judgment, and stress due to the potential risk to the patient. The practice expense components include clinical staff time, medical supplies, and medical equipment.
The process of valuing CPT codes on the RBRVS contributes to determining whether use of modifier 25 is warranted. Global procedure CPT codes are valued to include pre-service (e.g., evaluation time, patient positioning, scrub/dress/wait time), intra-service (e.g., performing the procedure, also known as "skin-to-skin" time), and post-service (e.g., patient stabilization, communicating with the patient and other professionals) work.

For example, Medicare payment for CPT code 64635 (*Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint*), includes 28 minutes pre-service time. Reporting a problem-oriented Office or Other Outpatient E/M code in addition to CPT code 64635 when evaluation is limited to assessing the specific problem is essentially double billing for the pre-service evaluation. Therefore, use of modifier 25 would not be appropriate in this situation.

However, when a patient presents for their annual skin examination and a suspicious lesion is discovered, it is appropriate for the physician to proceed with a diagnostic or therapeutic procedure at the same visit after obtaining the patient's medical history, completing a review of systems, and conducting a clinical examination. This situation would warrant the use of modifier 25. The ability to assess and intervene during the same visit is optimal for patients who subsequently may require fewer follow-up visits and experience more immediate relief from their symptoms.

MULTIPLE PROCEDURE PAYMENT REDUCTIONS

In addition to two E/M services or a procedure plus an E/M service, "multiple services" can refer to two or more procedures provided by the same physician during a single patient encounter. Payers may utilize the CMS Multiple Procedure Payment Reduction (MPPR) policy to adjudicate claims involving more than one procedure.

Under the MPPR, Medicare makes full payment for the professional component (PC) and technical component (TC) of the highest priced procedure. Payment is made at 50 percent for subsequent PC services furnished by the same physician to the same patient in the same session on the same day. Payment is made at 50 percent for subsequent TC services furnished by the same physician to the same patient in the same session on the same day.[10]

The rationale behind CMS' MPPR policy is similar to that of its global surgical package definitions in that "most medical and surgical procedures include pre-procedure, intra-procedure, and post-procedure work. When multiple procedures are performed at the same patient encounter, there is often overlap of the pre-procedure and post-procedure work. Payment methodologies for surgical procedures account for the overlap of the pre-procedure and post-procedure work."[11]

CLAIMS ADJUDICATION AND COMPLIANCE

Policies on payment for multiple services during a single patient encounter are typically communicated via claims adjudication with the use of coding edits. Most private payers utilize customizable, propriety claims edit systems, while Medicare and Medicaid use the coordinated National Correct Coding Initiative (NCCI).

NCCI reinforces Medicare policies, and since it is common for private payers to adopt NCCI as part of their customizable claims editing systems, allowing physicians the opportunity to comment on NCCI takes on increased importance. Through a process coordinated by CMS and the AMA, national medical specialty societies are able to review and comment on proposed NCCI updates on a quarterly basis. In recent years, however, the NCCI review process has become less transparent and the AMA has continued to advocate toward a return to the "solid, transparent, collaborative track among all parties (CMS, AMA and specialty societies) that has been so beneficial in the past." (June 2021 letter, November 2021 letter)

Edits on code pairs may be overridden by appending the appropriate modifier on one of the codes. For example, NCCI includes an edit on the codes for vision screening (CPT code 99173) and a level 3 established patient Office or Other Outpatient visit (CPT code 99213) – but allows override of the edit with use of the appropriate modifier (i.e., modifier 25 appended to 99213). Payers' increased use of claims edits has resulted in a commensurate increase in physicians' use of modifiers in an effort to override restrictive payment polices. However, that strategy may backfire as some payers' code auditing processes will flag all claims billed with modifier 25 for prepayment claim validation prior to payment. Once a claim is validated, it is either released for payment or denied for incorrect use of

the modifier. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. If claim history or assigned diagnosis codes do not indicate that significant, separately identifiable services were performed, payers typically cover the primary procedure or other service and deny the secondary E/M billed with modifier 25.

Some payers have instituted policies where use of modifier 25 triggers an automatic reduction in payment for the second code to account for what they perceive to be "overlap" between the two codes (e.g., a Preventive Medicine Service E/M code reported with an Office or Other Outpatient Service E/M code appended with modifier 25 allows payment of the Preventive Medicine Service code at 100 percent and the Office or Other Outpatient code at 50 percent). While the work associated with performing the history, physical examination, and MDM for the problem-oriented E/M service may include some overlap with those performed as part of the comprehensive preventive medicine E/M service, the physician's use of modifier 25 signals that they performed a significant, separately identifiable problem-oriented E/M service. An insignificant or trivial problem or abnormality is not reported separately from the preventive medicine E/M service.

Reporting both preventive and problem-oriented E/M services during a single patient encounter can produce inconsistent results in terms of claims payment across payers. While some payers will pay the full allowable amount for both the problem-oriented E/M code and the preventive medicine services E/M code, some will assess a co-pay for each service, some will carve out the payment for the problem-oriented E/M service from the payment for the preventive medicine E/M service (which results in a total charge that does not exceed that of a comprehensive preventive examination alone), and some will reject the claim on the basis that they do not accept coding for both a preventive and problem-oriented service on the same date regardless of the amount of the charge due to the perception of overlap between the two services. In response, physicians may decide to report only one of the services, depending on which of the two is the primary focus of the visit and requires the most amount of physician time and work; however, this is not a tenable solution as it fails to recognize the value of services provided. Alternatively, the physician may ask the patient to return for another visit to address the management of the problem or the preventive care; however, many physicians are hesitant to do this as it places significant burden on patients, particularly those with limited resources, and may risk deterioration of the patient's condition until another appointment can be scheduled.

Certain payers have considered requiring documentation for all modifier 25 claims. Most recently, Cigna proposed a policy requiring practices to send documentation with "a cover sheet indicating the office notes support the use of modifier 25 appended to the E/M code."[12] While advocacy by the California Medical Association and the AMA was initially able to delay implementation, Cigna has re-released the policy, which was scheduled to become effective in May 2023. At the time this report was written, the AMA was preparing a sign-on letter to allow state medical associations and national medical specialty societies to join in opposition against Cigna's policy. Previous AMA advocacy efforts opposing proposed modifier 25 payment reductions by Anthem (November 2017) and UnitedHealthcare (July 2018) have proven successful.

Misunderstanding and/or misuse of modifier 25 has made it a top billing compliance risk area. It has been the focus several False Claims Act and civil monetary penalty settlements,[13] as well as CMS comparative billing reports (CBR). The CMS CBR program is an educational tool intended to encourage accurate reporting and support physicians' internal compliance activities. A CBR tracks a given physician's billing patterns as compared to their peers' patterns within a Medicare service area. Since CBRs are private and shared only with the physician, CMS is able to maintain that "receiving a CBR is not an indication of or precursor to an audit, and it requires no response on a provider's part."[14]

Compliance is impacted by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which only allows extrapolation of overpayments based on statistical sampling when there's "a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error."[15] If an audit does not use a random sample of claims, MMA dictates that extrapolation of that sample invalidates any claim of overpayment.

AMA POLICY

The AMA has robust policy to guide advocacy for appropriate payment for multiple services performed during a single patient encounter.

Among the most relevant policies are those that:

- Focus on recognition of modifier 25 by:
  - Advocating for the acceptance of CPT modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers (Policy D-70.971);
  - Aggressively and immediately advocating through any legal means possible to ensure that when an E/M code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate (Policy D-385.956);
  - Supporting insurance company payment for E/M services and procedures performed on the same day (Policy H-385.944); and
  - Advocating that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure (Policy D-70.959).

- Preserve discrete E/M code levels by:
  - Communicating to CMS and private payers that the current levels of E/M services should be maintained and not compressed, with appropriate payment for each level (Policy D-70.979) and
  - Opposing any health insurance code collapsing policies that result in unfair payment practices (Policy H-70.995).

- Combat bundling and downcoding by:
  - Opposing the bundling of procedure and laboratory services within the E/M services (Policy H-70.985);
  - Opposing the use of time elements to deny or downgrade services submitted based on a cumulative time (Policy H-70.976);
  - Advocating to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately coded services (Policy H-70.949);
  - Vigorously opposing the practice of unilateral, arbitrary recoding and/or bundling by all payers (Policy H-70.937);
  - Introducing or supporting legislation that would require managed care plans to be monitored and prohibited from the arbitrary and inappropriate bundling of services to reduce payment (Policy H-70.962); and
  - Working with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies (Policy
  - H-70.980).

AMA policy targets payer policies that deviate from CPT guidelines, such as those that:

- Oppose inappropriate bundling of medical services by third party payers (Policy D-70.983);
- Support the recognition and payment for all CPT codes by all third party payers (Policy H-70.974);
- Seek legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers (Policy H-70.954);
- Intensify efforts to ensure uniform application of coding principles (Policy H-70.986);
- Assure that CMS and local carriers appropriately reimburse all E/M services (Policy H-385.952);
- Develop national (state) standards and model legislation that require full disclosure in plain English of multiple procedure reimbursement policies (Policy H-285.946);
- Step up ongoing review of the proper use of CPT codes in medical billing claims payments by the US Health Insurance Industry (Policy D-385.949);
- Support the elimination of Medicare arbitrary visit frequency parameters (Policy H-280-974); and
- Pursue proper use of CPT codes, guidelines, and modifiers by software claims editing vendors and their customers (Policy H-70.927).

Given that CPT is copyrighted by the AMA, there are many policies that support the development, updating, and maintenance of clinically valid codes in order to accurately reflect current clinical practice and innovation in medicine, including those that:

- Work with CMS to continue to refine E/M coding (Policy H-70.961);
- Advocate that the Department of Health and Human Services designate CPT guidelines and instructions as contained in the CPT codebook and approved by the CPT Editorial Panel as the national implementation standards for CPT codes (Policy D-70.987); and
- Limit future efforts to substantially revise E/M codes to the CPT Editorial Panel (Policy H-70.921) to appropriately allow the accurate reporting of E/M services provided by all physicians (Policy H-70.982).

AMA policy advocates that payer policies must align with CPT guidelines and reduce the burden of documentation for E/M services (Policy H-70.952), including opposition to the requirement that all Level 4 or Level 5 E/M codes require submission of medical record documentation (Policy D-70.991). Furthermore, AMA policy indicates that payer audit tools must be based on the factors for arriving at complexity as defined in the CPT codebook (Policy H-70.918).

The AMA is invested in ensuring that CPT codes are appropriately valued on the RBRVS via the RUC process. AMA policy advocates that annually updated and rigorously validated RBRVS values should provide a basis for physician payment schedules, opposes CMS' policy that reduces payment for additional surgical procedures after the first procedure by more than 50 percent, and encourages third party payers and other public programs to utilize the most current CPT codes, modifiers, and RBRVS relative values (Policy D-400.999). CMS is urged to adopt RUC recommendations for new and revised CPT codes (Policy H-400.969).

AMA policy supports development of CPT educational programs for physicians and health insurance carriers (Policy H-70.993) and working with national medical specialty societies to educate their members concerning CPT coding issues (Policy H-70.973). Policy H-400.972 states that the AMA will take all necessary legal, legislative, and other action to assure that all modifiers are well publicized and include adequate descriptors.

In addition to advocating for compliance with CPT modifier 25 guidelines, AMA policy has addressed other relevant issues:

- Recognition of modifiers 54, 55, and 56 for postoperative care of surgical patients (Policy D-70.955) and modifier 26 to report the professional component separate from the technical component for the interpretation of laboratory tests (Policy D-70.957);
- Appropriate payment for office-based procedures (Policy H-330.925), emergency care (Policy H-130.978), telephone consultations (Policy H-390.889), counseling of serious medical problems (Policy H-385.977), diagnostic and laboratory panel tests (Policy H-390.923 and Policy H-70.950), vaccine administration (Policy D-440.937), consultations (Policy D-70.953 and Policy H-70.939), care plan oversight services (Policy H-70.960), and after hours services (Policy H-385.940);
- Delineation of the physician role and responsibility in supervising patient care in non-office ambulatory settings, including fair and equitable payment for those services (Policy H-70.991);
- Insurer recognition of CPT codes that allow primary care physicians to report and receive payment for physical and behavioral health care services provided on the same date of service (Policy H-385.915);
- Development of coding for non-physician services (Policy H-70.994); and
- Appropriate payment for the additional work and expenses required in treating patients during the COVID-19 pandemic (Policy D-390.947).

DISCUSSION

There is currently robust infrastructure to allow the reporting of multiple services during a single patient encounter. However, there may be a need to ensure that key stakeholders are well educated on the various reporting options. It is essential that both physicians and payers understand the nuanced concepts involved, such as existing CPT nomenclature, how the RUC process eliminates overlap of physician work and practice expense between services and procedures, and how appropriate reporting and payment for multiple services can lead to greater value to the patient, improved access to care, increased patient satisfaction, and improved overall patient care.

With the ongoing development of coding resources, it is imperative that CMS align with CPT guidelines in order to reduce potential confusion. For example, CPT and CMS do not presently agree on the interpretation of the Prolonged Service CPT codes, which have a direct bearing on physicians' ability to accurately report multiple services during a single patient encounter. This has resulted in many payers challenging physicians' use of the Prolonged Service codes or denying them all together. As such, the AMA is strongly advocating for alignment of CMS's interpretation of the Prolonged Service codes with the CPT definition. This approach is consistent with past AMA advocacy initiatives, most of which have been successful in reducing the gaps between CMS and CPT.

A comprehensive education on the appropriate reporting of multiple services should start early in physicians' careers, possibly during residency. A curriculum could focus on concepts such as how to use total visit time to report a higher-level E/M service rather than two E/M codes plus modifier 25, allowing them to bypass the administrative rigor imposed by payers who routinely flag modifier 25 claims. It would be ideal if a similar curriculum could be shared with, and undertaken by, the payer community, possibly through organizations such as America's Health Insurance Plans. With these potential resolutions, both "sides" would be cognizant of the guidelines, fostering full transparency between claims submission and claims adjudication.

As of 2021, 78 percent of office-based physicians used certified EHR systems.[16] Most EHRs include software tools to help physicians determine the appropriate E/M codes for patient encounters and when used correctly, they support accurate coding. However, these EHR-based computer-assisted E/M coding (CAEMC) tools are generally associated with higher levels of E/M coding due to factors such as "cloning" of documentation from the previous visit, which may contribute to restrictive payer policies that require burdensome documentation in order to justify payment. OIG is concerned about EHRs "aiding" providers with coding and documentation decisions, but there has been limited testing of how EHRs capture and use information to recommend E/M codes.

EHR CAEMC tools are limited in their ability to assist physicians in documenting and reporting multiple services. As such, it may be beneficial for EHR CAEMC tools to be developed to facilitate the appropriate reporting of modifier 25. Such tools might include an algorithm to ascertain the potential areas of perceived overlap between two services, which could then be synchronized to the documentation provided for each service.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 824-I-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support mechanisms to report modifiers appropriately with the least administrative burden possible, including the development of electronic health record tools to facilitate the reporting of multiple, medically necessary services supported by modifier 25.

2. That our AMA support comprehensive education for physicians and insurers on the appropriate use of modifier 25.

3. That our AMA reaffirm Policy D-70.971, which advocates for the acceptance of Current Procedural Technology (CPT®) modifiers, particularly modifier 25, and the appropriate alteration of payment based on CPT modifiers.

4. That our AMA reaffirm Policy D-385.956, which directs the AMA to aggressively and immediately advocate through any legal means possible to ensure that when an evaluation and management (E/M) code is reported with modifier 25, that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate.

5. That our AMA reaffirm Policy H-385.944, which supports insurance company payment for E/M services and procedures performed on the same day.

6. That our AMA reaffirm Policy D-70.959, which advocates that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure.

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8. IMPACT OF INTEGRATION AND CONSOLIDATION ON PATIENTS AND PHYSICIANS

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policy H-160.885

At the 2022 Interim meeting, the Council presented CMS Report 3 which was informational and provided background on the broad issue of health system consolidation. Consistent with Policy D-215.984, which requested regular updates, this report examines the impact of horizontal and vertical integration on health care prices and spending, patient access to care, quality of care, and physician wages and labor. This report also includes an

overview of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) merger review process and how physicians can play a role in preventing anticompetitive behavior and outcomes.

BACKGROUND

It is important to distinguish the difference between horizontal integration and vertical integration. A horizontal transaction often refers to a merger, purchase, or acquisition of an entity. Horizontal integration (or consolidation) reflects arrangements between entities that "operate in a similar position along the production process,"[1] meaning that they offer the same services and compete with one another. One hospital acquiring or merging with another hospital would be considered horizontal consolidation. Vertical integration reflects arrangements between entities that "operate at different points along the production process,"[2] meaning that they do not directly compete with one another. An example of this could be a hospital acquiring a physician practice. For the purposes of this report, hospital-hospital mergers will be referred to as horizontal consolidation, while hospital-physician practice transactions will be referred to as vertical integration, although the latter may also have horizontal aspects if the hospital already owned other physician practices before the transaction. We note that mergers and acquisitions are complex economic issues and recognize that there are many different types of transactions – and nuances within each of those transactions – but the Council has chosen to focus on these two types of transactions for this report.[3]

HOSPITAL-PHYSICIAN INTEGRATION AND HOSPITAL-HOSPITAL CONSOLIDATION

This report specifically addresses the impact of hospital-hospital horizontal consolidation and hospital-physician vertical integration on physicians, patients, and local markets. At the onset, an important distinction to make is that private equity investment in a hospital or a physician practice is not the same as vertical or horizontal integration, but instead is an issue of a change in ownership. Recently there has also been an uptick in the number of physicians employed by corporate-owned or publicly traded practices (i.e., CVS, Amazon). While these are also prevalent issues in health care, they are not the focus of this report, and we would encourage members to reference CMS Report 2-I-22, Corporate Practice of Medicine, for more information on this topic.

In the United States, 90 percent of Metropolitan Statistical Areas (MSAs) are considered concentrated for hospital services, and 65 percent of MSAs are considered concentrated for outpatient specialty care. Research suggests that the impact of hospital-hospital horizontal consolidation includes higher prices for services, higher insurance premiums and consumer cost sharing, lack of quality gains and decrements in the patient experience. Hospital markets are not the only component of care delivery that is concentrated, with an estimated 39 percent of MSAs considered concentrated for primary care physicians and 65 percent for specialty care. Rising prices and reduced choice for patients are often the outcome following hospital-hospital consolidation and/or hospital-physician integration.[4]

Vertically integrated health care entities may engage in a range of potentially anticompetitive behaviors, including raising prices, excluding rivals (or raising their costs), bargaining with health plans to demand higher prices for affiliated providers, and including anticompetitive terms in their contracts (such as restrictive covenants on employed physicians).[5]

Although billions of dollars in COVID-19 federal relief funds have been dispersed across the health care industry, a majority of the funding has gone to large hospital systems. This has left many independent physician practices to suffer reductions in patient visits and revenues, making them vulnerable to hospital-physician practice vertical integration.[6] The risks such transactions pose to patients include higher prices, increased spending, and reduced choice. The economic impact of the COVID-19 pandemic on independent physician practices has accelerated pressure for vertical integration between hospitals and physician practices. Remaining independent physician practices are under financial strain due to the economic impact of the pandemic, and even those who previously resisted acquisition face new pressure to sell to large hospital systems or private equity investors for financial stability and survival.[7]

Data from the AMA's 2022 Physician Practice Benchmark Survey indicates that physicians in practices wholly owned by physicians have decreased from 60 percent to 47 percent from 2012 to 2022. Conversely, physicians in practices wholly or jointly owned by hospitals have increased from 23 percent to 31 percent over the same time period. In 2022, ten percent of physicians were directly employed by or contracting with a hospital (up from six percent in 2012). While there are many factors driving these changes, it is important to note the trends in physician practice ownership over the last decade.

Impact on Health Care Prices and Costs

Evidence suggests that hospital-physician integration leads to higher health care prices – including higher hospital prices, percent higher physician prices, and 10-20 percent higher total expenditures per patient.[8] Prices have been shown to increase in hospitals following such integration. The harms of hospital-hospital consolidation also include higher prices for patients.[9]

There are several ways hospital-physician integration can increase health care prices. These include the addition of facility fees that hospitals can charge for outpatient services provided by acquired physicians, increased market power when negotiating with payers, and direct referrals of captive physician practices to a greater extent than independent physicians not related to the hospital system, which could increase referrals to higher-cost providers and services.[10]

Generally, prices will ascend to the level a market will pay. If a certain entity has market power, prices can rise to offset rising expenses and declining patient volume.[11] According to a paper prepared for Congress by economists Martin Gaynor, Farzad Mostashari, and Paul B. Ginsburg addressing horizontal consolidation of hospitals, hospitals without local competitors are estimated to have prices nearly 16 percent higher on average than hospitals with four or more competitors, which is a difference of nearly $2,000 per admission.[12] A large body of economic literature summarized by Gaynor in 2021 found substantial increases in hospital prices as a result of hospital-hospital consolidation. Increases are widely seen, but vary significantly, from three percent to 65 percent. A 2019 study by Cooper et al., found an average price increase of six percent as a result of hospital mergers, and Arnold and Whaley (2020) found an average price increase of 3.9 percent.[13,14,15,16]

Impact on Patient Access to Care

Current data on the impact hospital-physician integration has on patient access to care is limited, making this issue one to continue to monitor. Nonetheless, the Council is concerned that vertical integration may lead to a more difficult environment for the remaining physician-owned practices in terms of competition and referral steering. To the extent that consolidation may narrow networks or make areas harder for new practices to enter, this may have the effect of reducing patient choice. Thus far, there have only been two peer reviewed studies that examined the effect of vertical integration of hospitals and physician practices on access to care.[17]

Increased vertical integration in health care could also potentially reduce consumer choice by creating larger, exclusive networks and driving patients and health plans to pay higher prices. Data does not yet indicate that these higher costs and reductions in choice among independent providers are offset by higher quality or efficiency from improved care coordination. As vertical integration continues to occur, states are increasingly searching for ways to curb the rising costs and loss of choices.[18]

Data on the impact of hospital-hospital consolidation are also limited. There have been two recent studies that examine the effect of consolidation on rural hospitals specifically, but there is no conclusive data on other markets. Henke et al., (2021) found that merged rural hospitals were more likely than independent hospitals to eliminate maternal, neonatal, and surgical care services. There was also a decrease in the number of mental health and substance use disorder-related stays. However, there is an important caveat to consider: without a merger a rural hospital may be forced to close and even limited services would be eliminated from a community entirely.[19,20] Similarly, O'Hanlon et al. (2019), found that rural hospitals that became affiliated with integrated health systems experienced a significant reduction in diagnostic imaging technologies, obstetric and primary service availability, and outpatient nonemergency visits.[21,22] While these results could be an early indication of a trend following hospital-hospital consolidation, more evidence is needed before conclusions can be drawn. For more information on Rural Health Care, please see CMS Report 9-A-23.

Impact on Quality of Care

Empirical studies examining the effect of vertical integration of hospitals and physician practices on quality of care showed mixed effects.[23] Findings from two studies suggest no effects on quality of care while two other studies using data from the American Hospital Association (AHA) found mixed effects. The findings of the studies using

AHA data suggest that organizations that are fully clinically integrated had small positive effects on some measures of quality while arrangements that were not fully clinically integrated had no effect on the quality of care.[24] Studies on hospital-hospital consolidation on quality of care are also inconclusive. Some have found no change in the quality of care while others have shown a decrease in the quality of care. A 2020 study by Beaulieu et al., examined 246 hospital mergers between 2007 and 2016 and found that relative to similar hospitals that did not experience a merger, hospitals acquired in a merger saw no significant differential change in 30-day readmission rate and 30-day mortality rate in the Medicare population. Interestingly, patient experience measures declined. However, it is important to note that the association between mergers and declines in patient experience does not necessarily imply causality; other factors may be in play. Therefore, one should be cautious in the interpretation of those findings. Additionally, it is important to note that data on the impact of integration and consolidation on quality is meaningless without clearly defined quality metrics.[25,26]

Impact on Physicians

The AMA has long supported physician-led care teams and physician supervision of non-physicians. When either hospital-physician integration or hospital-hospital consolidation occurs, motives may shift to focus on profit and physicians may be replaced with non-physician practitioners in an effort to achieve cost savings. However, emerging data suggests that a provider mix (i.e., the number of physicians vs. non-physician practitioners) shift occurs in the years following a merger or acquisition, with physicians being replaced by non-physicians to lower costs and increase profits. Emerging data suggest shifting more patients to non-physician practitioners could ultimately increase cost and simultaneously decrease quality of care.

Available data from recent studies on the impact of vertical integration on health care wages and labor supply are limited, insufficient, and ultimately, inconclusive. In terms of compensation, a 2021 study by Whaley, Arnold, et.al., found that ownership of a physician's practice by a hospital or health system was associated with lower income among physicians overall.[27,28] As with the data on patient access to care, further evidence is needed to conclusively determine the impact of hospital-physician integration on health care wages and labor market changes.[29] There are even fewer studies available on the effect of hospital-hospital consolidation on physician wages. There is some evidence that nurses' and pharmacists' wages decrease following a hospital merger, but there is no significant data on the impact on physician wages.[30]

On January 5, 2023, the FTC proposed a rule to ban future noncompete clauses and invalidate existing agreements. In the proposed rule, the FTC stated that noncompete clauses depress worker wages and limit competition. Typically, a noncompete clause would bar a physician from practicing medicine for a certain period of time within a defined geographic area or specific mile radius. FTC regulators argue that noncompete clauses stifle competition and cause price increases for patients in markets that are highly concentrated, as many health care markets are in the United States. Critics question whether this proposed rule is within the purview of the FTC. One of those critics is the AHA, which stated in its comments that "the proposed regulation errs by seeking to create a one-size-fits-all rule for all employees across all industries, especially because Congress has not granted the FTC the authority to act in such a sweeping manner. Even if the FTC had the legal authority to issue this proposed rule, now is not the time to upend the health care labor markets with a rule like this."[31] The public comment period for this proposed rule was open until April 19, 2023.[32] At the time of writing, AMA comments were still being prepared. The Council will continue to monitor the issue and its impact on physicians.

OVERSIGHT AND ENFORCEMENT

There is shared jurisdiction between the FTC and the DOJ when reviewing mergers and acquisitions. Typically, the FTC reviews mergers between providers (hospitals, physician groups, etc.), while the DOJ reviews mergers between health insurance companies. DOJ has exclusive control over criminal enforcement.

The FTC, DOJ, and private parties suffering antitrust injury use the Clayton Act, the Sherman Act, and in the case of the FTC, the FTC Act to enforce antitrust laws. The Sherman Act of 1890 is the US antitrust law which prescribes the rule of free competition among those engaged in commerce. Importantly, the Sherman Act does not prohibit every restraint of trade, only those that are unreasonable. Certain acts are considered so harmful to competition that they are almost always illegal under the Sherman Act. These include plain arrangements among competing individuals or businesses to fix prices, divide markets or rig bids. The Clayton Act of 1914 addresses specific practices that are not directly addressed by the Sherman Act, including mergers. Specifically, Section 7 of the

Clayton Act prohibits mergers and acquisitions where the effect "may be substantially to lessen competition or tend to create a monopoly." The Clayton Act was amended in 1976 by the Hart-Scott-Rodino Act, which purposely exempts small transactions (valued at less than $111.4 million as of February 27, 2023) from pre-merger notification to not increase the regulatory burden on small enterprises in addition to avoiding generating unnecessary transactions for FTC staff to review. This threshold is adjusted annually and results in many health system, hospital and/or physician mergers proceeding without FTC and/or DOJ review.

Another hurdle contributing to increases in consolidation in recent years is FTC constraints on its ability to enforce antitrust laws in the not-for-profit health care sector. Vertical integration is particularly challenging for the FTC to monitor because it is often the result of hospitals acquiring many smaller practices and each of those transactions may fall under the $111.4 million threshold of having to notify the FTC. Additionally, the FTC has raised concerns about its inability to enforce antitrust rules on most non-profit organizations, including most non-profit hospitals. The FTC can only enforce Section 5 of the FTC Act against persons, partnerships, or corporations. "Corporations" are defined as those entities organized to carry on business for-profit. Accordingly, the FTC Act does not give the FTC the ability to enforce Section 5 against most non-profit entities, which constitute the vast majority of hospitals.

The Council met with representatives from the FTC to discuss the process of reviewing mergers and acquisitions. When examining a potential merger or acquisition, FTC staff focus on four areas: price effects, clinical quality effects, patient access, and provider wages. When a proposed merger filing comes in, FTC staff have 30 days to decide whether or not to issue a challenge. If a challenge is issued, the deal is prohibited from closing until further investigations are completed. During these investigations, the merging entities may negotiate further to receive the approval of the FTC, or the case could go to court. Alternatively, the two merging entities may decide to abandon the deal altogether.

The representatives from FTC stressed the importance of physicians as the best advocates for patients, especially regarding mergers between health care facilities. FTC staff time is limited, especially given the quick timeline in which the FTC must decide whether or not to challenge a merger, so input from impacted communities is helpful in flagging potential concerns. Information shared by physicians is used by the FTC when evaluating potential mergers and acquisitions and is immensely helpful in providing a voice for physicians and patients who would be impacted most. The FTC encourages physicians to share their experience via email to the following address which is monitored regularly by staff: antitrust@ftc.gov. Physicians are encouraged to work with their state medical associations and/or state attorneys general (AG) to report mergers or acquisitions that fall below the FTC threshold for review. Alternatively, physicians (or any member of the public) are welcome to report potential antitrust violations to the FTC here: https://www.ftc.gov/enforcement/report-antitrust-violation.

In 2020, the FTC and DOJ published, and the FTC subsequently withdrew, revised Vertical Merger Guidelines. After withdrawing the guidelines because they cited "unsound economic theories" the FTC stated that it will continue working with the DOJ Antitrust Division to update merger guidance to better reflect market realities. Updated Vertical Merger Guidelines are expected in 2023. Physicians are strongly encouraged to review these guidelines when they are available and provide comments during the public comment period.

States also have a critical role in oversight because vertical integration transactions often fly under the radar of federal antitrust agencies because they tend to be too small in size to be reported under the Hart-Scott-Rodino Act, which has a threshold of $111.4 million in 2023. States can be proactive in the merger process by data gathering using all-payer claims databases, pre-transaction review and approval, oversight of vertically integrated entities, and controlling outpatient costs (i.e., restrictions on facility fees to counteract private-equity based acquisitions).[33] States can study the price, utilization, or referral effects of vertical transactions; detect targets for enforcement; provide oversight of vertically integrated entities; plan and assess the need for new and additional services; quantify the amount of facility fees charged; enforce compliance with surprise out-of-network billing rules; or implement global budgets. Many states already require hospitals to notify state officials of proposed mergers or acquisitions; however, states could expand the requirement to transactions involving physicians. One example of this is in Washington state, which passed a law in 2019 to require notification to the state AG of health care transactions, including those involving "provider organizations," below the Hart-Scott-Rodino threshold. Connecticut requires 30-day notice] to the AG and the head of the Office of Health Strategy of any proposed transaction involving a physician practice of eight or more physicians. In Massachusetts, all provider organizations must provide the AG, the Health Policy Commission, and the Center for Health Information Analysis with a 60-day notice of any mergers, acquisitions, or affiliations. Unlike the FTC, state AGs can regulate transactions involving nonprofit entities.[34]

AMA POLICY

The AMA has long-standing policy emphasizing the importance of competition in health care markets and striving to protect physician autonomy and well-being before, during, and after health care mergers and acquisitions (H-215.960, H-215.969).

Policy D-215.984 states that the AMA will study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing health care consolidation for the benefit of patients and physicians who face an existential threat from health care consolidation; and regularly review and report back on these issues to keep the House of Delegates apprised on the relevant changes that may impact the practice of medicine. Furthermore, Policy D-383.980 affirms that the AMA will 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 develop an action plan for legislative and regulatory advocacy to achieve a more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

DISCUSSION

In general, empirical evidence is emerging on the impact of vertical integration on patients, physicians, and health care. While evidence of impacts on health care prices and spending is stronger and more consistent, evidence on effects on patient access, changes in quality outcomes, and physician wages and workforce are insufficient to draw meaningful conclusions at this time. However, research continues to be conducted, such as on the effects of hospital-physician integration on quality as well as on the potential mechanisms underlying its effects on prices and spending, especially as this and other acquisitions of physician practices become more common The Council will continue to stay informed of new data and research and will address future policy recommendations as needed. As data continue to be collected and vertical integration involving physicians continues to occur regularly, physicians should work with their state medical associations who in turn should work with their state attorneys general and state legislators to address these transactions. Potential state policy solutions include notification of health care transactions to public officials and pre-transaction review by states for those mergers and acquisitions that fall under the FTC/DOJ review threshold. Flagging these transactions will allow time to review the impacts each would have on the patients and physicians within a community and broader market concentration effects in the impacted areas.

When meeting with representatives from the FTC, it was repeatedly stressed that the most important thing physicians can do regarding concerning mergers and acquisitions is to share individual perspectives on how consolidation has impacted their practice, their patients, and their community. When published, physicians should review the FTC's update to the Vertical Merger Guidelines and provide feedback during the public comment period.

The Council believes that changes in provider mix and wages following a merger or acquisition is an issue that should be monitored closely but that peer-reviewed data on the topic is not yet robust enough for policy recommendations at this time. Similarly, the Council believes that mergers or acquisitions may impact access and quality of care and will continue to monitor this data as it becomes available.

The recommendations presented in this report are more actionable and supersede the recommendations in Policy D-215.984, Health System Consolidation. Thus, we recommend that policy be rescinded with the adoption of the following recommendations.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) continue to monitor the impact of hospital-physician practice and hospital-hospital mergers and acquisitions on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor.

2. That our AMA continue to monitor how provider mix may change following mergers and acquisitions and how non-compete clauses may impact patients and physicians.

3. That our AMA broadly support efforts to collect relevant information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in states or regions that may fall below the Federal Trade Commission(FTC)/Department of Justice review threshold.

4. That our AMA encourage state and local medical associations, state specialty societies, and physicians to contact their state attorney general with concerns of anticompetitive behavior.

5. That our AMA encourage physicians to share their experiences with mergers and acquisitions, such as those between hospitals and/or those between hospitals and physician practices, with the FTC via their online submission form.

~~6. That our AMA rescind policy D-215.984.~~

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9. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CARE

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies D-390.923, H-35.965, H-160.947, H-465.977 and H-465.994

Adequately addressing the issues that contribute to poor health outcomes and significant disparities for those who live in rural communities continues to be challenging. Approximately 14 percent of Americans live in a rural area, representing approximately 46 million people.[1] The health disparities for rural Americans are quite stark, as these communities tend to be poorer, older, sicker, and die at a 50 percent higher rate from unintentional injury.[2] One contributing factor to these disparities is the lack of accessible health care facilities and physicians. Approximately 66 percent of all Primary Care Health Professional Shortage Areas are in rural communities, indicating a disproportionately high lack of access to care[3]. Additionally, those in rural areas are geographically further from hospitals and physicians, increasing barriers to access care[3]. Although the American Medical Association (AMA) has robust existing policy regarding improving the health of rural America, there is limited policy directly related to the centers that serve these populations.

This report, initiated by the Council, provides information and background on Federally Qualified Health Centers (FQHCs) and similar clinics serving areas of medical need. Additionally, the report discusses the importance of these centers to providing essential health care and the physician experience for those who work in these settings. The report also details relevant AMA policy and provides recommendations to ensure that these clinics are funded adequately and that physicians are able to practice without undue burden.

BACKGROUND

Although rural communities are often woefully underserved, FQHCs and Rural Health Clinics (RHCs) are two types of practices working to bring additional care to these communities. While FQHCs do not exclusively serve rural communities, many do serve these areas. FQHCs are health centers that serve communities, regardless of population density, that are designated health care shortage areas. These clinics are unique in that they not only provide medical care services, but also wraparound and social services. RHCs are clinics that serve designated health care shortage areas that are also considered rural. These clinics provide health care services to their communities, and may, but are not required to, provide social support services. FQHCs and RHCs are similar in many ways but do have distinct differences with RHCs only serving rural communities and FQHCs providing services beyond the traditional health care paradigm. Each of these centers work to provide health care to communities that are in desperate need and, in turn, help to mitigate health care disparities.

Federally Qualified Health Centers

As previously noted, FQHCs are health care centers that provide health care services to rural or urban shortage areas. FQHCs are often the last line of care for individuals who otherwise may go without health care services. These practices are a central location for patients to receive coordinated preventive care and disease management. FQHCs provide medical services and are often able to support patients in accessing dental, social, and mental health services. These centers are vital for the communities they serve by providing care to approximately 30 million people in over 1,400 locations across the country.[3] Not only are the communities served by FQHCs often underserved, but they are also often underinsured. Approximately 59 percent of patients at FQHCs are insured publicly and 20 percent are uninsured.[3,4] These centers are vital in rural communities, with nearly half (45 percent) of all centers serving rural communities where they are, if not the only, one of very few sources of health care services.[4]

These health centers were originally created in 1965 by President Lyndon B. Johnson as an element of his administration's "War on Poverty." These centers were initially called community health centers and operated in a semi-permanent capacity for about a decade. In 1975, these health centers were officially authorized as a permanent program with their incorporation in section 330 of the Public Health Services (PHS) Act. After gaining permanency, the program continued to receive bipartisan support and was continually funded by Congress. In the late 1980s and early 1990s, FQHCs were established as a part of Medicare and Medicaid and were given a $150 million increase in funding. The following decade brought additional funding increases and reauthorization for FQHCs via efforts by Congress and the Administration. In 2009, $2 billion was invested in FQHCs through the reauthorization of Children's Health Insurance Program and the American Recovery and Reinvestment Act. An additional funding increase was earmarked in 2011 with the passage of the Affordable Care Act (ACA). However, in the same year a significant budget deficit tempered the initially indicated $11 billion investment and slowed the expansion of FQHCs. Over the next decade, FQHCs continued to receive funding through reauthorizations and, both directly and indirectly, the implementation of the ACA in 2014. More recently, FQHCs faced significant challenges, as did all of health care, in battling the COVID-19 pandemic. In 2021, the American Rescue Plan was enacted and FQHCs received approximately $7.6 billion through a variety of different programs.[5] Notably, FQHCs provided care to 30 million Americans in 2021, indicating their vital place in the landscape of American health care.

In practice, FQHCs are diverse in the services they provide to their patients, with some providing expanded services like mental and behavioral health, but at the core they all meet the basic definition of providing at least primary care services to rural or urban shortage areas. Within these types of practices, clinics fall under one of three categories, a health center program grantee, a "look-alike" program, or an Outpatient Tribal facility. Health center program grantees are what are traditionally referred to as an FQHC. Along with meeting a host of eligibility requirements, in order to receive this designation, the center must receive a grant under section 330 of the PHS Act. FQHC "look-alike" clinics are those that meet many of the same eligibility requirements as the aforementioned health center program grantees, but do not receive grants or funding from section 330 of the PHS Act. Finally, Outpatient Tribal facilities are similar, in that they meet many of the same requirements as a PHS Act granted FQHC; however, they are operated by a tribe, tribal organization, or urban Indian organization. These clinics are funded through either the Indian Self-Determination Act or Title V of the Indian Health Improvement Act. In specific circumstances these clinics are able to be grandfathered in and may not meet each of the eligibility requirements of FQHCs or "look-alikes".[6] In the remainder of this report the use of the term FQHC will be inclusive of each of these three types of clinics, unless specifically distinguished. Clinics that are classified as FQHCs serve a wide variety of patients and

can be seen across the country referred to as organizations like, Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers.[6]

In order to be designated a FQHC, a center must meet a multitude of practice requirements. Specifically, care must be provided by a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist, clinical social worker, or a certified diabetes self-management training/medical nutrition therapy provider. FQHCs must be under the medical direction of a physician, but each of the previously mentioned nonphysician practitioners are able to independently see patients. When seeing a patient, the visit must be deemed either medically necessary or a qualified preventive health visit. Visits generally occur at the health center but may take place in the patient's residence if the patient is home-bound.[6] Traditionally, these visits were required to occur in person and face-to-face, however during the COVID-19 Public Health Emergency, exceptions were made for increased telehealth visits. These exceptions have been extended beyond the end of the health emergency and will allow for practitioners to continue to see some patients virtually.

While FQHCs provide a diverse range of services that vary from clinic to clinic, there are a core set of services that must be offered in order to receive a FQHC certification. Required services include primary health services like family medicine, internal medicine, pediatric, and obstetrics and gynecology care. FQHCs are required to provide diagnostic lab services, preventive health services, emergency medical services, and referrals. FQHCs are also required to provide dental screenings to determine if further dental care is needed and while some may have an on-site dentist, full dental care is not a requirement. Additionally, FQHCs are required to provide supplemental services to enable access to care, like transportation, and community education. While not required, FQHCs may also provide care including pharmaceutical services (e.g., pharmacies and/or drug monitoring), behavioral and mental health services, environmental health services, screening and control of infectious diseases, and/or injury prevention programs.[6] In short, the medical services provided by an FQHC are designed to allow for a "one stop shop" mentality where patients are able to receive care for a variety of needs.

In addition to the medically centered requirements of an FQHC, there are also more administrative requirements that must be met. These clinics must demonstrate effective procedures for tracking, compiling, and reporting operating costs and patterns of service use as well as the availability, accessibility, and acceptability of services offered. These records should be provided to the governing body upon request. Additionally, the FQHC must complete and file an annual independent financial audit with the Secretary of the Department of Health and Human Services. Regarding payment, FQHCs must have a contracted agreement with the state for those who are eligible for state insurance plans and encourage patients to participate in any insurance plan for which they are eligible. These centers are also responsible for collecting appropriate payment from patients through an established sliding scale fee/payment plan. Finally, they must ensure that no patient is turned away from receiving services due to the lack of ability to pay.[6]

FQHC governance boards must be comprised of a majority (51 percent+) of individuals who receive care at the clinic, and must meet at least once a month. Additional ongoing quality improvement processes must be continuous and include both clinical services and management operations. Additionally, FQHCs must have established continuing referral relationships with at least one hospital and must demonstrate continued efforts to establish and maintain relationships with other health care providers in the area.[6]

Any patient can be served at an FQHC, regardless of insurance status or ability to pay. While some FQHCs have a more specified focus, for example a migrant population, there is no restriction on who they are able to provide care for. To ensure that the services offered are geographically accessible, clinics must regularly review the size of their catchment area and adjust if needed. Whenever possible, these boundaries should conform with existing local boundaries and work to eliminate any geographical barriers. FQHCs must operate in an area that has been designated as a Medically Underserved Area (MUA) or with a population that has been designated a medically underserved population. Should the clinic operate in an area in which a "substantial portion" of the community are limited-English speakers, there are specific cultural and language requirements that must be met. Clinics in these areas must ensure that services are provided in the language and cultural context that is appropriate for the community. Additionally, the clinic must employ at least one staff member who is fluent in the language dominant in the community and English in order to provide assistance in bridging cultural or linguistic differences.[6]

The COVID-19 pandemic and subsequent vaccination campaign highlighted the importance of FQHCs in delivering care to those who are underserved, underrepresented, and underinsured. The Office of the Assistant Secretary for Planning and Evaluation's Office of Health Policy's research report investigating the barriers and facilitators in

COVID-19 vaccine outreach indicated the widespread success of FQHCs in delivering high rates of vaccination in the communities they serve. Specifically, 62 percent of FQHCs held vaccination events or mobile clinics in their communities, distributing 14+ million doses of the vaccine to communities. Importantly, these FQHCs were not only successful in vaccinating their communities, but 66 percent of vaccinations were given to people of color, supporting work to decrease health disparities.[7] In a more specific example, an FQHC, Proteus, serving primarily H2-A visa workers in Iowa, Nebraska, and Indiana, set up an innovative program to mitigate the spread of COVID-19. In a non-COVID year the FQHC provides these farm workers with preventive health care and training on topics like heat stress and pesticide safety. When the pandemic arose, this model was modified to include infection mitigation training for the workers and farm owners, COVID testing, providing personal protective equipment, housing, virtual town halls, and contact tracing. As most of the H2-A visa workers were Spanish-speaking, this work was all done in a bilingual and culturally responsive fashion. This program was able to mitigate the spread of COVID while the workers were in the United States, when they went to their home country, and when they returned to the United States for the subsequent agricultural season.[8]

However, the success of FQHCs providing care to underserved communities is not limited to COVID. FQHCs across the country provide care to individuals who are in underserved communities, with 62 percent of patients reporting being a person of color. One specific example is a FQHC, Dartmouth Geisel Migrant Health Center, that serves primarily Latino patients in the Northeast United States. It was found that the work done by this FQHC, especially around care coordination and interpreter services, improved the access to care for the community they served.[9] These examples demonstrate the power of FQHCs to support communities in not only times of crisis, like a pandemic, but in everyday health care needs. These centers are vital to providing health care services to the communities they serve.

Rural Health Clinics

While RHCs are similar to FQHCs in many ways, there are some key differences. Most significantly, RHCs only serve rural areas and populations. Similar to FQHCs, RHCs can vary in type, from independent, hospital-based, or provider-based centers. These clinics are designed to increase the accessibility of primary care in areas that are underserved due to their rural status.[10,11]

As a point of clarification, although RHCs and rural hospitals may sound similar in name, they are two separate types of practice. They face distinct differences in financial support, eligibility, and operating requirements. To avoid confusion, rural hospitals will not be included in the current report. A recent report from the Council (Council on Medical Service Report 9-J-21) addressed rural hospitals.

RHC services are provided by a physician, NP, PA, or CNM and must be under the medical direction of a physician. RHCs are required to have a NP, PA, or CNM providing care services at least half of the time the center is open. These centers are required to provide primary care and routine diagnostic and lab services and, while not required, may provide other types of services such as Transitional Care Management, General Behavioral Health Integration, Chronic Care Management, Principal Care Management, and Psychiatric Collaborative Care Management. Although these clinics are able to provide behavioral and mental health serves, they cannot be designated as a rehabilitation agency or a primarily mental disease treatment facility. Patient visits follow very similar requirements as an FQHC in that they must be medically necessary or a qualified preventive health visit and can take place at the center, the patient's home, a skilled nursing facility, or hospice. Visits are not able to take place in an inpatient or outpatient hospital department. Similar to FQHCs, visits were historically required to be in person, but the COVID-19 pandemic allowed for telehealth exceptions that have now been extended beyond the Public Health Emergency.[7,8]

In order to meet the administrative requirements of RHC certification, centers must file annual cost reports that include payment rates, reconcile interim payments, graduate medical education adjustments, bad debt, and administrative payments. Payment is primarily made through a bundled All-Inclusive Rate (AIR) that is determined for all qualified primary and preventive care services. Dependent upon the patient's insurance status, a co-pay may be applied to the services. For example, patients with Part B Medicare coverage would pay for 20 percent of the AIR once their deductible is met. These centers must also maintain a contractual agreement with at least one hospital to provide services that are not available at the RHC.[7,8]

Unlike FQHCs there are no specific requirements related to the governance, quality improvement, nor culture or language of patients. RHCs do have specific requirements related to their service areas. These centers must serve a

community that has been designated as a Primary Care Geographic Health Professional Shortage Area, Primary Care Population-Group Health Professional Shortage Area, MUA, or a governor-designated and secretary-certified shortage area. Additionally, these communities must be designated as non-urbanized. Each year RHCs serve approximately 7 million people throughout 47 states.[8]

While FQHCs and RHCs are mutually exclusive, they are similar in their basic mission which is to provide health care to individuals who are underserved. There are also similarities in the types of health care providers and types of services permitted. One of the defining differences between the two is the source of funding. FQHCs must receive funding via Section 330 of the PHS Act, while RHC funding comes from alternative federal avenues, such as appropriations from the Centers for Medicare & Medicaid Services. A full comparison outlining the certification requirements for FQHCs and RHCs has been appended to this report.

PHYSICIAN EXPERIENCE IN FQHCs

Physicians who work in FQHC settings may experience unique benefits and challenges. While the benefits of working in an FQHC are somewhat difficult to quantify, many physicians report that their work is more gratifying than other settings and that they believe they are helping communities that otherwise would not have adequate access to health care. There are also more tangible benefits to working in an FQHC, such as student loan repayment programs and visas for foreign-born physicians.

Although these specific benefits and the ability to serve communities that are desperate for quality health care can provide physicians with a sense of fulfillment, there are significant challenges that these physicians face working in FQHCs[12]. For example, working in an FQHC does not relieve the physician burden of administrative paperwork. Serving a patient base that has higher rates of public insurance means that physicians are spending more time dealing with the rules, protocols, and paperwork associated with payment. The voluminous amount of paperwork that patients are required to complete to register as an FQHC patient can frequently lead to disruptions in scheduling and physicians spending significant amounts of time reviewing and signing the paperwork. In addition to the increased administrative and regulatory burdens, since physicians at FQHCs are operating in underserved areas it is often difficult to find reasonable timely referrals and coordinate care for patients who may need advanced or specialty care. Some physicians who work in FQHCs report feeling that they are practicing medicine without the support of a medical team or other physicians. For physicians in these settings, providing care to their patients, who are often facing complex medical conditions, can be a significant undertaking. Physicians practicing in FQHCs are frequently part of a limited network of providers in the area they serve, leading to increased stress and working hours in order to attempt to provide quality care on a reasonable timeline to the patients they serve.[9,10]

Finally, physicians working in FQHCs often have additional duties related to the supervision of nonphysician providers, which adds another set of tasks to already full schedules. FQHC physicians report spending considerable time on weekends and evenings reviewing cases that are handled by the non-physician practitioners in order to remain in compliance with federal regulations and provide quality care. Notably, physicians working in FQHCs report 11 percent higher burnout than their colleagues working in other practice settings.[13]

RELEVANT AMA POLICY

The AMA has a number of existing policies related to rural health and FQHCs. Many of the current AMA policies related to rural health are centered around rural hospitals. Policies H-465.979 and H-465.990 focus on the economic viability of rural hospitals. Each encourages efforts and legislation to support these hospitals' efforts to stay open and serve their communities. Policy D-465.998, established with Council on Medical Service Report 9-J-21, and Policies H-240.971, H-465.978, and H-240.970, all deal with the payment challenges that are faced by many rural physicians and hospitals. The policies both recognize and offer potential solutions for remedying the payment differentials between rural and urban medical care. Finally, Policies H-465.984, H-465.996, and H-465.999 focus on the certification and regulations of rural health care centers and hospitals.

The Council believes that, in conjunction with FQHCs and RHCs, rural hospitals are another vital strategy to deliver care to rural communities. Notably, the Council's recent 2021 report, "Addressing Payment and Delivery in Rural Hospitals" (Council on Medical Service Report 9-J-21) included policy recommendations that remain informative and relevant as to the current state of rural hospitals in America. As previously noted, in order to avoid confusion, this current report has remained focused on health care in non-hospital settings, like FQHCs and RHCs.

	away due to a lack of ability to pay. Must encourage patients to participate in insurance programs and plans for which they are eligible.	pay 20 percent once their deductible is met and the AIR would pay 80 percent.
GOVERNANCE	Governed by a board comprised of a majority (51+ percent) of individuals who receive care at the center. The board must meet at least monthly.	No specific governance requirements.
SERVICE AREA	Must regularly review to ensure that the size of the catchment area is appropriate to ensure that services are available and accessible. Service boundaries should conform with local boundaries to the extent practical and should eliminate barriers to access due to geography.	Must serve a community designated as one of the following: a Primary Care Geographic Health Professional Shortage Area, Primary Care Population-Group Health Professional Shortage Area, MUA, Governor-designated and Secretary-certified shortage area.
COLLABORATIVE AGREEMENTS	Continued efforts to establish and maintain relationships with other health care providers. Must have an ongoing referral relationship with at least one hospital.	Must have arrangements with at least one hospital to provide services that are not available at the clinic.
CULTURAL & LANGUAGE CONSIDERATIONS	If a center serves a community with a "substantial portion" of limited-English speakers, services must be provided in the language and cultural context that is most appropriate. A staff member who is fluent in that language and English must be identified to bridge cultural and linguistic differences.	No specific cultural or language consideration requirements.
VISITS	Each visit must be medically necessary or a qualified preventative health visit. These visits traditionally needed to be face-to-face, but extensions have been made to allow for continued telehealth visits. Should multiple visits be required in the same day, they are considered one cumulative visit. Visits may also take place in the patient's place of residence should they be home-bound.	Each visit must be medically necessary, a qualified preventive health visit. These visits can take place at the RHC, the patient's residence, Medicare-covered Part A skilled nursing facility, scene of an accident, or hospice. Visits cannot take place at an inpatient or outpatient hospital department or in a facility specifically excludes RHC visits. Should multiple visits be required in the same day, they are considered one cumulative visit.
EXCLUSIONARY CRITERIA	FQHCs cannot be designated as an RHC.	Cannot be designated as a FQHC, rehabilitation agency, or be a primarily mental disease treatment facility.

Appendix B - AMA Policies Recommended for Reaffirmation

Policy H-465.994, "Improving Rural Health"
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:

- Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Advocate for adequate and sustained funding for public health staffing and programs. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22)