECOMMENDATIONS

18  
19 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
20 203-N-21 and that the remainder of the report be filed:

- 21  
22 1. That our American Medical Association (AMA) affirm that poverty is detrimental to health.  
23 (New HOD Policy)  
24
- 25 2. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should  
26 include plans for adjusting the minimum wage level in the future and an explanation of how  
27 these adjustments can keep pace with inflation. (New HOD Policy)  
28
- 29 3. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should  
30 be consistent with the AMA's commitment to speak against policies that create greater health  
31 inequities and be a voice for our most vulnerable populations who will suffer the most under  
32 such policies, further widening the gaps that exist in health and wellness in our nation. (New  
33 HOD Policy)  
34
- 35 4. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should  
36 be consistent with the AMA's principle that the highest attainable standard of health, in all its  
37 dimensions, is a basic human right and that optimizing the social determinants of health is an  
38 ethical obligation of a civil society. (New HOD Policy)  
39
- 40 5. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should  
41 include an explanation of how variations in geographical cost of living have been considered.  
42 (New HOD Policy)  
43
- 44 6. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should  
45 include an estimate of the policy's impact on factors including:  
46
  - 47 a. Unemployment and/or reduction in hours;
  - 48 b. First-time job seekers;
  - 49 c. Qualification for public assistance (e.g., food, housing, transportation, childcare, health  
50 care, etc.);
  - d. Working conditions;

- 1 e. Health equity, with specific focus on gender and minoritized and marginalized
- 2 communities;
- 3 f. Income equity;
- 4 g. Local small business viability, including independent physician practices; and
- 5 h. Educational and/or training opportunities. (New HOD Policy)
- 6
- 7 7. That our AMA reaffirm Policy D-440.922, which states that the AMA will enhance advocacy
- 8 and support for programs and initiatives that strengthen public health systems to address health
- 9 inequities and the social determinants of health. (Reaffirm HOD Policy)
- 10
- 11 8. That our AMA reaffirm Policy H-165.822, which encourages coverage pilots to test the
- 12 impacts of addressing certain non-medical, yet critical health needs, for which sufficient data
- 13 and evidence are not available, on health outcomes and health care costs. (Reaffirm HOD
- 14 Policy)

Fiscal Note: Less than \$500.

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701  
(A-22)

Introduced by: Private Practice Physician Section

Subject: Appeals and Denials – CPT Codes for Fair Compensation

Referred to: Reference Committee G

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1 Whereas, Our American Medical Association (AMA) has previously affirmed that physicians and  
2 healthcare practices should be fairly compensated for work involved in administrative work; and  
3

4 Whereas, The AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,  
5 update, or modify Current Procedural Terminology (CPT) codes, descriptors, rules, and  
6 guidelines; and  
7

8 Whereas, Studies have shown that wrongful adverse determinations by health plans are  
9 common, including denial of prior authorization, denial of payment for previously provided  
10 service; and  
11

12 Whereas, Good public and economic policy must align costs, benefits and incentives; currently,  
13 all costs in appealing wrongful denials are incurred by healthcare professionals and all financial  
14 savings and benefits from wrongful denials accrue to health insurance plans leading to perverse  
15 incentive that disadvantage patients and endanger their health; and  
16

17 Whereas, Healthcare professionals cannot afford to advocate on patients' behalf to reverse  
18 wrongfully denied medically necessary services while health plans have a perverse incentive to  
19 deny medically necessary services knowing that healthcare providers cannot afford to appeal  
20 every wrongful denial of service; and  
21

22 Whereas, Compensation for work performed by healthcare providers is accomplished via CPT  
23 codes; therefore be it  
24

25 RESOLVED, That our American Medical Association support the creation of CPT codes for  
26 consideration by the CPT® Editorial Panel to provide adequate compensation for administrative  
27 work involved in successfully appealing denials of services (visits, tests, procedures,  
28 medications, devices, and claims), whether pre- or post-service denials, that reflect the actual  
29 time expended by physicians and healthcare practices to advocate on behalf of patients, appeal  
30 denials, and to comply with insurer and legal requirements and that compensate physicians fully  
31 for the time, effort, and legal risks inherent in such work (Directive to Take Action); and be it  
32 further  
33

34 RESOLVED, That our AMA support the creation of CPT codes for consideration by the CPT  
35 Editorial Panel for primary, secondary, and tertiary appeals to independent review organizations  
36 (IROs), state and federal regulators, and ERISA plan appeals, including codes for appeals,  
37 reconsiderations, and other forms of appeals of adverse determination (Directive to Take  
38 Action); and be it further



- 1 RESOLVED, That our AMA advocate for fair compensation based on CPT codes for appeal of
- 2 denied services in any model legislation and as a basis for all advocacy for prior authorization
- 3 reforms. (Directive to Take Action)

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

Received: 03/17/22

## **RELEVANT AMA POLICY**

### **Remuneration for Physician Services H-385.951**

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly. Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

### **Prior Authorization Reform D-320.982**

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens. Citation: Res. 704, A-19

### **CPT Coding H-70.992**

The AMA continues to support a national uniform descriptor system including, but not limited to, the following initiatives: (1) accelerate the process followed by the AMA CPT Editorial Panel, as feasible, to effect expeditiously changes by adding or deleting codes and nomenclature in order to keep CPT-4 as the best single source for up-to-date reference; (2) encourage CMS to direct Medicare carriers to refrain from unilateral deletion of CPT descriptors; and (3) work with national medical specialty societies and state medical associations to review the current status of local carrier descriptor systems and work with CMS to develop an oversight mechanism to monitor carrier compliance with CMS directives on the appropriate use of the national coding system. Citation: Sub. Res. 47, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

### **Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans D-320.995**

- (1) Our AMA will re-distribute its model legislation that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization. (2) Our AMA will work with private sector accreditation organizations to ensure that their health plan and utilization management accreditation standards adequately address fair and appropriate mechanisms for retrospective review. (3) AMA's Private Sector Advocacy unit will work with state medical associations, county medical societies, and national medical specialty societies to (a) develop a survey instrument for use by the Federation to gather information from physicians who experience retrospectively denied and/or down-coded claims, (b) seek information on a regular basis from those associations that collect such information, and (c) respond with appropriate legislation, advocacy, and communication initiatives. Citation: CMS Rep. 5, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Sub. Res. 728, A-10; Reaffirmed: A-18

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702  
(A-22)

Introduced by: Private Practice Physician Section

Subject: Health System Consolidation

Referred to: Reference Committee G

Whereas, The COVID-19 pandemic resulted in unprecedented human suffering on a scale unbeknownst to modern society since the 1918 Flu Pandemic with over 700,000 Americans dead nationwide while physicians suffered moral injury, burnout, exhaustion, and depression due to a lack of preparedness; and

Whereas, The healthcare delivery system faced massive operational challenges<sup>1</sup>, stimulating policymakers to re-examine care delivery markets, including the harms of health system consolidation and mergers<sup>2</sup>; and

Whereas, In a large part because of mergers, the majority of Americans now live in highly concentrated health care delivery markets<sup>3</sup>, including both hospital systems and health systems, the latter comprised of both outpatient practice chains, hospitals, and other healthcare service markets; and

Whereas, The harms of healthcare delivery consolidation and mergers are significant and directly negatively affect patients. Specific harms are numerous and well-documented<sup>4</sup>, including a lack of quality benefits and decrements in patient experience<sup>5</sup>, higher hospital prices<sup>6</sup>, decreasing patient access and driving rising health insurance premiums, both of which harm patients; and

Whereas, Increasing consolidation of physicians into health systems<sup>7,8</sup> decreases physician control over medical practice, hampers independent practice and choices over how and where

<sup>1</sup> Ramachandran, S., et al; "Coronavirus cases strain New York City hospitals: 'We're getting pounded'"; The Wall Street Journal; May 20, 2020. <https://www.wsj.com/articles/coronavirus-cases-strain-new-york-city-hospitals-were-getting-pounded-11584719908> Accessed 10/17/21

<sup>2</sup> United States Senate Committee on the Judiciary; "Antitrust applied: Hospital consolidation concerns and solutions"; May 19, 2021. <https://www.judiciary.senate.gov/meetings/antitrust-applied-hospital-consolidation-concerns-and-solutions>. Accessed 10/17/21

<sup>3</sup> Health Care Cost Institute; "Hospital concentration index: An analysis of U.S. hospital market consolidation"; <https://healthcostinstitute.org/hcci-origins/hmi-interactive#HMI-Concentration-Index> Accessed 10/17/21

<sup>4</sup> Schwartz, K., et al; "What we know about provider consolidation"; Kaiser Family Foundation; Sep 2, 2020. <https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/> Accessed 10/17/21

<sup>5</sup> Beaulieu, N., et al; (2020); "Changes in quality of care after hospital mergers and acquisitions"; The New England Journal of Medicine; 382: 51-59. <https://www.nejm.org/doi/full/10.1056/NEJMsa1901383> Accessed 10/17/21

<sup>6</sup> Gaynor, M. & Town, R.; "The impact of hospital consolidation"; Robert Wood Johnson Foundation; June 1, 2012; <https://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html> Accessed 10/17/21

<sup>7</sup> Furukawa, M., et al; (2020); "Consolidation of providers in health systems increased substantially, 210-18"; Health Affairs; 39, 8. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00017> Accessed 10/17/21

<sup>8</sup> Gibler, K., et al; "Physician employment: The path forward in the COVID-19 era"; McKinsey & Company; July, 2020; <https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/Physician%20employment%20The%20path%20forward%20in%20the%20COVID%2019%20era/physician-employment-the-path-forward-in-the-covid-19-era.pdf?shouldIndex=false> Accessed 10/17/21

physicians practice medicine<sup>9</sup>, and places corporations at the center of the patient-physician relationship, thus driving burnout due to a loss of control over the public environment<sup>10</sup>; and

Whereas, Systemic harms of health system and hospital consolidation are more insidious and long-term, including a loss of innovation in care delivery and productivity as manifested by over twenty years of absent labor productivity growth, a finding unparalleled by other industries<sup>11</sup>; and

Whereas, Health care delivery consolidation is a bipartisan problem, acknowledged by both Democrats<sup>12</sup> and Republicans<sup>13</sup>; and

Whereas, The AMA is a national leader in addressing consolidation in healthcare and bringing the patient voice to these conversations with its “Competition in health insurance: A comprehensive study of U.S. Markets” now in its twentieth year<sup>14</sup>. The AMA successfully used this study in 2016 to conduct further analyses to assist the U.S. Department of Justice and National Association of Attorneys General to successfully challenge the Anthem-Cigna and Aetna-Humana mergers<sup>15</sup>; therefore be it

RESOLVED, That our American Medical Association undertake an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation. (Directive to Take Action)

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

Received: 03/17/22

## RELEVANT AMA POLICY

### Hospital Consolidation H-215.960

Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations

<sup>9</sup> Kane, C.; “Recent changes in physician practice relationships: Private practice dropped to less than 50 percent of physicians in 2020”; American Medical Association; May, 2021; <https://www.ama-assn.org/system/files/2021-05/2020-prp-physician-practice-arrangements.pdf> Accessed 10/17/21

<sup>10</sup> National Academies of Sciences, Engineering, and Medicine; 2019; *Taking action against clinician burnout: A systems approach to professional well-being*; Washington, DC: The National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK552615/> Accessed 10/17/21

<sup>11</sup> Kocher, R. & Sahni, N.R.; (2011) “Rethinking health care labor”; The New England Journal of Medicine; 365: 1370-1372. <https://www.nejm.org/doi/full/10.1056/nejmp1109649> Accessed 10/17/21

<sup>12</sup> Gee, E. & Gurwitz, E.; “Provider consolidation drives up health care costs”; Center for American Progress; Dec 5, 2018. <https://www.americanprogress.org/issues/healthcare/reports/2018/12/05/461780/provider-consolidation-drives-health-care-costs/> Accessed 10/17/21

<sup>13</sup> Miller, T.P.; “More consolidation and more ‘political’ competition, less patient-centered market competition”; American Enterprise Institute; Sep 19, 2013. <https://www.aei.org/research-products/testimony/more-consolidation-and-more-political-competition-less-patient-centered-market-competition/> Accessed 10/17/21

<sup>14</sup> American Medical Association Division of Economic and Health Policy Research; (2021); “Competition in health insurance: A comprehensive study of U.S. Markets – 2021 update”; American Medical Association. <https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf> Accessed 10/17/21

<sup>15</sup> American Medical Association; “Ensuring health insurance competition”; American Medical Association; <https://www.ama-assn.org/delivering-care/patient-support-advocacy/ensuring-health-insurance-competition> Accessed 10/17/21

to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Citation: CMS Rep. 07, A-19

#### **Health Care Entity Consolidation D-383.980**

Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

Citation: BOT Rep. 8, I-15

#### **Hospital Merger Study H-215.969**

1 It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:

- (A) medical staff representation on the board of directors;
- (B) clinical services to be offered by the institutions;
- (C) process for approving and amending medical staff bylaws;
- (D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
- (E) credentialing and recredentialing of physicians and limited licensed providers;
- (F) quality improvement;
- (G) utilization and peer review activities;
- (H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
- (I) conflict resolution mechanisms;
- (J) the role, if any, of medical directors and physicians in joint ventures;
- (K) control of medical staff funds;
- (L) successor-in-interest rights;
- (M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and

2. Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

Citation: CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11; Appended: Res. 3, I-13; Reaffirmed: CMS Rep. 07, A-19

#### **Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988**

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Citation: Res. 299, A-12; Reaffirmed: Res. 206, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703  
(A-22)

Introduced by: Maryland, Mississippi

Subject: Mandating Reporting of All Antipsychotic Drug Use in Nursing Home Residents

Referred to: Reference Committee G

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1 Whereas, The federal government does not publicly disclose the use of antipsychotic drugs  
2 given to nursing home residents diagnosed with schizophrenia; and  
3

4 Whereas, Antipsychotic drugs have historically been used as chemical restraints to keep  
5 nursing home residents docile, circumventing the costs associated with additional staffing  
6 required to manage nursing home residents; and  
7

8 Whereas, Because the Food and Drug Administration has issued “black box” warnings  
9 regarding the risks of antipsychotic use among elderly patients with dementia, high rates of  
10 antipsychotic drug use can lower a nursing home’s star rating from the federal government, thus  
11 damaging the reputation and desirability of the nursing home;<sup>1</sup> and  
12

13 Whereas, The percentage of nursing home residents diagnosed with schizophrenia has  
14 increased in 2021;<sup>2</sup> and  
15

16 Whereas, Nearly one-third of nursing home residents reported in the Centers for Medicare and  
17 Medicaid Services (CMS) Minimum Data Set (MDS) as having schizophrenia did not have any  
18 evidence of this diagnosis in their Medicare claims history, meaning they were likely prescribed  
19 antipsychotic drugs but were excluded because of their diagnosis;<sup>3</sup> and  
20

21 Whereas, Current AMA policy “will ask CMS to cease and desist in issuing citations or financial  
22 penalties for medically necessary and appropriate use of antipsychotics for the treatment of  
23 dementia-related psychosis; and ask CMS to discontinue the use of antipsychotic medication as  
24 a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited  
25 to medically inappropriate administration of these medications”;<sup>4</sup> therefore be it

1 RESOLVED, That American Medical Association Policy D-120.951, "Appropriate Use of  
2 Antipsychotic Medications in Nursing Home Patients," be amended by addition and deletion to  
3 read as follows:

4  
5 Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS)  
6 for a determination that acknowledges that antipsychotics can be an appropriate  
7 treatment for dementia-related psychosis if non-pharmacologic approaches have  
8 failed and will ask CMS to cease and desist in issuing citations or financial penalties  
9 for medically necessary and appropriate use of antipsychotics for the treatment of  
10 dementia-related psychosis; ~~and~~ (2) ask CMS to discontinue the use of  
11 antipsychotic medication as a factor contributing to the Nursing Home Compare  
12 rankings, unless the data utilized is limited to medically inappropriate administration  
13 of these medications; and (3) ask CMS to require the reporting of all antipsychotic  
14 drugs used and the diagnoses for which they are prescribed. (Modify Current HOD  
15 Policy)

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

Received: 03/01/22

<sup>1</sup> Five-Star Quality Rating System | CMS <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS> (accessed 2021 -09 -21).

<sup>2</sup> MDS 3.0 Frequency Report | CMS <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report> (accessed 2021 -09 -21).

<sup>3</sup> CMS Could Improve the Data It Uses to Monitor Antipsychotic Drugs in Nursing Homes, OEI-07-19-00490. 22.

<sup>4</sup> D-120.951 Appropriate Use of Antipsychotic Medications in Nursi | AMA <https://policysearch.ama-assn.org/policyfinder/detail/Appropriate%20Use%20of%20Antipsychotic%20Medications%20in%20Nursing%20Home%20Patients%20D-120.951?uri=%2FAMADoc%2Fdirectives.xml-0-77.xml> (accessed 2021 -09 -21).

## RELEVANT AMA POLICY

### Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951

Our AMA will: (1) meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis; and (2) ask CMS to discontinue the use of antipsychotic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications.

Res. 523, A-12; Appended: Res. 708, A-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704  
(A-22)

Introduced by: New York

Subject: Employed Physician Contracts

Referred to: Reference Committee G

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1 Whereas, Employed physician contracts contain clauses to the effect that the physician  
2 maintains privileges ONLY if the physician remains employed by the hospital/health system; and  
3

4 Whereas, An employed physician due to circumstances beyond the physician's control could be  
5 dismissed and upon that dismissal, lose all privileges despite having been credentialed  
6 according to hospital/health system bylaws; and  
7

8 Whereas, Hospital medical staff bylaws ensure rights and due process for all members of the  
9 medical staff; therefore be it  
10

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

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

Received: 03/22/22

### 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.***

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

#### **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 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, close medical staff departments, or to transfer patients into, out of, or within the health care organization.
- 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.
- e. 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.

- f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
- h. 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, 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.
- e. 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.
- f. 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.
- g. 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. 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.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMS Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705  
(A-22)

Introduced by: New York

Subject: Fifteen Month Lab Standing Orders

Referred to: Reference Committee G

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1 Whereas, Federal Medicaid rules limits a laboratory standing order's validity to six months which  
2 necessitates practitioners to reorder laboratory studies every six months for regular and routine  
3 laboratory studies that often are required for a patient's lifetime (such as standard of care  
4 monitoring of HemoglobinA1Cs every three to six months for diabetics); and  
5

6 Whereas, There is no documented benefit to limiting laboratory orders to six months and  
7 expiration of standing lab orders has led to patient and physician dissatisfaction; and  
8

9 Whereas, "Busywork" that is not perceived as meaningful contributes to burnout which is a harm  
10 negatively impacting the American medical work force and has deleterious implications on  
11 patient care quality, outcomes and patient satisfaction; and  
12

13 Whereas, Reordering laboratory studies only for the sake of a regulation leads to unnecessary  
14 and not meaningful work, the kind of activity that contributes to burnout among practitioners and  
15 increases the cost of healthcare because of the time and labor required for each practice to  
16 reorder routine laboratory studies; therefore be it  
17

18 RESOLVED, That our American Medical Association advocate the Centers for Medicare and  
19 Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months.  
20 (Directive to Take Action)

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

Received: 03/22/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706  
(A-22)

Introduced by: New York

Subject: Government Imposed Volume Requirements for Credentialing

Referred to: Reference Committee G

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1 Whereas, The government will sometimes create volume requirements for credentialing; and

2  
3 Whereas, Depending on the details, these requirements may or may not be appropriate and  
4 justified; and

5  
6 Whereas, The AMA has no policy or guideline for determining whether such requirements would  
7 or would not be appropriate; therefore be it

8  
9 RESOLVED, That our American Medical Association create guidelines and standards for  
10 evaluation of government-imposed volume requirements for credentialing that would include at  
11 least the following considerations:

- 12 (a) the evidence for that volume requirement;  
13 (b) how many current practitioners meet that volume requirement;  
14 (c) how difficult it would be to meet that volume requirement;  
15 (d) the consequences to that practitioner of not meeting that volume requirement;  
16 (e) the consequences to the hospital and the community of losing the services of the  
17 practitioners who can't meet that volume requirement; and  
18 (f) whether volumes of similar procedures could also reasonably be used to satisfy such a  
19 requirement. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 03/22/22

### RELEVANT AMA POLICY

#### Reentry into Physician Practice H-230.953

Our AMA encourages: (1) hospitals to establish alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges; and (2) The Joint Commission and other accrediting organizations to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges.

Citation: Res. 717, A-19; Reaffirmed: CMS Rep. 4, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707  
(A-22)

Introduced by: New York

Subject: Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

Referred to: Reference Committee G

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1 Whereas, Scalp Cooling (Cold Cap Therapy) has been cleared by the FDA for use during  
2 chemotherapy treatment to reduce the likelihood of chemotherapy-induced alopecia in cancer  
3 patients with solid tumors such as ovarian, breast, colorectal, bowel, and prostate cancers; and  
4

5 Whereas, The National Comprehensive Cancer Network® (NCCN) has given Scalp cooling a  
6 Category 2A designation indicating uniform NCCN consensus that the intervention is  
7 appropriate; and  
8

9 Whereas, Peer-reviewed studies have shown Scalp Cooling (Cold Cap Therapy) prevented hair  
10 loss in 53-66.3% of patients with breast cancer receiving adjuvant chemotherapy, compared to  
11 a control group where all patients experienced significant hair loss; and  
12

13 Whereas, Scalp cooling treatment (Cold Cap Therapy) in peer reviewed studies was well-  
14 tolerated with no scalp metastases observed; and  
15

16 Whereas, Minimizing hair loss during cancer treatment helps patients to preserve personal  
17 identity and self-esteem and appear normal as opposed to sick; and  
18

19 Whereas, Protecting privacy and gaining the ability to choose whether to disclose a cancer  
20 diagnosis is significant to many patients; and  
21

22 Whereas, Scalp cooling can give patients a sense of control in what can be an overwhelming  
23 experience; and  
24

25 Whereas, The American Medical Association (AMA) has issued two (2) separate Category III  
26 CPT codes for "mechanical scalp cooling": 0662T and 0663T, effective July 1, 2020; and  
27

28 Whereas, Aetna, issued a policy statement in 2017 stating that they consider scalp cooling  
29 medically necessary as a means to prevent hair loss during chemotherapy but insurance  
30 coverage for scalp cooling is not yet standard in the United States; and  
31

32 Whereas, Reimbursement varies depending on plan, coverage, and location with some  
33 insurance companies covering up to \$2,000 for wigs but denying coverage for scalp cooling in  
34 similar price range (\$1,500-\$3,000); and  
35

36 Whereas, Many patients have encountered the circumstance where their health insurance  
37 carrier will not provide coverage for scalp cooling therapy, forcing patients to pay out of pocket  
38 for this essential therapy; and  
39

40 Whereas, This significant out of pocket expense puts this treatment out of range for many; and

Whereas, Our AMA advocates for health equity; therefore be it

RESOLVED, That our American Medical Association advocate for and seek through legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy (Directive to Take Action); and be it further

RESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to independent third-party reviewers. (Directive to Take Action)

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

Received: 03/22/22

1. NCCN scalp cooling recommendations from the [NCCN Clinical Practice Guidelines in Oncology \(NCCN Guidelines®\)](#). NCCN provides the following recommendations: breast cancer (Version 1.2019), ovarian cancer (Version 1.2020)

#### References

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Number: 0290

Policy Effective Date 10/13/1998

Last Review: 7/1/2021

Aetna considers scalp cooling (i.e., using ice-filled bags/bandages, cryogel packs, or specially designed products (e.g., Chemo Cold Cap, DigniCap, ElastoGel, Paxman Scalp Cooling System and Penguin Cold Cap)) medically necessary as a means to prevent hair loss during chemotherapy.

Note: Cooling caps and other products for scalp cooling are considered incidental to the chemotherapy administration and are not separately reimbursed. Cooling caps and other scalp cooling products purchased by the member are considered supplies that are generally excluded from coverage under plans that exclude supplies. See benefit plan descriptions.

## RELEVANT AMA POLICY

### Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate



hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708  
(A-22)

Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

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1 Whereas, Repetitive Strain (Stress) Injury or RSI is defined as a category of injuries "to the  
2 musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful  
3 exertions, vibrations, mechanical compression, or sustained or awkward positions; and  
4

5 Whereas, RSI is a known work-related injury which falls under the purview of the Occupational  
6 Safety and Health Administration (OSHA); and  
7

8 Whereas, Most RSI results from cumulative trauma rather than a single event; and  
9

10 Whereas, Repeated exposure to work-related stressors can result in physician burnout; and  
11

12 Whereas, Cerebral centers and activity are most certainly within the domain of the nervous  
13 system; and  
14

15 Whereas, Physician burnout resulting from work-related stressors should be regarded as RSI  
16 and, as such, should fall under the aegis of OSHA; therefore be it  
17

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

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

Received: 03/22/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709  
(A-22)

Introduced by: New York

Subject: Physician Well-Being as an Indicator of Health System Quality

Referred to: Reference Committee G

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1 Whereas, Physician well-being is measurable and existing instruments can assess physician  
2 wellness at a system level; and  
3

4 Whereas, The Triple Aim, now adopted as a set of principles for health system reform within  
5 many organizations around the world, fails to acknowledge the critical role of physicians in  
6 healthcare transformation and ignores the threats of psychological and physical harm that are  
7 common in medical practice; and  
8

9 Whereas, Intimate caregiving relationships have been reduced to a series of transactional  
10 demanding tasks, with a focus on productivity and efficiency, fueled by the pressures of  
11 decreasing reimbursement; and  
12

13 Whereas, These forces have led to an environment which exhibits a lack of teamwork,  
14 disrespect between colleagues, and lack of workforce engagement from the level of the front-  
15 line caregivers, doctors and nurses, who are burdened with non-caregiving work, to the  
16 healthcare leader with bottom-line worries and disproportionate reporting requirements; and  
17

18 Whereas, By ignoring the experience of providing care in our healthcare delivery framework,  
19 this has eliminated consideration of human limitations in the delivery of care and this deficit in  
20 the framework of healthcare delivery results in unreasonable expectations upon physicians that  
21 affects them personally and the patients they serve; and  
22

23 Whereas, The Triple Aim framework perpetuates the high occupational stress environment  
24 currently experienced by physicians when this framework is followed by all decision makers in  
25 healthcare, be they hospital leaders, electronic medical record and other medical device  
26 vendors, as well as law makers; and  
27

28 Whereas, Physician burnout can be a drag on health system quality and outcomes;  
29 therefore be it  
30

31 RESOLVED, That our American Medical Association support policies that acknowledge  
32 physician well-being is both a driver and an indicator of hospital and health system quality (New  
33 HOD Policy); and be it further  
34

35 RESOLVED, That our AMA promote dialogue between key stakeholders (physician groups,  
36 health-system decision makers, payers, and the general public) about the components needed  
37 in such a quality-indicator system to best measure physician and organizational wellness  
38 (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA (with appropriate resources) develop the expertise to be available to
- 2 assist in the implementations of effective interventions in situations of suboptimal physician
- 3 wellness. (Directive to Take Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710  
(A-22)

Introduced by: New York

Subject: Prior Authorization – CPT Codes for Fair Compensation

Referred to: Reference Committee G

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1 Whereas, The American Medical Association (AMA) has previously affirmed that physicians and  
2 physician practices should be fairly compensated for work involved in prior authorizations; and  
3

4 Whereas, AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,  
5 update, or modify CPT codes, descriptors, rules and guidelines; and  
6

7 Whereas, Studies have shown that wrongful adverse determinations by health plans are  
8 common, including denial of prior authorization and denial of payment for previously provided  
9 services; and  
10

11 Whereas, Costs involved in prior authorizations provide perverse disincentives and lead to sub-  
12 optimal healthcare outcomes, especially for marginalized and economically vulnerable  
13 communities; and  
14

15 Whereas, Good public and economic policy must align costs, benefits and incentives; currently,  
16 all costs are incurred by physician practices, and all financial savings and benefits from prior  
17 authorization accrue to health insurance plans leading to perverse incentives that disadvantage  
18 patients and endanger their health; and  
19

20 Whereas, Compensation for work performed by physician practices is accomplished via CPT  
21 codes; therefore be it  
22

23 RESOLVED, That our American Medical Association include in any model legislation and as a  
24 basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied  
25 services, including those for prior authorization reforms and that CPT codes must fully reflect  
26 the aggregated time and effort expended by physician practices (Directive to Take Action); and  
27 be it further  
28

29 RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT®  
30 Editorial Panel to account for administrative work involved in prior authorizations that reflects the  
31 actual time expended by physician practices to advocate on behalf of patients and to comply  
32 with insurer requirements (Directive to Take Action); and be it further  
33

34 RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT®  
35 Editorial Panel to account for administrative work that reflects the actual time expended by  
36 physician practices and their billing vendors involved in successfully appealing wrongful pre-and  
37 post-service denials. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000  
Received: 03/22/22

## **RELEVANT AMA POLICY**

### **Prior Authorization and Utilization Management Reform H-320.939**

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.
4. Our AMA will advocate 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.

Citation: 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; Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21

### **Remuneration for Physician Services H-385.951**

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

### **Prior Authorization Reform D-320.982**

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711  
(A-22)

Introduced by: New York

Subject: Reducing Prior Authorization Burden

Referred to: Reference Committee G

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1 Whereas, A prescription drug may require an insurance prior authorization; and

2  
3 Whereas, Patients on chronic therapy experience a change in the rules during the interval  
4 between office visits and this results in extra work for a physician to review forms, medical  
5 records, complete paperwork, provide documentation and create an entry in the medical record  
6 so that a patient's therapy not suffer interruption; and

7  
8 Whereas, The documentation process can be as resource intensive as a patient encounter; and

9  
10 Whereas, The prior authorization diverts physician time away from direct patient care, thereby  
11 diminishing patient access and physician job satisfaction; and

12  
13 Whereas, Reducing prior authorizations can protect patients from unnecessary delays in care;  
14 therefore be it

15  
16 RESOLVED, That our American Medical Association seek regulation or legislation that:

- 17
- 18 • restricts insurance companies from requiring prior authorizations for generic medications;
  - 19
  - 20 • contains disincentives for insurers demanding unnecessary prior authorizations, including
  - 21 payments to physicians' practices for inappropriate prior authorizations;
  - 22
  - 23 • requires payment be made to the physician practice for services related to prior
  - 24 authorization when those services do not coincide with a visit; and
  - 25
  - 26 • ensures a requirement for an independent external review organization to review disputes
  - 27 involving prior authorizations and require insurer payments be made to the practice when
  - 28 the review organization agrees with the physician practice. (Directive to Take Action)

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

Received: 03/22/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712  
(A-22)

Introduced by: New York

Subject: The Quadruple Aim – Promoting Improvement in the Physician Experience of Providing Care

Referred to: Reference Committee G

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1 Whereas, In 2008, Donald Berwick and the Institute of Healthcare Improvement provided a  
2 framework for the delivery of high value care in the USA, the *Triple Aim*, centered around three  
3 overarching goals: improving the individual experience of care; improving the health of  
4 populations; and reducing the per capita cost of healthcare; and  
5

6 Whereas, The *Triple Aim*, adopted as a set of principles for health system reform within many  
7 organizations around the world, fails to acknowledge the critical role of physicians in healthcare  
8 transformation and ignores the threats of psychological and physical harm that are common in  
9 medical practice; and  
10

11 Whereas, For decision makers in healthcare (hospital leaders, EMR and other medical vendors,  
12 lawmakers and insurance companies) to abide by the *Triple Aim* is to ignore the threats of  
13 psychological and physical harm that are common to [clinicians] and patients; and  
14

15 Whereas, The focus on productivity and efficiency, fueled by the pressures of decreasing  
16 reimbursement, has reduced intimate caregiving relationships to a series of transactional  
17 demanding tasks; and  
18

19 Whereas, That by ignoring the experience of providing care in our healthcare delivery  
20 framework, this has eliminated consideration of human limitations in the delivery of care and this  
21 deficit in the framework of healthcare delivery results in unreasonable expectations upon  
22 physicians that affects them personally and the patients they serve; and  
23

24 Whereas, The *Triple Aim* framework perpetuates the high occupational stress environment  
25 currently experienced by physicians when this framework is followed by all decision makers in  
26 healthcare, be they hospital leaders, electronic medical record and other medical device  
27 vendors, as well as law makers; and  
28

29 Whereas, Intimate caregiving relationships have been reduced to a series of transactional  
30 demanding tasks, with a focus on productivity and efficiency, fueled by the pressures of  
31 decreasing reimbursement; therefore be it  
32

33 RESOLVED, That to the *Triple Aim* which was established by Dr. Berwick and the Institute of  
34 Healthcare Improvement, our American Medical Association adopt a fourth goal: namely the  
35 goal of improving physicians' experience in providing care. (Directive to Take Action)

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

Received: 03/22/22



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713  
(A-22)

Introduced by: Private Practice Physician Section

Subject: Enforcement of Administrative Simplification Requirements - CMS

Referred to: Reference Committee G

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1 Whereas, Our American Medical Association has previously affirmed that administrative  
2 simplification, including automation and standardization of electronic transactions, is a high  
3 priority in order to provide affordable, timely, and effective care; and  
4

5 Whereas, The National Standards Group (NSG) at the Centers for Medicare and Medicaid  
6 Services (CMS) Office of Burden Reduction is empowered to enforce administrative  
7 simplification requirements to ensure standardization throughout the ecosystem of payers,  
8 physicians, and clearinghouses; and  
9

10 Whereas, Violations of administrative simplification requirements by health plans and payer  
11 business associates, including clearinghouses, are prevalent and have an adverse effect on  
12 healthcare practices and patients via higher costs and resulting in limited access to affordable  
13 healthcare; and  
14

15 Whereas, The NSG at the CMS Office of Burden Reduction has stated that the enforcement  
16 mechanism against health plan violations is based on the idea of “voluntary compliance,” the  
17 only program of this type in the federal government where compliance is “voluntary;” and  
18

19 Whereas, The NSG at the CMS Office of Burden Reduction has failed to impose any financial  
20 penalties in the past seven years on health plans for violation of HIPAA administrative  
21 simplification requirements while at the same time, CMS imposed numerous penalties on  
22 physicians and the healthcare producer industry, including for violations of HIPAA privacy rules  
23 which are governed by the same rules as the HIPAA administrative simplification requirements,  
24 MACRA MIPS penalties, “Open Payments” Sunshine Act violation penalties, and numerous  
25 other financial penalties; therefore be it  
26

27 RESOLVED, That our American Medical Association take the position that the failure by the  
28 National Standards Group at the Centers for Medicare and Medicaid Services Office of Burden  
29 Reduction to effectively enforce the HIPAA administrative simplification requirements as  
30 required by the law and its failure to impose financial penalties for non-compliance by health  
31 plans is clearly unacceptable (New HOD Policy); and be it further  
32

33 RESOLVED, That our AMA take the position that the National Standards Group at the Centers  
34 for Medicare and Medicaid Services Office of Burden Reduction practices of closing complaints  
35 without further investigation and ignoring overwhelming evidence that contradicts health plan  
36 assertions is also unacceptable (New HOD Policy); and be it further  
37

38 RESOLVED, That our AMA advocate for enhanced enforcement of the HIPAA Administrative  
39 Simplification requirements for health plans. (Directive to Take Action)

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

Received: 03/17/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714  
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Prior Authorization Reform for Specialty Medications

Referred to: Reference Committee G

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1 Whereas, Since the inception of prior authorization (PA) requirements it has been a strategic  
2 priority of the AMA to improve efficiency in the process to prevent delays in treatment; and  
3

4 Whereas, In spite of attempts to specialize PA forms, approval is often delayed for the following  
5 reasons: 1) insurers often require information that was not part of the original PA form, and 2)  
6 information submitted to the pharmacy PA manager isn't made available to other offices  
7 involved in the PA system; and  
8

9 Whereas, It is painfully clear that market forces often drive the PA process; i.e. during the  
10 Covid-19 pandemic the price of Planquenil (hydroxychloroquine) increased and a restriction was  
11 placed on the number of pills dispensed monthly at a substandard level. The insurer not the  
12 physician is now writing the orders. Although we now have studies that demonstrate a limited  
13 value of Planquenil in critically ill ICU Covid patients, this restriction in dispensing continues at  
14 the present time; and  
15

16 Whereas, A delay in receiving medications on a timely basis and in adequate doses has  
17 resulted in many patients experiencing flare-ups in their diseases; and  
18

19 Whereas, The PA process has greatly increased the burden on medical practices often  
20 requiring ten to fifteen hours weekly to obtain approval for the physician's order; and  
21

22 Whereas, Even a medical staff person well-trained in obtaining PAs often requires the help of  
23 the physician to complete; and  
24

25 Whereas, The peer-to-peer review component of the PA process is problematic because the  
26 physician reviewer often does not have access to the original information submitted, thus  
27 requiring the resending of the information and creating further delay of the process; therefore be it  
28

29 RESOLVED, That our American Medical Association encourage Congress and the President to  
30 issue a moratorium on the specialty medicine prior authorization process for one year to allow  
31 further study (New HOD Policy); and be it further  
32

33 RESOLVED, That our AMA work with other stakeholders to encourage pharmaceutical  
34 companies and other entities that offer assistance programs to increase eligibility for their  
35 assistance programs. (Directive to Take Action)

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

Received: 03/17/22

## **RELEVANT AMA POLICY**

### **Prior Authorization and Utilization Management Reform H-320.939**

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.
4. Our AMA will advocate 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. Citation: 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; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21

### **Prior Authorization Reform D-320.982**

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

### **Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

- (1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
- (2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require 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; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release

of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMD Rep. 4, A-95; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMD Rep. 13, I-98; Reaffirmed: I-98; Reaffirmed: A-99; Reaffirmed: I-99; Reaffirmed: A-00; Reaffirmed in lieu of Res. 839, I-08, Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of Res. 242, A-17; Reaffirmed in lieu of Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: I-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20

#### **Opposition to Prescription Prior Approval D-125.992**

Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians.

Citation: Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed: CMS Rep. 1, A-21

#### **Administrative Simplification in the Physician Practice D-190.974**

1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.

2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.

3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.

4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.

5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.

6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmed: A-14; Reaffirmed: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmed: I-17; Reaffirmed: A-19; Modified: CMS Rep. 09, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715  
(A-22)

Introduced by: Private Practice Physician Section

Subject: Prior Authorization – CPT Codes for Fair Compensation

Referred to: Reference Committee G

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1 Whereas, Our AMA has previously affirmed that physicians and healthcare practices should be  
2 fairly compensated for work involved in prior authorizations; and  
3

4 Whereas, The AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,  
5 update, or modify Current Procedural Terminology (CPT) codes, descriptors, rules, and  
6 guidelines; and  
7

8 Whereas, Studies have shown that costs involved in prior authorizations provide perverse  
9 disincentives and lead to sub-optimal healthcare outcomes, especially for marginalized and  
10 economically vulnerable communities; and  
11

12 Whereas, Good public and economic policy must align costs, benefits, and incentives; currently,  
13 all costs are incurred by healthcare providers and all financial savings and benefits from prior  
14 authorization accrue to health insurance plans, leading to perverse incentives to impose more  
15 and more prior authorization requirements that are of questionable clinical benefit; and  
16

17 Whereas, Compensation for work performed by healthcare providers is accomplished via CPT  
18 codes; therefore be it  
19

20 RESOLVED, That our American Medical Association support the creation of CPT codes to  
21 provide adequate compensation for administrative work involved in prior authorizations,  
22 including pre-certifications and prior notifications, that reflects the actual time expended by  
23 physicians and healthcare practices to advocate on behalf of patients and to comply with insurer  
24 requirements and that compensates physicians fully for the time, effort, and legal risks inherent  
25 in such work (New HOD Policy); and be it further  
26

27 RESOLVED, That our AMA advocate for CPT codes to be developed for prior authorizations to  
28 fully reflect the aggregated time and effort involved in prior authorization, including multiple  
29 contracts, wait time on the phone, chat, or other platforms preferred by payers or their agents,  
30 among other costs to physician practice (New HOD Policy); and be it further  
31

32 RESOLVED, That our AMA advocate for fair compensation based on CPT codes for prior  
33 authorization in any model legislation and as a basis for all advocacy for prior authorization  
34 reforms. (Directive to Take Action)

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

Received: 03/17/22

## RELEVANT AMA POLICY

### Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.

2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.

3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

### Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

### CPT Coding H-70.992

The AMA continues to support a national uniform descriptor system including, but not limited to, the following initiatives: (1) accelerate the process followed by the AMA CPT Editorial Panel, as feasible, to effect expeditiously changes by adding or deleting codes and nomenclature in order to keep CPT-4 as the best single source for up-to-date reference;

(2) encourage CMS to direct Medicare carriers to refrain from unilateral deletion of CPT descriptors; and (3) work with national medical specialty societies and state medical associations to review the current status of local carrier descriptor systems and work with CMS to develop an oversight mechanism to monitor carrier compliance with CMS directives on the appropriate use of the national coding system.

Citation: Sub. Res. 47, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716  
(A-22)

Introduced by: Organized Medical Staff Section

Subject: Discharge Summary Reform

Referred to: Reference Committee G

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1 Whereas, Our ability to do complicated surgical and medical procedures is unprecedented, with  
2 the aid of electronic medical records our ability to produce a logical, concise, and accurate  
3 discharge summary has deteriorated to the point of nonexistence; and  
4

5 Whereas, Current discharge summaries can be over 100 pages long and contain a multitude of  
6 completely unnecessary information; and  
7

8 Whereas, Incomprehensible, bloated discharge summaries are a significant patient hazard  
9 since physicians resuming care of the patient find it nearly impossible to determine discharge  
10 diagnosis, hospital course, procedures performed, medications prescribed, or follow-up care;  
11 and  
12

13 Whereas, All medical students and residents have been taught how to dictate and produce a  
14 discharge summary in their training which includes discharge diagnosis, procedures performed,  
15 hospital course, pertinent lab and radiology findings, discharge medications, and follow-up care;  
16 and  
17

18 Whereas, All the equipment to produce a competent discharge summary is currently in place  
19 since surgeons still use the equipment to produce an operation note; therefore be it  
20

21 RESOLVED, That our American Medical Association coordinate with the American Hospital  
22 Association with input from the Centers for Medicare & Medicaid Services and other  
23 professional organizations as appropriate to revive the concise discharge summary that existed  
24 prior to electronic medical records for the sake of much improved patient care and safety  
25 (Directive to Take Action); and be it further  
26

27 RESOLVED, That our AMA internally develop a model hospital discharge summary in such a  
28 manner as to be concise but informational, include to promote excellent, safe patient care and  
29 improve coordinated discharge planning. This model use shall be promoted to our AMA and  
30 federation of medicine colleagues. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 03/17/22



## RELEVANT AMA POLICY

### Hospital Discharge Communications H-160.902

1. Our AMA encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization.
2. Our AMA encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care.
3. Our AMA encourages hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
  - a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.
  - b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
  - c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
  - d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
  - e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.
4. Our AMA supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers.
5. Our AMA supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
  - a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
  - b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug, should be communicated to patients.
  - c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
  - d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.
6. Our AMA encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization.
7. Our AMA encourages hospitals to review early readmissions and modify their discharge processes accordingly.

Citation: CMS Rep. 07, I-16

### Evidence-Based Principles of Discharge and Discharge Criteria H-160.942

- (1) The AMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process by following the principle that the needs of patients must be matched to settings with the ability to meet those needs.
- (2) The AMA calls on physicians, specialty societies, insurers, and other involved parties to join

in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients and that are flexible to meet advances in medical and surgical therapies and adapt to local and regional variations in health care settings and services.

(3) The AMA encourages incorporation of discharge criteria into practice parameters, clinical guidelines, and critical pathways that involve hospitalization.

(4) The AMA promotes the local development, adaption and implementation of discharge criteria.

(5) The AMA promotes training in the use of discharge criteria to assist in planning for patient care at all levels of medical education. Use of discharge criteria will improve understanding of the pathophysiology of disease processes, the continuum of care and therapeutic interventions, the use of health care resources and alternative sites of care, the importance of patient education, safety, outcomes measurements, and collaboration with allied health professionals.

(6) The AMA encourages research in the following areas: clinical outcomes after care in different health care settings; the utilization of resources in different care settings; the actual costs of care from onset of illness to recovery; and reliable and valid ways of assessing the discharge needs of patients.

(7) The AMA endorses the following principles in the development of evidence-based discharge criteria and an organized discharge process:

(a) As tools for planning patients' transition from one care setting to another and for determining whether patients are ready for the transition, discharge criteria are intended to match patients' care needs to the setting in which their needs can best be met.

(b) Discharge criteria consist of, but are not limited to: (i) Objective and subjective assessments of physiologic and symptomatic stability that are matched to the ability of the discharge setting to monitor and provide care. (ii) The patient's care needs that are matched with the patient's, family's, or caregiving staff's independent understanding, willingness, and demonstrated performance prior to discharge of processes and procedures of self care, patient care, or care of dependents. (iii) The patient's functional status and impairments that are matched with the ability of the care givers and setting to adequately supplement the patients' function. (iv) The needs for medical follow-up that are matched with the likelihood that the patient will participate in the follow-up. Follow-up is time-, setting-, and service-dependent. Special considerations must be taken to ensure follow-up in vulnerable populations whose access to health care is limited.

(c) The discharge process includes, but is not limited to: (i) Planning: Planning for transition/discharge must be based on a comprehensive assessment of the patient's physiological, psychological, social, and functional needs. The discharge planning process should begin early in the course of treatment for illness or injury (prehospitalization for elective cases) with involvement of patient, family and physician from the beginning. (ii) Teamwork: Discharge planning can best be done with a team consisting of the patient, the family, the physician with primary responsibility for continuing care of the patient, and other appropriate health care professionals as needed. (iii) Contingency Plans/Access to Medical Care: Contingency plans for unexpected adverse events must be in place before transition to settings with more limited resources. Patients and caregivers must be aware of signs and symptoms to report and have a clearly defined pathway to get information directly to the physician, and to receive instructions from the physician in a timely fashion. (iv) Responsibility/Accountability: Responsibility/accountability for an appropriate transition from one setting to another rests with the attending physician. If that physician will not be following the patient in the new setting, he or she is responsible for contacting the physician who will be accepting the care of the patient before transfer and ensuring that the new physician is fully informed about the patient's illness, course, prognosis, and needs for continuing care. If there is no physician able and willing to care for the patient in the new setting, the patient should not be discharged. Notwithstanding the attending physician's responsibility for continuity of patient care, the health care setting in which

the patient is receiving care is also responsible for evaluating the patient's needs and assuring that those needs can be met in the setting to which the patient is to be transferred. (v) Communication: Transfer of all pertinent information about the patient (such as the history and physical, record of course of treatment in hospital, laboratory tests, medication lists, advanced directives, functional, psychological, social, and other assessments), and the discharge summary should be completed before or at the time of transfer of the patient to another setting. Patients should not be accepted by the new setting without a copy of this patient information and complete instructions for continued care. (8) The AMA supports the position that the care of the patient treated and discharged from a treating facility is done through mutual consent of the patient and the physician; and (9) Policy programs by Congress regarding patient discharge timing for specific types of treatment or procedures be discouraged.

Citation: CSA Rep. 4, A-96; Reaffirmation I-96; Modified by Res. 216, A-97; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 1, A-08; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 16, A-19

**Activities of The Joint Commission and a Single Signature to Document the Validity of the Contents of the Medical Record H-225.965**

The AMA supports the authentication of the following important entries in the medical record, history and physical examinations, operative procedures, consultations, and discharge summaries. Unless otherwise specified by the hospital or medical staff bylaws, or as required by law or regulation, a single signature may document the validity of other entries in the medical record.

Citation: BOT Rep. 58, A-96; Reaffirmed: CLRPD Rep. 2, A-06; Modified: CMS Rep. 01, A-16; Reaffirmed: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717  
(A-22)

Introduced by: Resident and Fellow Section

Subject: Expanding the AMA's Study on the Economic Impact of COVID-19

Referred to: Reference Committee G

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1 Whereas, The 2019 Coronavirus Disease (COVID-19) pandemic has had a large impact on  
2 healthcare spending, utilization, and employment; and  
3

4 Whereas, The American healthcare system and hospital revenue drastically declined as a result  
5 of COVID-19, experiencing monthly financial losses on average exceeding \$50 billion dollars  
6 during the earliest months of the COVID-19 pandemic;<sup>1</sup> and  
7

8 Whereas, It has been estimated that the cancellation of elective surgeries and procedures as a  
9 result of the COVID-19 pandemic could cost the healthcare system and hospitals \$20-50 billion  
10 in revenue each month, with monthly net income losses exceeding \$5 billion dollars<sup>1,2,3</sup>; and  
11

12 Whereas, The economic support for offsetting the financial strain of the COVID-19 pandemic  
13 that was provided by the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act  
14 likely disadvantaged healthcare systems treating at-risk populations because it initially used a  
15 formula based on Medicare fee-for-service billings to distribute financial aid to hospitals<sup>3,4</sup>; and  
16

17 Whereas, Urban and rural hospitals, and other medical centers that disproportionately treat  
18 underserved populations may face higher existential threats due to lost revenue, higher costs,  
19 and other the economic burdens incurred during the COVID-19 pandemic<sup>3,5</sup>; and  
20

21 Whereas, The economic impact on residents and fellows seems to have been significant  
22 regarding job loss<sup>6</sup>; and  
23

24 Whereas, The AMA has become a predominant source of information regarding the economic  
25 impact on physicians and their practices during the COVID-19 pandemic<sup>7,8</sup>; and  
26

27 Whereas, The AMA has yet to study how the economic impact of the COVID-19 pandemic on  
28 hospitals, clinics, surgeons, students, residents, fellows, and patients with respect to lost  
29 revenue and unanticipated healthcare costs; therefore be it  
30

31 RESOLVED, That our American Medical Association work with relevant organizations and  
32 stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic  
33 on healthcare institutions in order to identify and better understand which groups of physicians,  
34 patients and organizations may have been disproportionately affected by the financial burdens  
35 of the COVID-19 pandemic (Directive to Take Action); and be it further  
36

37 RESOLVED, That our AMA work with relevant organizations and stakeholders to study the  
38 overall economic impact of office closures, cancellations of elective surgeries and interruptions  
39 in patient care, as well as the economic impact of utilizing telemedicine for an increasing  
40 percentage of patient care. (Directive to Take Action)

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

Received: 04/04/22

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**RELEVANT AMA POLICY**

**Physician Payment Advocacy for Additional Work and Expenses Involved in Treating Patients During the Covid-19 Pandemic and Future Public Health Emergencies D-390.947**

Our AMA: (1) will work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to recognize the additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; (2) will work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and (3) encourages interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.

Citation: Res. 114, I-20

**Creating a Congressionally-Mandated Bipartisan Commission to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic to Inform Future Efforts D-440.923**

1. Our AMA will advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness.
2. In advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA will seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.

Citation: Res. 211, I-20

**Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program  
D-305.953**

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.

Citation: Res. 202, I-20

**Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program  
D-385.951**

Our AMA and the federation of medicine will work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:

- Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;
- Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and
- Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period.

Citation: Res. 202, I-20

**Crisis Payment Reform Advocacy D-405.979**

Our AMA will continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19, and continue to advocate for reforms that support and sustain physician medical practices.

Citation: Res. 218, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718  
(A-22)

Introduced by: Illinois

Subject: Degradation of Medical Records

Referred to: Reference Committee G

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1 Whereas, Medical records have traditionally served to help the physician in the care of patients;  
2 and  
3

4 Whereas, The electronic health record (EHR) was initially viewed and welcomed as an asset  
5 assisting the care of patients; and  
6

7 Whereas, EHRs have not been an asset in assisting in the care of patients because of the  
8 subsequently mandated and marked increase in documentation which effectively obliterated the  
9 intended benefit; and  
10

11 Whereas, Adding the additional component of data entry to patient visits was apparently done  
12 without providing financial reimbursement for the required time to complete; and  
13

14 Whereas, The reality is that the need for extra data entry often impairs the physician's ability to  
15 care for the patient given the time pressure of the appointments; and  
16

17 Whereas, The burden of documentation impairs the doctor-patient relationship; and  
18

19 Whereas, The doctor-patient relationship has been a major incentive to practice primary care  
20 medicine; and  
21

22 Whereas, There is power in nomenclature and language; and  
23

24 Whereas, Mandated EHR documentation now more accurately represents "insurance and  
25 government reports" rather than "medical records" in the traditional sense; therefore be it  
26

27 RESOLVED, That our American Medical Association publish available data about the amount of  
28 time physicians spend on data entry versus direct patient care, in order to inform patients,  
29 insurers, and prospective primary care physicians about the real expectations of the medical  
30 profession. (Directive to Take Action)

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

Received: 04/07/22

**RELEVANT AMA POLICY****D-478.966 - Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records**

Our AMA will work with health care leaders and policymakers to use industrial engineering principles and evidence-based best practices to study and then propose systematic reforms to reduce physicians' electronic health record workload. Alt. Res. 716, A-17

**H-478.981 - Health Information Technology Principles**

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules. BOT Rep. 19, A-18 Reaffirmation: A-19



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719  
(A-22)

Introduced by: Ohio

Subject: System Wide Prior and Post-Authorization Delays and Effects on Patient  
Care Access

Referred to: Reference Committee G

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1 Whereas, The time and effort spent on prior authorization is a burden which negatively impacts  
2 the time physicians can spend caring for patients, negatively impacts the resiliency of  
3 physicians and the ability to provide high quality access to all patients; and  
4

5 Whereas, The AMA has policy prioritizing advocacy to ease prior authorization burdens and  
6 further advance prior authorization reforms (H-320.939, D-285.960); and  
7

8 Whereas, Current AMA policy, H-320.939, D-285.960 and related policies, have neither  
9 satisfactorily unyoked the practicing physicians' burdens on the topic of prior authorizations, nor  
10 created widespread real-time authentication best practice applications as may be seen in other  
11 industries, and  
12

13 Whereas, Health care insurers and Medicaid/Medicare Products have communication systems  
14 that cause excessive response times through creation of websites that are difficult to navigate,  
15 and submissions to these websites have neither a response to submissions nor a received  
16 confirmation; and  
17

18 Whereas, Prior authorization websites are inherently dysfunctional and promote delay, through  
19 excessive downtime, phone systems that take an average of 45 minutes or often greater than  
20 85 minutes in order to speak to a human insurance specialist, a high rate of disconnection while  
21 waiting on the phone with no call back option, limitation of the number of patients that can be  
22 authorized upon waiting with instructions to call back again to authorize other patients, Prior  
23 Authorization taking up to 14 days from the time submitted to await a decision, etc. to just name  
24 a few; and  
25

26 Whereas, There is no overseeing entity to review these unfair business practices which are  
27 substandard as compared with other entities who have upgraded their business models to  
28 ensure end user functionality and efficiency; and  
29

30 Whereas, It appears that these business practices by Health Care Insurers and  
31 Medicaid/Medicare Products are indirectly limiting, restricting or delaying patient care and  
32 unintentionally rationing of health care services; therefore be it  
33

34 RESOLVED, That our American Medical Association encourage and advocate health care  
35 insurers and Medicare/Medicaid Products to ensure that the systems of communication for prior  
36 authorization include: live personnel access, simplification of website navigation, immediate  
37 response with confirmation number of submission and an expedient decision for authorizations.  
38 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000  
Received: 04/08/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 720  
(A-22)

Introduced by: Illinois

Subject: Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety

Referred to: Reference Committee G

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1 Whereas, Insurance companies use pharmaceutical step therapy programs and non-medical  
2 drug switching policies as means to control costs; and  
3

4 Whereas, These policies can serve to try to replace a physician's judgment and interfere with  
5 the doctor-patient relationship; and  
6

7 Whereas, These policies can restrict patient access to effective treatments, putting patient  
8 health and safety in jeopardy by subjecting patients to potential adverse effects, and absorbing  
9 practice resources with burdensome approvals and documentation requirements; and  
10

11 Whereas, The process of nonmedical drug switching mandates that a patient go off their current  
12 therapies for no other reason than to save money, which can include increasing out-of-pocket  
13 costs, moving treatments to higher cost tiers or terminating coverage of a particular drug; and  
14

15 Whereas, The American College of Physicians (ACP) has recognized the need to balance costs  
16 and that any such programs should contain flexibilities so that physicians can, based on their  
17 knowledge of a patient's status and co-morbid conditions, be able to easily deviate from the  
18 usual approach to optimize patient care and minimize disruptions to effective care; and  
19

20 Whereas, The ACP has adopted recommendations to help physicians and patients who are  
21 subjected to these types of policies; therefore be it

1 RESOLVED, That our American Medical Association adopt policy supporting the  
2 recommendations of the American College of Physicians with respect to insurance step therapy  
3 and nonmedical drug switching policies, including:  
4

- 5 • All step therapy and medication switching policies should aim to minimize care  
6 disruption, harm, side effects and risks to the patient.  
7
- 8 • All step therapy and nonmedical drug switching policies should be designed with  
9 patients at the center, while accounting for unique needs and preferences.  
10
- 11 • All step therapy and nonmedical drug switching protocols should be designed with  
12 input from frontline physicians and community pharmacists; feature transparent,  
13 minimally burdensome processes that consider the expertise of a patient's  
14 physician; and include a timely appeals process.  
15
- 16 • Data concerning the effectiveness and potential adverse consequences of step  
17 therapy and nonmedical drug switching programs should be made transparent to  
18 the public and studies by policymakers. Alternative strategies to address the rising  
19 cost of prescription drugs that do not inhibit patient access to medications should  
20 be explored. (New HOD Policy)

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

Received: 04/08/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 721  
(A-22)

Introduced by: Resident and Fellow Section

Subject: Amend AMA Policy H-215.981, "Corporate Practice of Medicine"

Referred to: Reference Committee G

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1 Whereas, The American Academy of Emergency Medicine released a statement on the  
2 corporate practice of medicine and the effects on physician education, patient care and the  
3 physician-patient relationship<sup>1</sup>; and  
4

5 Whereas, The corporatization of medicine, at the expense of high quality, safe healthcare, has  
6 led to physicians being fired and replaced by mid-level providers, especially in states that allow  
7 independent practice for mid-level providers<sup>2</sup>; and  
8

9 Whereas, The corporate practice of medicine has led to situations in which physicians are  
10 expected to provide on-the-job training to mid-level providers before being dismissed, in effect  
11 "training their replacements"<sup>2</sup>; and  
12

13 Whereas, Postgraduate programs for mid-level providers have expanded at a rate far greater  
14 than for physician post-graduate training programs<sup>2</sup>; therefore be it  
15

16 RESOLVED, That our American Medical Association amend policy H-215.981, "Corporate  
17 Practice of Medicine," by addition to read as follows:  
18

19 4. Our AMA acknowledges that the corporate practice of medicine has led to the  
20 erosion of the physician-patient relationship, erosion of physician-driven care and  
21 created a conflict of interest between profit and training the next generation of  
22 physicians. (Modify Current HOD Policy)

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

Received: 04/08/22

### References:

1. [New Position Statement: State of Emergency Medicine | AAEM - American Academy of Emergency Medicine](#)  
Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020.

## **RELEVANT AMA POLICY**

### **Corporate Practice of Medicine H-215.981**

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Citation: Res. 247, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11;  
Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified: Res. 713, A-18;  
Reaffirmed: CMS Rep. 11, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 722  
(A-22)

Introduced by: Oklahoma

Subject: Eliminating Claims Data for Measuring Physician and Hospital Quality

Referred to: Reference Committee G

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1 Whereas, The US Centers for Medicare and Medicaid Services (CMS) has been publishing  
2 mortality data of hospitalized patients since 2008; and  
3

4 Whereas, Public reporting has been expanded to cover multiple quality measures by many  
5 entities over the past few years; and  
6

7 Whereas, The debate rages over whether to focus on outcomes versus care processes when  
8 assessing quality; and  
9

10 Whereas, The validity of outcomes measures is under scrutiny when the data used for reporting  
11 purposes is claims data; and  
12

13 Whereas, Any models that are used for assessing quality should be reliable and valid; and  
14

15 Whereas, Models using data on severity of illness consistently outperform models using only  
16 comorbidity data; and  
17

18 Whereas, Factors associated with severity of illness are the strongest predictors of quality; and  
19

20 Whereas, Data from hospital billing systems contain no factors associated with the severity of  
21 illness; and  
22

23 Whereas, Because of the variability of information in the medical record, claims data cannot  
24 reliably code comorbid conditions; and  
25

26 Whereas, It is time to eliminate measures based on claims data from public reporting and other  
27 programs designed to hold physicians and hospitals accountable for improving outcomes;  
28 therefore be it  
29

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

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

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

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

Received: 04/26/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 723  
(A-22)

Introduced by: American Medical Women's Association

Subject: Physician Burnout

Referred to: Reference Committee G

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1 Whereas, Burnout was an issue for physicians, especially women, prior to the pandemic; and

2  
3 Whereas, The reported rates of physician burnout have increased significantly to over 60%  
4 since the start of the pandemic; and

5  
6 Whereas, Physicians, especially women, are leaving the workforce due to professional and  
7 personal stressors and burnout that have exacerbated during the pandemic; and

8  
9 Whereas, Burnout can lead to mental health conditions, such as depression and anxiety; and

10  
11 Whereas, Hospital credentialing applications and renewals typically include questions about  
12 specific mental or physical health conditions and related treatments; and

13  
14 Whereas, Physicians are reluctant to seek mental health care due to concerns about the impact  
15 of that on their ability to gain or maintain hospital credentialing; and

16  
17 Whereas, The Joint Commission accredits over 20,000 organizations and programs in the  
18 United States; and

19  
20 Whereas, The goals of The Joint Commission and the Centers for Medicare and Medicaid  
21 Services are to set standards that improve care through assuring patient and staff safety; and

22  
23 Whereas, Physician reluctance to seek care can impact their wellbeing and that of their patients;  
24 be it therefore

25  
26 RESOLVED, That our American Medical Association work with the Centers for Medicare and  
27 Medicaid Services and The Joint Commission to assure that clinician, including physician,  
28 wellbeing is a component of standards for hospital certification (Directive to Take Action); and  
29 be it further

30  
31 RESOLVED, That our AMA work with hospitals and other stakeholders to determine areas of  
32 focus on clinician wellbeing, to include the removal of intrusive questions regarding clinician  
33 physical or mental health or related treatments on initial or renewal hospital credentialing  
34 applications. (Directive to Take Action)

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

Received: 05/09/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 724  
(A-22)

Introduced by: Texas

Subject: Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic

Referred to: Reference Committee G

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1 Whereas, The impact of COVID-19 has been evident in primary care physician and specialist  
2 offices throughout the nation; and  
3

4 Whereas, Government shutdowns and mandates have decreased the patient volume seen in  
5 physicians' offices as well as the volume of elective procedures (including inpatient and  
6 outpatient surgeries); and  
7

8 Whereas, In areas with a large proportion of Medicaid patients, the volume of patients needed  
9 to maintain practice viability could be as much as three times more than that in other areas; and  
10

11 Whereas, Daily patient volume has remained low throughout the pandemic; and  
12

13 Whereas, Currently uncompensated physician workload in this pandemic has increased  
14 because patient panel responsibility has remained unchanged; and  
15

16 Whereas, Federal, state, and commercial payers function primarily as fee-for-service; and  
17

18 Whereas, Uniformly decreased patient visits (services) across the nation leads to increased  
19 savings (revenue) for federal, state, and commercial payers; therefore be it  
20

21 RESOVLED, That our American Medical Association continue to advocate for and educate  
22 members about practice viability issues (Directive to Take Action); and  
23

24 RESOLVED, That our AMA work with private payers to encourage them to pass along savings  
25 generated during the pandemic to patients (Directive to Take Action); and  
26

27 RESOLVED, That our AMA advocate that all plans follow medical loss ratio requirements and,  
28 as appropriate and with particular mindfulness of the public health emergency, issue rebates to  
29 patients (Directive to Take Action); and  
30

31 RESOLVED, That our AMA urge health plans to offer practices per-patient-per-month fees for  
32 innovative practice models to improve practice sustainability. (Directive to Take Action)

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

Received: 05/09/22



## **RELEVANT AMA POLICY**

### **Insurance Industry Antitrust Exemption H-180.975**

It is the policy of the AMA (1) to continue efforts to have the insurance industry be more responsive to the concerns of physicians, including collective negotiations with physicians and their representatives regarding delivery of medical care;

(2) to continue efforts to have the insurance industry be more responsive to the concerns of physicians and their representatives regarding reasonable requests for appropriate information and data;

(3) to analyze proposed amendments to the McCarran-Ferguson Act to determine whether they will increase physicians' ability to deal with insurance companies, or increase appropriate scrutiny of insurance industry practices by the courts; and

(4) to continue to monitor closely and support appropriate legislation to accomplish the above objectives.

Citation: BOT Rep. DD, I-91; Reaffirmed: Res. 213, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmed: BOT Rep. 10, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19

### **Domestic Disaster Relief Funding D-130.966**

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.

2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass causality events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: (Res. 421, A-11; Reaffirmation A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 725  
(A-22)

Introduced by: Texas

Subject: Compensation to Physicians for Authorizations and Preauthorizations

Referred to: Reference Committee G

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1 Whereas, Insurance and managed care companies ("payers") demand authorization and  
2 preauthorization for coverage and for payment of prescriptions, laboratory tests, radiology tests,  
3 procedures, surgeries, hospitalizations, and physician visits; and  
4

5 Whereas, Other professionals, such as attorneys and accountants, bill and get paid for time  
6 spent personally and by their staff in providing services; and  
7

8 Whereas, The effect of such authorization and preauthorization is to delay and deny care, thus  
9 allowing payers to save, keep, and invest money that otherwise would provide patient care; and  
10

11 Whereas, Such authorization and preauthorization procedures cause unnecessary testing and  
12 delay of care, which may harm patients; and  
13

14 Whereas, The overwhelming majority of such authorization and preauthorization requests  
15 eventually are authorized by payers; and  
16

17 Whereas, Physicians and their staff spend onerous amounts of time and money on  
18 authorization and preauthorization procedures, thus increasing physician overhead while  
19 decreasing availability for patient care by physicians and their staff; and  
20

21 Whereas, Authorization and preauthorization procedures and their direct and indirect costs  
22 endanger the viability of private medical practices; and  
23

24 Whereas, Physicians are not compensated for such authorization and preauthorization  
25 procedures, which benefit payers to the detriment of patients and physicians; therefore be it  
26

27 RESOLVED, That the American Medical Association support legislation that requires insurance  
28 and managed care companies, including companies managing governmental insurance plans  
29 ("payers"), to compensate physicians for the time physicians and their staff spend on  
30 authorization and preauthorization procedures. Such legislation is recommended to include the  
31 following: Compensation shall be paid in full by payers to physicians without deductible,  
32 coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such  
33 processes imposed by payers. Physicians shall bill payers for time spent by physicians and their  
34 staff in performing such tasks at a rate commensurate with that of the most highly trained  
35 professionals. Payers shall pay physicians promptly upon receiving such a bill with significant  
36 interest penalties assessed for delay in payment. Billable services for authorization and  
37 preauthorization include, but are not limited to, time spent filling out forms, making telephone  
38 calls (including time spent negotiating phone trees and hold time), documenting in the patient's  
39 medical record, communicating with the patient, altering treatment plans (such as changing  
40 medications to comply with formularies), printing, copying, and faxing. (Directive to Take Action)

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

Received: 05/09/22

## **RELEVANT AMA POLICY**

### **Payer Measures for Private and Public Health Insurance D-180.984**

Our AMA will work with state medical associations, employer coalitions, physician billing services, and other appropriate groups to evaluate on an annual basis and recommend standards for "payer measures" for the insurance industry and government payers to be publicly reported for consumers that may include information such as:

1. Number of patients enrolled
2. Total company and individual plan revenue/expense and profit
3. Procedures covered and not covered by policy
4. Number of primary and specialist physicians
5. Number of denied claims (and %)
  - a. Number denied based on "pre-existing condition"
  - b. Number denied and later allowed
  - c. Number denied for no reason
6. Waiting time for authorization of common procedures
7. Waiting time for authorization of advanced procedures
8. Waiting time for payment
9. Morbidity and mortality due to denied or delayed care
10. Number of appeals by customers or physicians
11. Number of successful appeals by customers or physicians
12. Number of consumer complaints
13. Number of government fines/sanctions
14. Use of economic profiling of physicians to limit physicians on panel
15. Use of quality measures approved by qualified specialty societies

Citation: Res. 703, I-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 828, I-08; Reaffirmed: CMS Rep. 01, A-18

### **Strengthening the Accountability of Health Care Reviewers D-185.977**

Our AMA will continue to advocate that all health plans, including self-insured plans, be subject to state prior authorization reforms that align with AMA policy.

Citation: Res. 206, I-20

### **Managed Care H-285.998**

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.

(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.

(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.

With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role.

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.

In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 04, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21

**Prior Authorization Relief in Medicare Advantage Plans H-320.938**

Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
- b. Notify providers of any changes to PA requirements at least 45 days prior to change.
- c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
- d. Standardize a PA request form.
- e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and prescription medications that are routinely approved.
- f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.
- g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.
- h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
- i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Citation: Res. 814, I-18

**Prior Authorization and Utilization Management Reform H-320.939**

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.
4. Our AMA will advocate 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.

Citation: 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; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21

**Abuse of Preauthorization Procedures H-320.945**

Our AMA opposes the abuse of preauthorization by advocating the following positions:

- (1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen.
- (2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories, e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial.

Citation: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 125, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmed: CMS Rep. 4, A-21

**Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

- (1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require 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; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20

#### **Processing Prior Authorization Decisions D-320.979**

Our AMA will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends.

Citation: Res. 712, I-20

#### **Require Payers to Share Prior Authorization Cost Burden D-320.980**

Our AMA will petition the Centers for Medicare and Medicaid Services to require the precertification process to include a one-time standard record of identifying information for the patient and insurance company representative to include their name, medical degree and NPI number.

Citation: Res. 811, I-19

#### **Payer Accountability H-320.982**

Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis.

(2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission.

(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a

physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

Citation: CMS Rep. O, A-89; Reaffirmation A-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation A-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, I-14; Reaffirmation: I-17

#### **Prior Authorization Reform D-320.982**

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

#### **Preauthorization D-320.988**

1. Our AMA will conduct a study to quantify the amount of time physicians and their staff spend on nonclinical administrative tasks, to include (a) authorizations and preauthorizations and (b) denial of authorization appeals.
2. There will be a report back to the House of Delegates at the 2015 Annual Meeting
3. Our AMA will utilize its advocacy resources to combat insurance company policies that interfere with appropriate laboratory testing by requiring advance notification or prior authorization of outpatient laboratory services.

Citation: Sub. Res. 215, I-14; Reaffirmed: CMS Rep. 07, A-16

#### **Remuneration for Physician Services H-385.951**

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 726  
(A-22)

Introduced by: Texas

Subject: Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs

Referred to: Reference Committee G

Whereas, In battling the opioid epidemic, payers have required that physicians spend time reviewing controlled substances prescription history for patients prior to prescribing such medications via state prescription monitoring programs (PMPs); and

Whereas, Many states require that physicians electronically prescribe controlled substances; and

Whereas, Electronic health record platforms charge physicians separately and additionally for controlled substances electronic prescriptions; and

Whereas, Because of these additional expenses of time and money imposed by the state PMP requirements, many physicians have chosen to not prescribe controlled substances, thus causing avoidable pain and suffering to patients; and

Whereas, Increasing expenses of time and money endanger the private practice of medicine; therefore it be

RESOLVED, That our American Medical Association advocate for appropriate physician payment through the resource-based relative value scale to cover the expense of technology required to electronically prescribe controlled substances (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for appropriate physician payment to cover the extra time and expense to query state prescription monitoring programs as required by law. (Directive to Take Action)

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

Received: 05/09/22

## RELEVANT AMA POLICY

### Electronic Prescribing D-120.972

1. Our AMA will (a) ask the Drug Enforcement Administration to accelerate the promulgation of digital certificate standards for direct electronic transmission of controlled substance prescriptions to support the patient safety goals and other governmental initiatives; and (b) urge Congress to work towards unifying state prescription standards and standard vocabularies to facilitate adoption of electronic prescribing.



2. Our AMA will support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when a valid patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care.

Citation: Res. 525, A-05; Reaffirmed in lieu of Res. 215, I-08; Reaffirmation A-09; Appended: Res. 237, A-18; Appended: Res. 250, A-18; Modified: BOT Rep. 20, A-19

### **Completing the Electronic Prescription Loop for Controlled Substances D-120.945**

Our AMA will seek from the US Drug Enforcement Administration (DEA) and/or Centers for Medicare & Medicaid Services (CMS) a requirement that all pharmacies and Pharmacy Benefits Managers (PBMs) acquire and implement the appropriate electronic prescribing of controlled substances (EPCS) software application to accept electronically transmitted controlled substance prescriptions from any physician or hospital-based computer system that complies with CMS and DEA certification requirements on e-scribing.

Citation: Res. 208, A-14; Reaffirmed: BOT Rep. 20, A-19

### **Federal Roadblocks to E-Prescribing D-120.958**

1. Our AMA will: work with the Centers for Medicare and Medicaid Services and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs, including removal of the Medicaid requirement in all states that continue to mandate that physicians write, in their own hand, brand medically necessary or the equivalent on a paper prescription form.

2. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of e-prescribing.

3. Our AMA will work with the largest and nearly exclusive national electronic pharmacy network, all related state pharmacy regulators, and with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.

4. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.

5. Our AMA will work to substantially reduce regulatory burdens so that physicians may successfully submit electronic prescriptions for controlled substances.

6. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.

7. Our AMA will work with the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions for prescription drugs.

Citation: Res. 230, A-08; Reaffirmed in lieu of Res. 215, I-08; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 244, A-12; Appended: Res. 714, A-13; Appended: Res. 203, A-14; Modified: BOT Rep. 06, I-17; Reaffirmed: BOT Rep. 20, A-19

### **Safe and Efficient E-Prescribing H-120.921**

Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

A. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.

B. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.

C. Implementation teams to prioritize the adoption of features like structured and codified Sig

formats that can help address quality issues, allowing for free text when necessary.

D. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.

E. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.

F. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.

G. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.

H. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.

i. Organizational leadership to designate e-prescribing as the default prescription method.

J. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.

K. States to allow integration of PDMP data into EHR systems.

L. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.

M. Functionality supporting the electronic transfer and cancellation of prescriptions.

Citation: BOT Rep. 20, A-19

### **Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947**

Our AMA:

(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;

(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;

(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperable, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;

(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;

(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;

(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;

(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;

(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and

(9) will seek clarification from SAMHSA on whether opioid treatment programs and other

substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Citation: BOT Rep. 3, A-08; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16; Appended: BOT Rep. 13, A-17

**Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs H-95.920**

Our AMA: (1) will advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care; (2) urges EHR vendors and Health Information Exchanges (HIEs) to increase transparency of custom connections and costs for physicians to integrate their products in their practices; (3) supports state-based pilot studies of best practices to integrate EHRs, HIEs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring; (4) supports initiatives to improve the functionality of state PDMPs, including: (a) lessening the time delay between when a prescription is dispensed and when the prescription would be available to physicians through a PDMP; and (b) directing state-based PDMP’s to support improved integrated EHR interfaces; and (5) will advocate, at the state and national levels, to promote Prescription Drug Monitoring Program (PDMP) integration/access within Electronic Health Record workflows (of all developers/vendors) at no cost to the physician or other authorized health care provider.

Citation: BOT Rep. 07, I-18; Appended: Res. 244, A-19

**Support for Prescription Drug Monitoring Programs H-95.929**

Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.

Citation: Res. 218, I-16

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 727  
(A-22)

Introduced by: Texas

Subject: Utilization Review, Medical Necessity Determination, Prior Authorization  
Decisions

Referred to: Reference Committee G

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1 Whereas, Prior authorization requirements are increasing in number yearly, and this burden is  
2 driving administrative costs to an estimated \$68,274 per physician per year, which equates to  
3 \$31 billion annually, according to *Health Affairs*; and  
4

5 Whereas, Prior authorizations delay care and create obstacles to patients receiving optimal  
6 care. A recent American Medical Association survey reported 91% of physicians said prior  
7 authorization had a significant or somewhat negative impact on their patients' clinical outcome,  
8 and 28% said prior authorization intrusion led to a serious adverse event for a patient under  
9 their care; and  
10

11 Whereas, Decisions made by insurance medical directors, physicians conducting utilization  
12 reviews, and physicians providing peer-to-peer reviews on behalf of insurance companies affect  
13 patient care and can lead to adverse outcomes; therefore be it  
14

15 RESOLVED, That the American Medical Association advocate for implementation of a federal  
16 version of Texas' "gold card" law (House Bill 3459), which aims to curb onerous prior  
17 authorization practices by many state-regulated health insurers and health maintenance  
18 organizations (Directive to Take Action); and be it further  
19

20 RESOLVED, That our AMA House of Delegates adopt a similar policy to Texas's "gold card" law  
21 (House Bill 3459) (Directive to Take Action); and be it further  
22

23 RESOLVED, That our AMA request that the Council on Ethical and Judicial Affairs devise  
24 ethical opinions similar to the Texas Medical Association's Board of Councilors' opinions  
25 regarding medical necessity determination and utilization review. (Directive to Take Action)

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

Received: 05/09/22

### RELEVANT AMA POLICY

#### Utilization Review by Physicians H-320.973

1. It is the policy of the AMA to urge its constituent medical associations to (a) seek the enactment of legislation requiring that utilization review for insurers shall be conducted by physicians licensed by the state in which they are doing the review; and (b) seek enactment of legislation that would require all agencies or groups doing utilization review to be registered with the appropriate health regulatory agency of the state in which they are doing review and to have an appropriately staffed office located in the state in which they are doing the review.

2. Our AMA will continue to work with state medical associations to monitor utilization management policy

to ensure that hospital admissions are reviewed by appropriately qualified physicians and promote related AMA model legislation.

Citation: Sub. Res. 175, A-90; Reaffirmation A-97; Reaffirmation A-06; Appended: CMS Rep. 1, I-14; Reaffirmation: A-18

### **Principles of Drug Utilization Review H-120.978**

Our AMA adopts the following Principles of Drug Utilization Review.

Principle 1: The primary emphasis of a DUR program must be to enhance quality of care for patients by assuring appropriate drug therapy. Characteristics: (a) While a desired therapeutic outcome should be cost-effective, the cost of drug therapy should be considered only after clinical and patient considerations are addressed; (b) Sufficient professional prerogatives should exist for individualized patient drug therapy.

Principle 2: Criteria and standards for DUR must be clinically relevant. Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.

Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process. Characteristics: (a) The criteria and standards development and revision process should allow for and consider public comment in a timely manner before the criteria and standards are adopted. (b) The criteria and standards development and revision process should include broad-based involvement of physicians and pharmacists from a variety of practice settings. (c) The criteria and standards should be reviewed and revised in a timely manner. (d) If a nationally developed set of criteria and standards are to be used, there should be a provision at the state level for appropriate modification.

Principle 4: Interventions must focus on improving therapeutic outcomes. Characteristics: (a) Focused education to change professional or patient behavior should be the primary intervention strategy used to enhance drug therapy. (b) The degree of intervention should match the severity of the problem. (c) All retrospective DUR profiles/reports that are generated via computer screening should be subjected to subsequent review by a committee of peers prior to an intervention. (d) If potential fraud is detected by the DUR system, the primary intervention should be a referral to appropriate bodies (e.g., Surveillance Utilization Review Systems). (e) Online prospective DUR programs should deny services only in cases of patient ineligibility, coverage limitations, or obvious fraud. In other instances, decisions regarding appropriate drug therapy should remain the prerogative of practitioners.

Principle 5: Confidentiality of the relationship between patients and practitioners must be protected.

Characteristic: The DUR program must assure the security of its database.

Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.

Principle 7: The DUR program operations must be structured to achieve the principles of DUR.

Characteristics: (a) DUR programs should maximize physician and pharmacist involvement in their development, operation and evaluation. (b) DUR programs should have an explicit process for system evaluation (e.g., total program costs, validation). (c) DUR programs should have a positive impact on improving therapeutic outcomes and controlling overall health care costs. (d) DUR programs should minimize administrative burdens to patients and practitioners.

Citation: (BOT Rep. PPP, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 6, A-03; Reaffirmed: CMS Rep. 4, A-13)

### **Medical Necessity and Utilization Review H-320.942**

Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery.

Citation: Res. 810, I-16; Reaffirmation: A-18