

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Lynn Jeffers, MD, Chair:

1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2013 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.110 reads as follows:

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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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

RECOMMENDATION

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

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
D-130.965	On-Call Coverage Models	Our AMA will compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to unrealistic and unduly burdensome on-call demands and educate AMA physician members regarding these options.	Retain. Still relevant.
D-160.934	Physician Participation in Multiple Medicare Accountable Care Organizations	Our AMA will continue to work with the Centers for Medicare & Medicaid Services to address accountable care organization (ACO) rules that preclude physician participation in multiple Medicare ACOs.	Retain. Still relevant.
D-165.939	Transitional Reinsurance Fees Under the Affordable Care Act	Our AMA will advocate that any proposed assessment on “issuers of insurance” (scheduled to commence in 2014 for a 3-year period), intended to fund a “risk adjustment program” to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, be taken from administrative and medical management costs.	Retain-in-part. All is still relevant other than “(scheduled to commence in 2014 for a 3-year period),” which should be removed.
D-165.955	Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured	<p>1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all.</p> <p>2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.</p>	<p>Rescind. Superseded by Policies H-165.920, H-165.865, D-290.979, H-165.823, and H-165.904.</p> <p>Individual Health Insurance H-165.920</p> <p>Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;</p> <p>(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;</p> <p>(3) actively supports the principle of the individual’s right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association’s position on achieving universal coverage and access to health care services. To do this, our AMA will:</p>

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			<p>(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;</p> <p>(b) Support the concept that the tax treatment would be the same as long as the employer’s contribution toward the cost of the employee’s health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee’s insurance directly;</p> <p>(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and</p> <p>(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;</p> <p>(4) will identify any further means through which universal coverage and access can be achieved;</p> <p>(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health</p>

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			<p>insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;</p> <p>(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;</p> <p>(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;</p> <p>(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;</p> <p>(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;</p> <p>(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;</p> <p>(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-</p>

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			<p>risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax; (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.</p> <p>(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.</p> <p>Medicaid Expansion D-290.979 Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will</p>

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			<p>reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.</p> <p>2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all.</p> <p>Principles for Structuring a Health Insurance Tax Credit H-165.865</p> <p>(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account,</p>

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			<p>and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.</p> <p>(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.</p> <p>(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.</p> <p>Options to Maximize Coverage under the AMA Proposal for Reform H-165.823</p> <p>That our AMA advocate for a pluralistic health care system, which may include a public option, that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians.</p> <p>2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:</p> <ul style="list-style-type: none"> a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. c. Physician payments under the

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			<p>public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.</p> <p>d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.</p> <p>e. The public option is financially self-sustaining and has uniform solvency requirements.</p> <p>f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.</p> <p>g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.</p> <p>3. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:</p> <p>a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.</p> <p>b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.</p>

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			<p>c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.</p> <p>d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.</p> <p>e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.</p> <p>f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.</p> <p>g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.</p> <p>h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.</p> <p>4. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states</p>

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			<p>that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.</p> <p>Universal Health Coverage H-165.904</p> <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 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.</p>
D-185.983	Diabetic Documentation Requirements	<p>1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies.</p> <p>2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and</p>	Rescind. Directive accomplished. Research by the AMA Office of General Counsel indicated a reasonable basis did not exist for bringing a lawsuit against CMS related to diabetic documentation requirements.

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		other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.	
D-225.986	Blue Cross of California Quality of Care Allegations	Our AMA will reiterate its position stating that medical staffs shall not be impugned and quality of care issues not be imposed between insurance plans and hospitals as a means of addressing economic or contractual issues.	Retain. Still relevant.
D-225.988	Elimination of 48-Hour Signature Rule for Verbal Orders	Our AMA will, through the Organized Medical Staff Section, encourage hospital medical staffs to include policies, which consider applicable state law, on authentication of all medical record entries, including telephone and verbal orders, in their medical staff bylaws.	Retain. Still relevant.
D-235.986	Random Drug Screening	Our AMA will develop model medical staff bylaws addressing random drug testing of medical staffs.	Rescind. Directive accomplished. The AMA Physician's Guide to Medical Staff Organization Bylaws includes sample bylaws that address drug screening for medical staff (see Section 5.7, "Drug Testing," pages 90-94).
D-285.998	Creation of Joint AMA Committee with Representatives from the America's Health Insurance Plans	Our AMA will continue to work with America's Health Insurance Plans and other appropriate organizations on issues of mutual interest.	Retain. Still relevant.
D-330.941	Medicare Outpatient Therapy Caps	Our AMA will not support Medicare outpatient rehabilitation therapy caps.	Retain. Still relevant.
D-330.958	Social Security Disability Medical Benefits	Our AMA will take an active role in supporting reduction of the waiting period to receive Social Security Disability medical benefits.	Retain. Still relevant.
D-330.961	Social Security Disability Medical Benefits	Our AMA will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients and will report and recommend further action to the House of Delegates as appropriate.	Retain. Still relevant.
D-335.983	Review of Self-Administered Drug List Alterations Under Medicare Part B	Our AMA will seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.	Retain. Still relevant. SAD List approval does not yet involve Carrier Advisory Committee review and advisement.
D-390.975	Payment for Facilities Expenses in Physicians' Offices	Our AMA will (1) advocate that CMS increase allowed expenditures subject to the SGR target whenever CMS assigns new office expenses to codes that historically have only been performed in	Rescind. MACRA repealed the SGR.

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		the hospital; and (2) incorporate this recommended administrative change into the other SGR system changes our AMA has advocated, such as removing drug spending from the SGR system and recognizing new coverage decisions.	
D-390.983	CMS Pharmaceutical Reimbursement Method	Our AMA will work to exclude pharmaceutical costs from the Sustainable Growth Rate formula.	Rescind. MACRA repealed the SGR.
D-400.985	Geographic Practice Cost Index	Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPICs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.	Retain-in-part: (4) (1) & (3) Accomplished; (2) Addressed by CMS . Suggest revising policy title to “MEI GPCI Impacts on the Physician Payment Schedule.”
D-440.937	Vaccines for Children Program and the New CPT Codes for Immunization Administration	Our AMA will work with the American Academy of Pediatrics and other groups to convince the Centers for Medicare & Medicaid Services to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program.	Retain. Still relevant.
D-450.960	Improve the HCAHPS Rating System	Our AMA will urge the Centers for Medicare & Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients.	Rescind. The directive was accomplished by correspondence sent to CMS .
D-450.963	Align the Recognition Periods for the Bridges to Excellence and the National Committee on Quality Assurance Recognition Programs	Our AMA will request the Bridges to Excellence program to align its validation periods for its recognition programs with the validation periods of the National Committee on Quality Assurance recognition programs.	Rescind. Directive accomplished. A letter was sent to the Executive Director of the Health Care Incentives Improvement Institute requesting that the Bridges to Excellence program align its validation periods with those of the NCQA.

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D-510.999	Veterans Health Administration Health Care System	<p>Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient’s health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA’s payment for prescriptions written by physicians who have no formal affiliation with the VHA.</p>	<p>Retain-in-part. The following subsections are superseded by Policy H-510.983:</p> <p>(1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and</p> <p>Expansion of U.S. Veterans Health Care Choices H-510.983</p> <ol style="list-style-type: none"> 1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans. 2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program. 3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways. 4. Our AMA will support consolidation of all the VA community care programs. 5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care. 6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.

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			<p>7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.</p> <p>8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.</p> <p>9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.</p> <p>10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.</p>
H-120.978	Principles of Drug Utilization Review	<p>Our AMA adopts the following Principles of Drug Utilization Review.</p> <p>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.</p> <p>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</p>	Retain. Still relevant.

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		<p>should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.</p> <p>Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised through an open professional consensus process.</p> <p>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.</p> <p>Principle 4: Interventions must focus on improving therapeutic outcomes.</p> <p>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.</p> <p>Principle 5: Confidentiality of the relationship between patients and practitioners must be protected.</p> <p>Characteristic: The DUR program must assure the security of its database.</p> <p>Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.</p>	

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		<p>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.</p>	
H-120.981	Drug Utilization Review	<p>(1) Our AMA supports DUR programs provided: (a) primary emphasis is placed on high quality patient care through improved prescribing by physicians, dispensing by pharmacists, and medication compliance by patients; (b) physicians are actively involved in the development, implementation, and maintenance of the DUR programs; (c) criteria and standards for prescribing are developed by physician organizations and they are based on the peer-reviewed medical literature and the experiences of physicians with expertise in drug therapy; (d) focused professional education is emphasized as the primary intervention strategy to improve physician prescribing, pharmacist dispensing, and patient compliance practices; and (e) the confidentiality relationship between physicians and their patients is maintained.</p> <p>(2) Our AMA supports interacting with appropriate pharmacy organizations to develop guidelines for prospective (point-of-sale) DUR that will decrease the incidence of adverse events from drug therapy.</p> <p>(3) Our AMA recognizes the right of government and private third party payers to include in DUR programs a component that addresses fraud and abuse, but reaffirms the right of physicians, who are so accused, to due process.</p> <p>(4) Our AMA opposes DUR programs of government or private third party payers that focus only on cost containment and prevent physicians from prescribing the most appropriate drugs for individual patients.</p>	<p>Rescind. Superseded by Policy H-120.978.</p> <p>Principles of Drug Utilization Review H-120.978</p> <p>Our AMA adopts the following Principles of Drug Utilization Review.</p> <p>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.</p> <p>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</p>

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			<p>utilization. (c) Criteria and standards should be validated prior to use.</p> <p>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.</p> <p>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.</p>

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			<p>Principle 5: Confidentiality of the relationship between patients and practitioners must be protected. Characteristic: The DUR program must assure the security of its database.</p> <p>Principle 6: Principles of DUR must apply to the full range of DUR activities, including prospective, concurrent and retrospective drug use evaluation.</p> <p>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.</p>
H-130.955	Patient Responsibility of On-Call Physicians	The AMA urges hospital medical staffs to have written policies and procedures in place to delineate clearly the patient follow-up responsibilities of staff members who serve in an on-call capacity to the hospital emergency department.	Retain. Still relevant.
H-160.910	Worksite Health Clinics	<p>It AMA policy that any individual, company, or other entity that establishes and/or operates worksite health clinics should adhere to the following principles:</p> <p>a) Worksite health clinics must have a well-defined scope of clinical services, consistent with state scope of practice laws.</p> <p>b) Worksite health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.</p> <p>c) Worksite health clinics that use nurse practitioners and other health professionals to deliver care must establish arrangements by which their health care practitioners have direct access to MD/DOs, as consistent with state laws.</p> <p>d) Worksite health clinics must clearly</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.</p> <p>e) Worksite health clinics should develop expertise in specific occupational hazards and medical conditions that are likely to be more common in the particular industry where the company offers products and services.</p> <p>f) Worksite health clinics must use evidence-based practice guidelines to ensure patient safety and quality of care.</p> <p>g) Worksite health clinics must measure clinical quality provided to patients and participate in quality improvement efforts in order to demonstrate improvement in their system of care.</p> <p>h) Worksite health clinics must adopt explicit and public policies to assure the security and confidentiality of patients' medical information. Such policies must bar employers from unconsented access to identifiable medical information so that knowledge of sensitive facts cannot be used against individuals.</p> <p>i) Worksite health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community. Such protocols must ensure after-hours access of employees and eligible family members, as well as the transmission of reports of all worksite clinic visits and treatments to the physicians of patients with an identified community physician.</p> <p>j) Worksite health clinics administering immunizations must establish processes to ensure communication to the patient's medical home and the state immunization registry documenting what immunizations have been given.</p> <p>k) Patient cost-sharing for treatment received outside of the clinic must be affordable and not prohibit necessary access to care.</p> <p>l) Worksite health clinics should allow the involvement of community physicians in clinic operations.</p> <p>m) Employers implementing worksite health clinics should communicate the eligibility for services of employees' family members.</p> <p>n) Worksite health clinics should be encouraged to use interoperable electronic</p>	

POLICY #	Title	Text	Recommendation
		health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities.	
H-160.911	Value of Group Medical Appointments	Our AMA promotes education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.	Retain. Still relevant.
H-160.952	Access to Specialty Care	The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.	Rescind. Accomplished through CMMI TCPi .
H-160.988	Health Care Coalitions	The AMA (1) supports health care coalitions that include strong physician participation so that primary emphasis is given to the quality, availability and access to medical care; and (2) encourages physicians in the clinical practice of medicine to take an active role in the development and activities of health care coalitions in their respective areas.	Retain. Still relevant.
H-165.830	Health Insurance Cancellations	Our AMA supports urgent efforts to maintain coverage while facilitating a smooth transition to alternative coverage options which offer ‘meaningful coverage’ as defined in Policy H-165.848 for individuals who have received cancellation notices from their health insurance companies as a result of the Affordable Care Act.	Retain. Still relevant for grandfathered plans.
H-185.961	Health Plan Coverage of Prescription Drugs	It is the policy of our AMA that third party payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process.	Amend Policy H-110.990 to include specification of medical exception process. Cost Sharing Arrangements for Prescription Drugs H-110.990

POLICY #	Title	Text	Recommendation
			<p>Our AMA:</p> <ol style="list-style-type: none"> 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient’s medical condition; and 4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information. <u>5. payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process.</u>

POLICY #	Title	Text	Recommendation
H-185.962	Payment for Advanced Technologies	Our AMA vigorously opposes actions by medical insurers to deny payment for services simply on the basis of the size of medical equipment.	Retain. Still relevant.
H-185.967	Coverage of Children's Deformities, Disfigurement and Congenital Defects	<p>1. The AMA declares: (a) that treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers; (b) that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated); and (c) that such insurability should be portable, i.e., not denied as a pre-existing condition if the patient's insurance coverage changes before treatment has been either initiated or completed.</p> <p>2. Our AMA will advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.</p>	Retain. Still relevant.
H-185.981	Third Party Responsibility for Payment	Our AMA (1) will develop, with the assistance of the Blue Cross and Blue Shield Association, the Group Health Association of America, the Health Insurance Association of America, and other relevant health care organizations, guidelines for a standardized system of verifying eligibility for health benefits; (2) will assume a leadership role with these organizations in the development of guidelines for a standardized system of verifying eligibility for health benefits;	Rescind. ACA established EHBs and HHS Administrative Simplification Eligibility and Benefits Transaction covers inquiries and responses about a patient's eligibility for insurance benefits.

POLICY #	Title	Text	Recommendation
		and (3) following the development of such guidelines, will work with major insurers and managed care plans to promote the development of a standardized, national health benefits verification system based on the guidelines, which would include an obligation on the part of the insurer or managed care plan to pay physicians for any services rendered to patients whose eligibility for benefits have been verified erroneously.	
H-185.983	Patient's Out-of-Pocket Contributions to Private Health Insurance	(1) The AMA takes the position that the practice of basing copayments on a different basis than the third party reimbursement should be condemned. (2) If physicians learn that their patients' copayments are being computed on a different basis than the third party's reimbursement, they should inform their patients and, when appropriate, help them make fully informed, cost-conscious alternative choices about their insurance coverage. (3) If physicians suspect that copayments are being set unfairly, they should bring these matters to the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society.	Retain. Still relevant. Suggest revising every iteration of "copayments" to "copayments and coinsurance."
H-190.956	Errors in Electronic Claims	Our AMA will publicize and encourage physicians to make use of AMA resources created to help physicians submit accurate electronic claims, and advocates that at the time of claim confirmation or no later than two business days after receiving an electronic claim, a third-party payer should provide the physician with an exception report notifying the physician of all information that is missing from the claim, any errors in the claim, any attachment that is missing or in error, and any other circumstances which preclude the claim from being a clean claim.	Retain. Still relevant.
H-190.983	Submission of Electronic Claims Through Electronic Data Interchange	The AMA: (1) will take a leadership role in representing the interests of the medical profession in all major efforts to develop and implement EDI technologies related to electronic claims submission, claims payment, and the development of EDI standards that will affect the clinical, business, scientific, and educational components of medicine; (2) supports aggressive time tables for implementation of EDI as long as the implementation is voluntary, and as long as all payers are required to receive standard electronic claims and provide	Rescind. Superseded by Policy H-190.978 . Promoting Electronic Data Interchange H-190.978 Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs

POLICY #	Title	Text	Recommendation
		<p>electronic reconciliation prior to physicians being required to transmit electronic claims;</p> <p>(3) supports the acceptance of the ANSI 837 standard as a uniform, but not exclusive, standard for those physicians who wish to bill electronically; and</p> <p>(4) will continue to monitor the cost effectiveness of EDI participation with respect to rural physicians.</p>	<p>of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted</p>

POLICY #	Title	Text	Recommendation
			<p>services; (2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and. (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.</p>
H-20.906	<p>Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases</p>	<p>(1) Health Insurance</p> <p>A currently held health insurance policy of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.</p> <p>(2) Disability Coverage</p> <p>a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of “sickness” or “disability,” an own-occupation clause, and guaranteed</p>	<p>Retain. Still relevant.</p>

POLICY #	Title	Text	Recommendation
		<p>renewability, future insurability, and partial disability provisions;</p> <p>b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician;</p> <p>c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly.</p>	
H-190.991	Excessive Requests for Information from Insurance Carriers and Delays in Processing Insurance Claims	<p>1. It is the policy of our AMA (A) to continue to oppose excessive and unnecessary requests for additional information and unexplained delays in processing and payment by third party insurance carriers where a completed standard claim form for reimbursement has been submitted, and (B) that state medical societies should pursue existing AMA model legislation to require the payment of claims with interest where clean claims are not paid on a timely basis.</p> <p>2. Our AMA will: (A) work with all payers to ensure that they stop the practice of delaying payments by asking for documentation to review, prior to payment; and (B) work with payers to establish rules to continue to allow the payer to conduct prepayment documentation review if the payer has performed a post payment documentation review and proven that the provider has been submitting incorrect claims.</p> <p>3. If efforts to work with payers to end the practice of delaying payments without reasonable justification fail, our AMA will seek legislation that would accomplish this.</p>	<p>Rescind. Superseded by Policy H-190.981.</p> <p>Required Timely Reimbursements by all Health Insurers H-190.981</p> <p>Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for “clean” claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims.</p>

<p>H-190.992</p>	<p>Electronic Claims Submission</p>	<p>It is the policy of the AMA to: (1) support, assist and encourage the use of electronic data interchange (EDI) and electronic media claims (EMC) by physicians; (2) support and continue its involvement in the development of uniform EMC format and technical requirements; (3) continue to support the elimination of the Medicare 14-day payment delay regulation following Medicare carrier receipt of a claim; and (4) oppose the establishment, at this time, of any time tables or plans for mandatory EMC or EDI use by physicians.</p>	<p>Rescind. Superseded by Policy H-190.978.</p> <p>Promoting Electronic Data Interchange H-190.978</p> <p>Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a) public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for “clean” paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and</p>
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POLICY #	Title	Text	Recommendation
			<p>NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval.</p>
H-220.931	Evidence-Based Value of Joint Commission Standards and Measures	Our AMA asks The Joint Commission that all present and future standards and performance measures set forth by The Joint Commission be supported by the best available evidence.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-220.991	AMA Policy on Hospital Accreditation	The AMA (1) believes that the objective of hospital accreditation should be primarily to evaluate the quality of patient care, to provide recommendations for remedying deficiencies and improving the quality of patient care, and to withhold accreditation from those institutions which do not meet an acceptable standard of patient care; (2) opposes accreditation requirements which impose rigid, uniform, mandatory administrative procedures, methods of operation, nomenclature, or forms of organization for the hospital, its governing board, attending staff and committees; and (3) recognizes that excellence in patient care is more easily attainable when the accreditation process is flexible and is concerned with evaluating the quality of hospital service and not the administrative procedures or form of organization used to provide patient care.	Retain. Still relevant.
H-225.958	Insurance Plan Inquiries Regarding Quality of Care and Peer Review Issues	Our AMA insists that all insurance plan inquiries regarding quality of care and peer review issues be evaluated through objective due process and peer review; and supports a position stating that all future peer review and quality of care issues between insurance companies and medical staffs be brought to an objective and neutral peer review body.	Retain. Still relevant.
H-225.962	Medical Staff Membership Category for Physicians Providing Telemedicine	The AMA recommends that organized medical staffs, as part of their responsibility for the quality of professional services provided by individuals with clinical privileges, identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical staffs (a) amend the medical staff bylaws to allow physicians providing telemedicine to be granted and maintain medical staff membership if they meet other obligations of such membership and (b) incorporate Policy 160.937, regarding their responsibility for supervision of non-physician providers and technicians delivering services via telemedicine, in the medical staff bylaws or rules and regulations.	Retain. Still relevant.
H-225.968	Standard Admitting Orders	It is the policy of the AMA that any standard admitting orders are the responsibility of and should be developed and approved by the medical staff.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-225.970	Full Participation for All Members of Hospital Medical Staff	The AMA opposes efforts by hospital administrations or governing boards to abrogate the voting rights of the physicians who serve on the medical executive committee. The AMA will communicate to its members its strong concern about hospital administrations' or governing boards' efforts to limit the participation of any physician who serves on the medical executive committee in the self-governing medical staff.	Retain. Still relevant. Will be discussed by OMSS Policy Committee.
H-225.985	Medical Staff Review of Quality of Care Issues Prior to Exclusive Contract	The AMA believes that the medical staff should review and make recommendations to the governing body related to exclusive contract arrangements, prior to any decision being made, in the following situations: (1) the decision to execute an exclusive contract in a previously open department or service; (2) the decision to renew or otherwise modify an exclusive contract in a particular department or service; (3) the decision to terminate an exclusive contract in a particular department or service; and (4) prior to termination of the contract the medical staff should hold a hearing, as defined by the medical staff and hospital to permit interested parties to express their views on the hospital's proposed action.	Retain. Still relevant.
H-225.996	Computer-Based Hospital and Order System	The AMA supports the concept of early involvement and participation by the hospital medical staff in decisions as to installation of a hospital information system and in the development of policies governing the use of such a system in the institution.	Retain. Still relevant.
H-235.961	Employment Status and Eligibility for Election or Appointment to Medical Staff Leadership Positions	<p>1. Our AMA adopted as policy the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.</p> <p>2. Our AMA will draft model medical staff bylaws provisions supporting the principle that a medical staff member's personal or financial affiliations or relationships, including employment or contractual relationships with any hospital or health care delivery system, should not</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>affect his or her eligibility for election or appointment to medical staff leadership positions, provided that such interests are disclosed prior to the member's election or appointment and in a manner consistent with the requirements of the medical staff bylaws.</p> <p>3. Our AMA encourages medical staffs and their advisors to consult the AMA Physician's Guide to Medical Staff Organization Bylaws and the AMA Conflict of Interest Guidelines for Organized Medical Staffs when developing policies for the disclosure of medical staff leaders' personal or financial affiliations or relationships and the management of resulting conflicts of interest.</p>	
H-235.962	Medical Staff-Hospital Compacts	<p>1. Given the limited utility of medical staff-hospital compacts relative to their significant potential unintended consequences, our AMA recommends that organized medical staffs and physicians not enter into compacts or similar agreements with their hospitals' governing bodies or administrations. Instead, the AMA encourages organized medical staffs and hospital governing bodies to:</p> <p>A. Clearly define within the medical staff bylaws the obligations of each party;</p> <p>B. Outline within the medical staff bylaws the processes by which conflicts between the organized medical staff and the hospital governing body are to be resolved; and</p> <p>C. Regard the medical staff bylaws as a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body.</p> <p>2. Our AMA will publicize to medical staffs the pitfalls of medical staff-hospital compacts and modify as needed the Physician's Guide to Medical Staff Organization Bylaws.</p>	Retain. Still relevant.
H-235.964	Preservation of Medical Staff Self-Governance	Our AMA strongly supports any hospital medical staff whose rights of self-governance are being threatened by the hospital administration or the governing body.	Retain. Still relevant.
H-235.972	Proxy Voting at Medical Staff Meetings	It is the policy of the AMA that proxy voting prior to or at medical staff meetings should not be permitted in medical staff bylaws.	Retain. Still relevant.
H-280.948	Long-Term Care Residents With	1. Our AMA encourages the long-term care provider and correctional care communities, including the American	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
	Criminal Backgrounds	<p>Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while ensuring the safety of all residents of the facilities.</p> <p>2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history.</p> <p>3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds.</p> <p>4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.</p>	
H-285.928	Health Plan and Fiscal Intermediary Insolvency Protection Measures	<p>(1) It is the policy of the AMA that health plans should be legally responsible to pay directly for physician services in the event of an insolvency of fiscal intermediaries like groups, independent practice associations, and physician practice management companies. (2) Our AMA continues to advocate at the state level for protective measures for patients and physicians who are adversely affected by health insurers and their fiscal intermediaries that declare insolvency, to include: (a) actuarially sound capitation rates and administrative costs; (b) submission of timely financial information by health plans to independent practice associations and medical groups; and (c) the establishment of financial and monetary standards for health plans, as well as for independent practice</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		associations, and groups that assume financial risk unrelated to direct provision of patient care.	
H-285.929	Patient Notification of Physician Contract Termination	Our AMA encourages medical groups and other corporate entities, such as physician practice management corporations and limited liability corporations, to include in the contract language governing notification of patients regarding termination of a physician’s contract, wording which is in compliance with Council on Ethical and Judicial Affairs Opinion 7.03 and/or model language developed by state medical societies.	<p>Rescind. Superseded by Policy H-225.950.</p> <p>AMA Principles for Physician Employment H-225.950</p> <p>1. Addressing Conflicts of Interest</p> <p>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.</p> <p>b) Employed physicians should be free to exercise their personal and professional judgment 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.</p> <p>c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.</p> <p>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</p>

POLICY #	Title	Text	Recommendation
			<p>or referral options are disclosed to patients.</p> <p>(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</p> <p>(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.</p> <p>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.</p> <p>2. Advocacy for Patients and the Profession</p> <p>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.</p> <p>b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.</p> <p>3. Contracting</p>

POLICY #	Title	Text	Recommendation
			<p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>

POLICY #	Title	Text	Recommendation
			<p>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.</p> <p>(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.</p> <p>(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</p>

POLICY #	Title	Text	Recommendation
			<p>to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.</p> <p>(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.</p> <p>(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.</p> <p>4. Hospital Medical Staff Relations</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.</p>

POLICY #	Title	Text	Recommendation
			<p>5. Peer Review and Performance Evaluations</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>

POLICY #	Title	Text	Recommendation
			<p>frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.</p> <p>(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:</p> <ul style="list-style-type: none"> 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. <p>6. Payment Agreements</p> <ul style="list-style-type: none"> 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

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			<p>professional fee component of the total payment received by the contractual arrangement.</p> <p>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.</p>
H-285.931	The Critical Role of Physicians in Health Plans and Integrated Delivery Systems	<p>Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS):</p> <p>(1) Practicing physicians participating in a health plan/IDS must:</p> <p>(a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a 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</p>	Retain. Still relevant.

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		<p>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 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 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</p>	

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		<p>governance and management for their time away from practice.</p> <p>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>	
H-285.940	Denials of Payment for Necessary Services Because of Lack of Authorization	<p>1. Our AMA seeks the elimination of clauses in managed care contracts that allow plans to refuse to pay for provision of covered services for the sole reason that required notification of these services was not reported in a timely manner.</p> <p>2. Our AMA supports a requirement that payers provide a retro-authorization process, with reasonable timeframes for submission and consideration and with reasonable procedural standards for all tests, procedures, treatments, medications and evaluations requiring authorization.</p>	<p>Rescind. Superseded by Policy H-320.939.</p> <p>Prior Authorization and Utilization Management Reform H-320.939</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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H-315.973	Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data	<p>1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:</p> <p>a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.</p> <p>b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.</p> <p>c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.</p> <p>d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.</p> <p>e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.</p> <p>f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.</p> <p>g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.</p> <p>h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.</p> <p>2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:</p> <p>a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses</p>	<p>Rescind. Superseded by Policy D-478.995.</p> <p>National Health Information Technology D-478.995</p> <p>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.</p> <p>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.</p> <p>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.</p>

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		<p>or disclosure of the information.</p> <p>b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.</p> <p>c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.</p> <p>d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.</p>	<p>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.</p> <p>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.</p> <p>6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.</p> <p>7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.</p> <p>8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.</p> <p>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.</p>
H-320.963	Disclosure of Medical Review Criteria and	The AMA will continue to press for the release of all Medicare carrier screens nationwide, including local screens,	Rescind. Superseded by Policies H-320.948 and H-340.898 .

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	Eligibility Guidelines	frequency parameters, and computer edits to identify claims for medical review.	<p>Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948</p> <p>It is the policy of our AMA, when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.</p> <p>Medicare Review Activities H-340.898</p> <p>Our AMA: (1) strongly urges CMS to provide physician organizations with the opportunity for significant comment and input on the Medicare Integrity Program; (2) continues to oppose any type of “bounty” system for compensation to any Medicare contractor, including those in the Medicare Integrity Program, and instead urge CMS to base compensation on the proper repayment of claims, rather than on the numbers of resulting referrals to law enforcement agencies; (3) continues to advocate for the ongoing involvement of physician organizations and hospital and organized medical staffs in refining and implementing any Medicare review contractor’s activities and the need to emphasize physician education and clinical improvements; (4) urges CMS to delete all “incentives” or other “award fees” for any Medicare review contractor; and (5) urges CMS to clarify that in any Statement of Work or contract with a Medicare review contractor that: (a) extrapolation should not</p>

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			occur unless it is to develop educational or compliance program interventions; and (b) referrals to the Office of Inspector General should not occur unless a hospital does not respond to intervention or when significant evidence of fraud exists.
H-330.886	Strengthening Medicare Through Competitive Bidding	<p>1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:</p> <ul style="list-style-type: none"> a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries. b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks. c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses. d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region. e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area. f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums. g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans. <p>2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.</p>	Retain. Still relevant.
H-330.902	Subsidizing Prescription Drugs for Elderly Patients	Our AMA strongly supports subsidization of prescription drugs for Medicare patients based on means testing.	Retain. Policy remains relevant through implementation of the IRA.
H-330.952	Medicare Carrier Advisory Committee	The AMA will advocate to all relevant parties (e.g., CMS and Medicare carriers) that the role of the state medical associations and state specialty societies in representing the interests and views of physicians in their respective states should	Retain. Still relevant.

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		not in any way be diminished by the operations of the Medicare Carrier Advisory Committee.	
H-330.958	Regionalization of Medicare Carriers	The AMA will continue to: (1) encourage state medical associations and national medical specialty societies to participate proactively in the Medicare Carrier "Notice and Comment" program with their respective carriers; and (2) monitor the impact of present and future Medicare carrier regionalization on the consistency of carrier interpretations and efficiency of operations.	Retain. Still relevant.
H-335.978	Medicare Fair Hearing	The AMA urges CMS to encourage Medicare carriers to utilize as Hearing Officers licensed physicians of the same specialty and in the same geographical area as that of the physician who requests the Fair Hearing and to make known to the requesting physician, prior to the Fair Hearing, the educational and medical credentials of the Hearing Officer.	Retain. Still relevant.
H-340.907	Notification When Physician Specific Information is Exchanged	The AMA will petition CMS to require notification of a physician under focused review that his or her name is being exchanged between any carrier and the QIOs and to identify the reason for this exchange of information.	Retain. Still relevant.
H-365.997	Corporation or Employer-Sponsored Examinations	The AMA encourages employers who provide or arrange for special or comprehensive medical examinations of employees to be responsible for assuring that these examinations are done by physicians competent to perform the type of examination required. Whenever practical, the employee should be referred to his or her personal physician for such professional services. In the many instances in which an employee does not have a personal physician, efforts should be made to assist him or her in obtaining one, with emphasis on continuity of care. This effort should be aided by the local medical society wherever possible.	Retain. Still relevant.
H-373.999	Patient Advocacy/Protection Activities	The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms.	Retain. Still relevant.
H-375.977	Peer Review - Caused Litigation	The AMA urges medical staffs to review their hospital's policies for directors and officers liability and general liability coverage to determine if the policy provides defense, indemnity, or loss of income coverage for those members of the	Retain. Still relevant.

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		medical staff who are involved in a lawsuit as a result of the activities they have performed in good faith, conducting official peer review responsibilities or other official administrative duties of the medical staff.	
H-375.978	Medical Peer Review Outside Hospital Settings	The AMA requests state medical associations to study the need for, and if appropriate, to pursue the enactment of, legislation designed to protect the records of peer review activities in ambulatory health care facilities against discoverability in judicial or administrative proceedings.	Rescind. Accomplished.
H-385.923	Definition of "Usual, Customary and Reasonable" (UCR)	<p>1. Our AMA adopts as policy the following definitions:</p> <p>(a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);</p> <p>(b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and</p> <p>(c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.</p> <p>2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-385.962	Physician Bargaining	The AMA acknowledges that some state medical associations are in favor of a budgeting process that incorporates the ability for physician groups to bargain collectively on state-level budgets and will continue to support such state medical associations in their negotiations and development of budgeting process.	<p>Rescind. Superseded by Policies H-165.888 and H-155.960.</p> <p>Evaluating Health System Reform Proposals H-165.888</p> <p>1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:</p> <p>A. Physicians maintain primary ethical responsibility to advocate for their patients’ interests and needs.</p> <p>B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.</p> <p>C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.</p> <p>D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and</p> <p>procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including</p>
			<p>procedures for medical review, quality assurance, grievance procedures, credentialing criteria,</p>

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			<p>and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.</p> <p>E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.</p> <p>F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.</p> <p>G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.</p> <p>H. True health reform is impossible without true tort reform.</p> <p>2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.</p> <p>3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.</p> <p>4. Our AMA supports health system reform alternatives that are</p>

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			<p>consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.</p> <p>Strategies to Address Rising Health Care Costs H-155.960</p> <p>Our AMA:</p> <p>(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;</p> <p>(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and</p> <p>(d) promote “value-based decision-making” at all levels;</p> <p>(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;</p> <p>(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;</p> <p>(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers</p>

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			<p>with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;</p> <p>(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;</p> <p>(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and</p> <p>(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.</p> <p>(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.</p>
H-385.963	Physician Review of Accounts Sent for Collection	(1) The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (2) The AMA urges physicians to use compassion and discretion in sending accounts of their patients to collection, especially accounts	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care.	
H-390.884	Medicare Policy Change	Primary Care Consultation Policy: The AMA opposes Medicare’s policy regarding denial of payment for consultation provided by primary care physicians for patients who are being cleared for surgery, as this policy is contrary to the best interests of Medicare patients and the fundamental goals of RBRVS, and will take any measures possible to have this policy changed.	<p>Rescind. Superseded by Policy D-70.953.</p> <p>Medicare’s Proposal to Eliminate Payments for Consultation Service Codes D-70.953</p> <p>Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services’ (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.</p>

POLICY #	Title	Text	Recommendation
H-390.891	Hospital Services Provided Within Three Days of Hospital Admission	The AMA will resist strongly efforts to incorporate payment for Medicare Part B physician services into hospital payments.	<p>Rescind. Superseded by Policy H-280.947.</p> <p>Three Day Stay Rule H-280.947</p> <ol style="list-style-type: none"> 1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients. 2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services. 3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement.
H-390.962	Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986	(1) The AMA opposes efforts by commercial carriers or the federal government which would require physicians to predict reimbursement for services rendered. (2) The AMA supports the repeal of the provision of OBRA 1986 regarding notification of patients receiving elective surgery of the physician charge, the expected amount of Medicare reimbursement, and the balance that the patient would be responsible for paying when the charge for the service is \$500 or more and the claim is not accepted on an assigned basis. (3) The AMA supports repeal of those provisions of OBRA that require physicians to refund payments associated with Medicare services that are deemed medically unnecessary by CMS after the fact. (4) The AMA believes that increases in Medicare reimbursement need to be universal, that current reimbursement should be adjusted and that there should be no discrimination in	<p>Rescind. Superseded by Policy H-335.992.</p> <p>Modifying the Medicare Unnecessary Services Program H-335.992</p> <p>(1) The AMA continues to support the repeal of the “medically unnecessary” provisions of Section 9332(c) of OBRA 1986. (2) Until such time as repeal is achieved, the AMA urges CMS to require that there be stated on the medically unnecessary notices mailed by carriers (a) the basis for the denial; (b) the name, position, and title of the person to be contacted regarding questions about the review; and (c) the screening criteria or parameter used in denying payment for the service.</p> <p>Additionally, Policy</p>

POLICY #	Title	Text	Recommendation
		schedules between participating and nonparticipating physicians	<p>H-330.892 supports physician choice of Medicare participation.</p> <p>Medicare Participation Status H-330.982 It is AMA policy to eliminate any restrictions, including timing, on physicians' ability to determine their Medicare participation status.</p>
H-390.992	Prospective Payment System and DRGs for Physicians	The AMA (1) endorses the concept that any system of reimbursement for physicians' services should be independent of reimbursement systems for other providers of health care; and (2) opposes expansion of prospective pricing systems until their impact on the quality, cost and access to medical care have been adequately evaluated.	<p>Rescind. Superseded by Policy H-385.989.</p> <p>Payment for Physicians Services H-385.989 Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by</p>

POLICY #	Title	Text	Recommendation
			<p>physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.</p> <p>Additionally, Policy H-385.922 supports using the term “payment” instead of “reimbursement” as the term for compensating physicians.</p> <p>Payment Terminology H-385.922 It is AMA policy to change the terminology used in compensating physicians from “reimbursement” to “payment.”</p>
H-400.984	Geographic Practice Costs	<p>1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic payment areas for use in the new Medicare physician payment system.</p> <p>2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices.</p>	Rescind. (1) Addressed by PPI ; (2) Addressed by CMS .
H-400.988	Medicare Reimbursement, Geographical Differences	The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas.	<p>Rescind. Superseded by Policy H-155.957.</p> <p>Geographic Variation in Health Care Cost and Utilization H-155.957 Our American Medical Association: (1) encourages further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk</p>

POLICY #	Title	Text	Recommendation
			<p>adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services; (2) encourages the development of interoperable national claims databases in order to facilitate research into health care utilization patterns across all segments of the health care delivery system; and (3) supports efforts to reduce variation in health care utilization that are based on ensuring appropriate levels of care are provided within the context of specific clinical parameters, rather than solely on aggregated benchmarks.</p>
H-410.980	Principles for the Implementation of Clinical Practice Guidelines at the Local/State/Regional Level	<p>Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..</p> <p>(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.</p> <p>(3) clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice parameters that conform to</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>established principles, including relevant AMA policy on practice parameters.</p> <p>(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.</p> <p>(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.</p> <p>(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.</p> <p>(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.</p> <p>(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.</p> <p>(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.</p> <p>(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.</p>	
H-415.999	Preferred Provider Organizations	The AMA believes that state and local medical societies should (1) monitor PPOs which develop in their areas and should apprise their members of the status, structure and extent of physician and	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		provider enrollment in any such plans; and (2) consider investigating the pros and cons of the society itself serving as an organizational focus for local physicians' effective and informed responses to PPOs, without compromising support for the existing policy of pluralism in health care delivery systems.	
H-440.840	Patient Access to Anti-Tuberculosis Medications	Our AMA supports state and federal policy to cover TB testing for individuals deemed to have a high risk for contracting TB infection and to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of this airborne infectious disease.	Retain. Still relevant.
H-465.982	Rural Health	The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.	Retain. Still relevant.
H-480.948	Medicare/Medicaid Coverage of Multi-Use Technology Platforms	AMA policy is that third party payers, including the Medicare and Medicaid programs, should investigate the possibility of allowing patients to use common consumer electronic devices as assistive devices and reimburse patient expenses related to the acquisition of such devices when used for bona fide health care needs.	Rescind. Superseded by Policies H-480.943 and H-385.919 . Integration of Mobile Health Applications and Devices into Practice H-480.943 1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure

POLICY #	Title	Text	Recommendation
			<p>patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state’s medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.</p> <p>2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients’ medical information.</p> <p>3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.</p> <p>4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.</p>

POLICY #	Title	Text	Recommendation
			<p>5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.</p> <p>6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient’s understanding of such risks</p> <p>7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.</p> <p>8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.</p> <p>Payment for Electronic Communication H-385.919 Our AMA will: (1) advocate that pilot projects of innovative payment models be structured to include incentive payments for the use of electronic communications such as Web portals, remote patient monitoring, real-time virtual office visits, and email and telephone communications; (2) continue to update its guidance on communication and information technology to help physicians meet the needs of their patients and practices; and (3) educate physicians on how to effectively and fairly bill for electronic communications between patients and their physicians.</p>
H-510.990	Health Care Policy for Veterans	Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).	Rescind. Superseded by Policies H-510.983 and H-510.985 . Expansion of US Veterans’ Health Care Choices H-510.983 1. Our AMA will continue to work with the Veterans Administration

POLICY #	Title	Text	Recommendation
			<p>(VA) to provide quality care to veterans.</p> <p>2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.</p> <p>3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.</p> <p>4. Our AMA will support consolidation of all the VA community care programs.</p> <p>5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.</p> <p>6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.</p> <p>7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.</p> <p>8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.</p> <p>9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.</p> <p>10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.</p>

POLICY #	Title	Text	Recommendation
			<p>Access to Health Care for Veterans H-510.985</p> <p>Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.</p>
H-55.994	Coverage of Chemotherapy in Physicians' Offices	The AMA advocates that physicians who bill any third party payer for administering chemotherapy should ensure that the services billed for are described adequately and fully on the appropriate claim form and that the chemotherapy descriptors and code numbers provided by CPT are utilized.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-55.995	Medicare Coverage of Outpatient Chemotherapy Drugs	Carriers should recognize and encourage the administration of chemotherapy in physicians' offices, wherever practical and medically acceptable, as being more cost-effective than administration in many other settings.	Retain. Still relevant.
H-70.980	Bundling CPT Codes	<ol style="list-style-type: none"> 1. Our AMA, through its CPT Editorial Panel and Advisory Committee, will continue to work with CMS to provide physician expertise commenting on the medical appropriateness of code bundling initiatives for Medicare payment policies. 2. Our AMA strongly urges the Centers for Medicare & Medicaid Services (CMS) to not treat bundling of existing services into a common code as a new procedure and new code. 3. Our AMA will advocate for a phase-in of new values for codes where the cuts resulting from the identification of misvalued services cause a significant reduction from the value of the existing codes and work with CMS to achieve a smooth transition for such codes. 4. The RUC will take into consideration CMS's willingness or reluctance to transition large payment reductions as it schedules the review of relative values for bundled services or other codes that come before the RUC as a result of the identification of potentially misvalued services. 5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA. 	Retain. Still relevant.
H-75.988	Extension of Medicaid Coverage for Family Planning Services	The AMA supports legislation that will allow states to extend Medicaid coverage for contraceptive education and services for at least two years postpartum for all eligible women.	Retain. Still relevant.
H-90.971	Enhancing Accommodations for People with Disabilities	Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.	Retain. Still relevant.
H-90.986	SSI Benefits for Children with Disabilities	The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.	Retain. Still relevant.

2. MEDICARE COVERAGE OF DENTAL, VISION, AND HEARING SERVICES (REFERRED RESOLVE CLAUSE OF ALTERNATE RESOLUTION 113-A-22)

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF REFERRED RESOLVES OF ALTERNATE RESOLUTION 113-A-22 REMAINDER OF REPORT FILED

See Policies D-160.925, D-390.946, H-25.990, H-185.929 and H-330.872

At the 2022 Annual Meeting, the House of Delegates partially referred Alternate Resolution 113, which asked the American Medical Association (AMA) to “support new funding that is independent of the physician fee schedule for Medicare coverage of 1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; 2) visual aids, including eyeglasses and contact lenses; and 3) aural rehabilitative services and hearing aids.

Resolution 119 was combined with similar resolutions 113 and 114 to become Alternate Resolution 113, which was passed in part to become Policy D-185.972, “Increasing Patient Access to Hearing, Dental, and Vision Services.” The policy states that the AMA will promote awareness of hearing impairment as a potential contributor to cognitive impairment later in life and encourage further research on this topic. This policy also encourages increased patient access to both vision and dental services.

There was mixed testimony heard on these related items. There were several calls for referral, but support for ensuring that patients have access to, and coverage for, essential hearing, dental, and vision services. Some testimony noted that some of the resolve clauses of the original resolutions did not align with the United States Preventive Task Services Task Force (USPSTF) recommendations for hearing and vision screening for older adults. Further testimony stressed that the expansion of health insurance coverage, and potentially Medicare benefits, for dental, vision, and hearing services needs to be considered not only from the patient perspective, but within the context of a Medicare payment infrastructure that is unsustainable for physician practices. In response to concerns regarding how coverage for these services would be paid for, an amendment was proffered to ensure that our AMA supports new Medicare funding that is independent of the Medicare Physician Payment Schedule to pay for these services. However, the Reference Committee noted in its report that expanding dental, vision, and hearing coverage would still require “pay-fors” in the current Congressional environment, pitting these coverage expansions against other AMA priorities that require funding. This referred clause was assigned by the Board of Trustees to the Council on Medical Service for study.

The Council has developed reports on these topics in recent years. In 2015, the Council authored CMS Report 6, “Hearing Aid Coverage” and concluded that a recommendation supporting adult hearing aid coverage mandates would conflict with Policies H-185.964 and H-165.856, which oppose new health benefit mandates unrelated to patient protections and which jeopardize coverage to currently insured populations, and supports the principle that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. Given the policy, the Council did not recommend that the AMA support Medicare coverage for hearing aids.

In 2019, the Council authored CMS Report 3, “Medicare Coverage for Dental Services” and concluded that the AMA should continue to explore opportunities to work with the American Dental Association (ADA) to improve access to dental care for Medicare beneficiaries, support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, explore optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and examine the impact of expanded dental coverage on health care costs and utilization.

BACKGROUND

The most recent enrollment data from the Centers for Medicare & Medicaid Services (CMS) show that over 65 million individuals are enrolled in Medicare. This includes 35 million individuals enrolled in traditional fee-for-service Medicare plans and a little over 30 million individuals enrolled in Medicare Advantage plans.¹ According to a 2019 Kaiser Family Foundation (KFF) poll, 16 percent of Medicare beneficiaries reported they could not get

access to dental, vision, or hearing care. These numbers were higher amongst those with low incomes, in poor health, and/or in communities of color.²

Another 2019 KFF poll indicated that 90 percent of the American public supported expanding Medicare to include dental, hearing, and vision care as a “top” or “important” priority for Congress.³ However, recent attempts at passing legislation in Congress have not been successful. In 2019, the House passed H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. Title VI of this bill would have added new benefits for dental, vision, and hearing coverage under Medicare, such as dentures, glasses, hearing aids, and preventive services. The Congressional Budget Office (CBO) estimate for this bill was \$358 billion over the next ten years (\$238 billion for dental coverage, \$30 billion for vision coverage, and \$89 billion for hearing coverage).⁴ In 2021, H.R. 4311, the Medicare Dental, Vision, and Hearing Benefit Act was introduced in the House and proposed repealing the statutory exclusion that restricts coverage of dental, vision, and hearing benefits, and expanding coverage to offer these services under Medicare Part B. Neither of these bills advanced out of Congress. In March 2023, Senators Bob Casey (D-PA) and Ben Cardin (D-MD) introduced a similar bill, S.842, The Medicare and Medicaid Dental, Vision, and Hearing Benefit Act. This bill would also repeal the statutory exclusion that restricts coverage of dental, vision, and hearing services and expand coverage to offer:

- Dental and oral care, including coverage of routine cleanings and exams, fillings and crowns, major services such as root canals and extractions, emergency dental care and other necessary services, and payment for both full and partial dentures.
- Vision care, including routine eye exams, procedures performed to determine the refractive states of the eyes and other necessary services, and payment for eyeglasses, contact lenses, and low-vision devices.
- Hearing care, including hearing exams, exams for hearing aids and other necessary services, and payment for hearing aids.

This bill also encourages states to provide these optional services to people with Medicaid by increasing the associated Federal Medical Assistance Percentage rate to 90 percent. At the time that this report was written, this bill was referred to the Senate Committee on Finance and the full text of the bill was not yet available.

DENTAL CARE AND COVERAGE

The medical-dental coverage divide first began in the 20th century. In the early 1900s, oral health was widely thought to have little to no bearing on overall health and efforts to combine medical and dental fields were opposed by dentists. In the 1920s, William Gies, a biological chemist, insisted that oral health was directly related to overall health and recommended dentistry should be integrated into the medical field, but dentists again resisted this change. During the 1940s and 1950s, the AMA and the ADA joined efforts to oppose health insurance nationalization and/or expansion. During this same period, tap water fluoridation improved oral disease prevention among Americans, which some believed mitigated the need for some dental services and reduced demand for dental insurance coverage. Moreover, because dental service coverage began being widely included in employer-sponsored benefit packages later than medical health service coverage, it was considered a “perk” or cosmetic-only benefit, a perception that continues as dental care is still regarded by many as auxiliary to general health care even though current research clearly demonstrates the critical relationship between oral health and optimal overall health. When Medicare legislation was passed in 1965, oral health coverage was not included. As a result, the medical profession has frequently had to respond to the challenges of Medicare and Medicaid coverage and changes in payment policy over the years, while dentistry has not.⁵

A statutory exclusion in Section 1862(a)(12) of the Social Security Act expressly prohibits coverage for most dental services, specifically, “services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth” by Medicare for its beneficiaries.⁶ Therefore, traditional Medicare regulations do not include coverage for routine oral health care including checkups, cleanings, and x-rays, or restorative procedures, tooth extraction, and dentures. To integrate dental benefits in Medicare, Congress would need to remove this exclusion, and add statutory changes, such as establishing the scope of dental services and a mechanism for provider payment that is independent from the Medicare Physician Payment Schedule.

As of 2018, almost half of Medicare beneficiaries did not have a dental visit within the past year (47 percent), with higher rates among those who are Black (68 percent) or Hispanic (63 percent), have low incomes (73 percent), or who are in fair or poor health (63 percent). Nonetheless, 94 percent of Medicare Advantage enrollees in individual plans are in a plan that offers access to some dental coverage. Nearly two-thirds of Medicare Advantage enrollees (64 percent) with access to preventive benefits, such as oral exams, cleaning and/or x-rays, pay no cost sharing for these services, though their coverage is typically limited to an annual dollar amount. Average out-of-pocket

spending on dental services among Medicare beneficiaries (both traditional fee-for-service and Medicare Advantage) who had any dental service was \$872 in 2019. Those enrolled in Medicare Advantage plans paid slightly less out-of-pocket than those enrolled in traditional Medicare (\$729 vs. \$995).⁷ A February 2023 study published in *Health Affairs* found substantial declines in dental service use and worsened health outcomes after individuals became eligible for traditional Medicare at age 65. Additionally, this study found that there was also evidence of lower dental service use by those beneficiaries who opted for a Medicare Advantage plan and who likely have some coverage for these services. The authors suggest that benefit and plan design should not only offer coverage of these services, but also address barriers to access to necessary care beyond whether or not a beneficiary has coverage (i.e., out of pocket affordability for co-pays/coinsurance, lack of familiarity with covered benefits, or inability to find local dentists accepting Medicare or Medicare Advantage patients).⁸

Historically, Medicare has paid for dental services when they are integral and inextricably linked to treating a beneficiary's primary medical condition. However, the services Medicare paid for were limited to those specified in sub-regulatory guidance, such as reconstruction of a ridge when performed as a result of and at the same time as the surgical removal of a tumor; stabilization or immobilization of teeth when done in connection with the reduction of a jaw fracture; extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; dental splints only when used in conjunction with medically necessary treatment of a medical condition; and dental services – including both examination and treatment – prior to organ transplants, cardiac valve replacements, and valvuloplasty.⁹ Beginning in 2023, CMS formally codified these existing services in rulemaking and added additional services to the dental exclusion exception including dental examination and treatment when performed prior to a cardiac valve replacement and valvuloplasty or organ transplant procedures. In 2024, coverage will be expanded to include dental services to eliminate infection prior to treatment for head and neck cancers.

Additionally, the new regulation establishes an annual process to review public input and clinical evidence on other medical circumstances that may allow for payment of relevant dental services under the same exception.¹⁰ Medical associations and their members are encouraged to participate in this annual review process by submitting their comments.

ADA policy states that for the purpose of presenting potential legislation that includes dental benefits for adults age 65 and over in a tax payer-funded public program such as, Medicaid, Children's Health Insurance Program (CHIP), privately administered Medicare or other federal or state programs, the ADA supports a program that: 1) covers individuals under 300 percent FPL; 2) covers the range of services necessary to achieve and maintain oral health; 3) is primarily funded by the federal government and not fully dependent on state budgets; 4) is adequately funded to support an annually reviewed reimbursement rate such that at least 50 percent of dentists within each geographic area receive their full fee to support access to care; 5) includes minimal and reasonable administration requirements; and 6) allows freedom of choice for patients to seek care from any dentist while continuing to receive the full program benefit.¹¹ The full text of the policy can be found here: <https://www.ada.org/about/governance/current-policies#medicare>.

VISION CARE AND COVERAGE

Medicare Part B covers certain vision services including treatment for glaucoma, macular degeneration, cataract surgery (if done using traditional surgical techniques or using lasers), annual eye exams for diabetic retinopathy for patients with diabetes, and annual glaucoma tests for patients at high risk for developing glaucoma. However, traditional Medicare does not typically cover routine eye examinations or refractions for eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves, other than eyeglasses following cataract surgery or corrective lenses if a patient has cataract surgery that implants an intraocular lens.^{12,13}

Beneficiaries typically spend significantly less on vision coverage compared to dental and hearing services. Traditional Medicare does not generally cover routine eye exams. However, beneficiaries can seek supplemental vision coverage from Medicare Advantage or other private insurance coverage. As of 2021, 99 percent of Medicare Advantage enrollees have access to some vision coverage. 93 percent of Medicare Advantage enrollees are in plans that provide access to both eye exams and eyewear (contacts and/or eyeglasses). However, enrollees may be limited in terms of frequency of obtaining certain covered services and may be subject to annual dollar limits.¹⁴

Another option for seniors to receive an eye exam and eye health services is through EyeCare America, which connects eligible seniors 65 and older with local volunteer ophthalmologists who provide a medical eye exam often

at no cost out-of-pocket, and up to one year of follow-up care for any condition diagnosed during the initial exam and for the physician services. To qualify, an individual must be a U.S. citizen or legal resident, aged 65 or older, not belong to a Health Maintenance Organization or have eye care benefits through the Veterans Affairs, and not have seen an ophthalmologist in three or more years. Notably, EyeCare America does not directly cover the cost of eyeglasses, but can provide information to patients on where to get help paying for eyeglasses if they are needed.^{15,16}

HEARING CARE AND COVERAGE

When Medicare was enacted in 1965, it did not include any coverage for hearing aids. Hearing aids were considered “not routinely needed and low in cost” and many Americans did not live long enough to need them. Today, hearing loss affects one-third of adults over the age of 65 and has a significant impact on health.¹⁷ Traditional Medicare does not cover hearing exams, hearing aids, or aural rehabilitative services. Medicare Advantage charges additional premiums for hearing coverage, with out-of-pocket costs and annual limits varying across plans. Traditional Medicare covers medically reasonable and necessary hearing tests and treatments when ordered by a physician or a non-physician practitioner including diagnostic services related to hearing loss that is treated with surgically implanted hearing devices, and covers cochlear implants if a beneficiary meets specific hearing loss criteria.¹⁸ Starting January 1, 2023 Medicare Part B expanded coverage of audiology services to allow beneficiaries to receive care from an audiologist without a physician or practitioner order once every 12 months for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.^{19,20,21} AMA policy supports coverage of hearing tests administered by a physician or a physician-led team under Medicare’s benefit (H-185.929).

In 2021, the USPSTF reviewed the need to screen asymptomatic adults over the age of 50 for hearing loss and concluded that the current evidence is insufficient to assess the balance of benefits versus the harms of screening for hearing loss in older adults. The USPSTF also stated that additional research was necessary.²²

In 2022, the Biden Administration issued an executive order for the Food and Drug Administration (FDA) to allow over the counter (OTC) purchase of hearing aids for those with mild to moderate hearing loss. OTC purchase of hearing aids became available in October 2022 and provides an immediate, low-cost option for adults with mild to moderate hearing loss. OTC hearing aids range in price from \$99 to \$3400 per pair and are readily available at local pharmacies, large retailers, and online. By increasing competition among OTC hearing aid companies, the FDA rule is designed to create more options for those who experience hearing loss and who want to purchase affordable hearing aids.^{23,24}

MEDICARE PART B AND BUDGET NEUTRALITY

Medicare law requires that increases and decreases in payment rates by CMS must be budget neutral – i.e., any changes resulting from regulatory changes made by CMS must have no impact on total Medicare spending. Typically, this is done by lowering the Medicare “conversion factor.” Increases in total Medicare spending are set by law. Unlike hospitals and nursing homes, Medicare physician payments lack an automatic annual update. As a result, Medicare payments have failed to keep pace with rising inflation.

The Statutory Pay-As-You-Go Act of 2010 (PAYGO) requires that all new legislation changing taxes, fees, or mandatory expenditures, when assessed together, must not increase projected deficits. If legislation is enacted that cuts taxes or increases expenditures without fully offsetting the cost, PAYGO applies a budget enforcement mechanism called sequestration. Sequestration is the automatic reduction of certain types of spending in the federal budget, generally by a uniform percentage.^{25,26}

If Congress adjourns at the end of a session with net costs on the Office of Management and Budget scorecard, the President is required to issue a sequestration order implementing across-the-board cuts to a select group of federal mandatory programs in an amount sufficient to offset the net costs. There are some exemptions from sequestration, such as Social Security, most unemployment benefits, interest on the national debt, federal retirement, and low-income entitlements (i.e., Medicaid, Supplemental Nutrition Assistance Program, and Supplemental Security Income). However, the major remaining mandatory programs are subject to sequestration – including Medicare. If sequestration is ordered, each non-exempt mandatory program is reduced for one year by the same percentage, with one notable exception: Medicare payments subject to sequestration cannot be reduced by more than four percent. If sequestration would require a percent reduction greater than four percent, other non-exempt mandatory programs

must make up the difference. To date, a sequester pursuant to PAYGO has not been applied, as Congress has either exempted legislation from PAYGO requirements or otherwise deferred the application of such requirements.²⁷

POTENTIAL MEDICARE COVERAGE OPTIONS FOR DENTAL, VISION, AND HEARING SERVICES

Expansion of Medicare coverage to new services has been considered and debated extensively. While many believe that Medicare beneficiaries should have coverage for a wider range of services, there are significant challenges to expanded coverage. Proponents of expanding Medicare coverage for dental, vision, and hearing services have suggested the following:

- Congress could change the law to add dental, vision, and hearing coverage under traditional Medicare Part B. The benefits of this option are that it would impact all 65 million Medicare beneficiaries and could lead to enhanced benefits that are integrated into other Medicare-covered services. The challenges facing this option include determining new claims systems and payment schedules that are independent of the Medicare Physician Payment Schedule. Perhaps the largest challenge to this approach is the price tag assigned by CBO: \$358 billion over the next ten years is an enormous sum, especially when the current level of inflation is added to this previous score. Another major challenge involves budget neutrality requirements. If these services were covered under Medicare Part B, the conversion factor would need to be significantly reduced to balance the increased spending, thereby reducing payment for other Medicare Part B services. Alternatively, if the conversion factor were to remain the same and the new funding was independent of the Medicare Physician Payment Schedule, the pool of money allotted for Medicare Part B would still have to increase substantially, which is also untenable. Under either of these scenarios, funding for this option would be diverted from another program and there is potential risk for competing federal priorities for the AMA (i.e., the AMA's Recovery Plan for America's Physicians).
- Beneficiaries could enroll in Medicare Advantage (Part C) plans. Coverage for dental, vision, and hearing services under Medicare Advantage is already an option for most beneficiaries. These services are often offered through supplementary coverage under Medicare Advantage plans. Most Medicare Advantage enrollees are in plans that offer dental (96 percent), vision (99 percent), and hearing (98 percent) coverage. Medicare Advantage plans can vary, but most plans cover both preventive and extensive dental services, access to eye exams and eyewear (contacts and/or glasses), and hearing exams and hearing aids. Medigap plans may also cover dental, vision, and hearing services to supplement traditional Medicare coverage.
- A new, optional part of Medicare for dental, vision, and hearing coverage that would be similar to Medicare Part D for prescription drug coverage could be created. Beneficiaries would have the option to sign up, likely for an additional premium. While this new part would not be subject to the specific budget neutrality requirements of adding coverage for these services under Medicare Part B, the challenge of how to pay for this coverage still remains. This solution could also further complicate the Medicare system and is largely redundant for Medicare Advantage beneficiaries since the vast majority of Medicare Advantage (Part C) plans already offer coverage for dental, vision, and hearing services for an additional premium. Again, there is also the risk that advocacy for this option would be in competition with other AMA priorities.
- A form of cash assistance or debit card for beneficiaries who do not have access to coverage for dental, vision, and/or hearing services could be established. While this option could be less costly than the others presented, there is still a funding challenge present. Other outstanding questions include the amount of money offered to each beneficiary, the impact on beneficiaries who already have some sort of supplemental coverage, and how government officials would ensure this assistance was only being utilized for covered services. More research would need to be completed before consideration of this option.

AMA POLICY

AMA Policy D-160.925 affirms the importance of oral health care. Policy H-330.872 affirms that the AMA supports continued opportunities to work with the ADA and other interested national organizations to improve access to dental care for Medicare beneficiaries. The policy goes on to affirm AMA support for initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

Policy H-25.990 states that the AMA encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients.

Policy H-185.929 states that the AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the cost of hearing aid purchases, hearing-related exams and related services; supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit; supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and supports the availability of over the counter hearing aids for the treatment of mild-to-moderate hearing loss.

Policy D-185.972, established with the adoption of Alternate Resolution 113-A-22, affirms that the AMA will promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia later in life and encourage other stakeholders to promote the conduct and acceleration of research into specific patterns of hearing loss to determine those most linked to cognitive impairment or dementia and amenable to correction. The AMA will work with interested national medical specialty societies and state medical associations to encourage and promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services; and promote research into vision and dental health and to increase patient access to vision and dental services.

More broadly, Policy H-185.964 states that the AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. Additionally, Policy D-390.946 affirms that the AMA will work towards the elimination of budget neutrality requirements within Medicare Part B; will eliminate, replace, or supplement budget neutrality in Merit-based Incentive Payment System with positive incentive payments; and will advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option.

Other related policies include D-330.935 and H-425.988, which state that the AMA will collaborate with relevant stakeholders to actively promote the value of the Welcome to Medicare Visit, the Tobacco Cessation Benefit, and other Medicare-covered preventive services, as well as work with the federal government and other stakeholders to support providing preventive service coverage for seniors.

As part of its Recovery Plan for America's Physicians, the AMA has dedicated an entire strategic pillar to reforming the Medicare physician payment system. In February 2023, the AMA led nearly 100 organizations in asking Congress to explore long-term solutions to the Medicare physician payment problems. The AMA is encouraging the 118th Congress to "work with us on long-term, substantive payment reforms and urge congressional hearings as soon as possible to begin exploring potential payment solutions to ensure America's seniors continue to receive access to the high-quality care they deserve."²⁸

DISCUSSION

There are several aspects to consider when exploring ways to expand coverage for dental, vision, and hearing services to Medicare beneficiaries, including cost, access, the current political environment, the relevance of these services to overall health, existing AMA efforts to improve Medicare payment to physicians, and the scope of the AMA's influence.

Given the current rate of inflation, the \$358 billion projection from CBO in 2019 to include coverage for dental, vision, and hearing services in the Medicare program over the next decade would likely be substantially higher today. In an environment in which Medicare is subject to statutory budget neutrality requirements, the Council believes it is impossible to consider this issue in a vacuum and the AMA must acknowledge the likely impact that adding these services would mean for payment and access to current health care services for Medicare beneficiaries. At the time that this report was written, the bill recently introduced by Senators Casey and Cardin did not have a CBO score nor was the full text of the bill available.

The Council acknowledges the potential value of expanded Medicare benefits. Nonetheless, dental, vision, and hearing services already are frequently offered through supplementary coverage under Medicare Advantage (Part C) or Medigap plans. Veterans can receive coverage for these services through Veterans Health Administration (VHA) plans (including free hearing aids), and low-income individuals can often receive coverage through Medicaid. Other beneficiaries have private coverage offered through an employer or an individually purchased plan.

In terms of the current political environment, at the time that this report was written, Congress had recently failed to prevent a budget neutrality cut to the Medicare physician conversion factor and was facing a stalemate on how to move forward with managing the national debt. At a time when physicians are already fighting to keep practices open amid continued payment cuts due to lack of an annual inflation-based update, frozen Medicare payment rates under the Medicare Access and CHIP Reauthorization Act, and budget neutrality restrictions, pursuing broader Medicare coverage expansions would be extremely challenging. Enacting Medicare physician payment reform remains one of the AMA's highest priorities under our Recovery Plan for America's Physicians.

The Council also reemphasizes the importance of working with the ADA when it comes to strategies to expand dental coverage to Medicare beneficiaries. It is crucial for the ADA and the AMA to work together to navigate the current policy landscape regarding infringements on the Medicare Physician Payment Schedule. While the Council acknowledges that oral health care is a critical part of overall health care, we believe that our dental colleagues are best positioned to assess the payment structures that work best for their needs. Notably, in 2020, the ADA enacted new policy to address dental coverage under Medicare. The AMA will continue to work closely with the ADA to share data on oral health care's impact on overall health, as stated in AMA policy.

The Council believes that the AMA can be most influential in addressing the need for hearing services through improving mechanisms already in place. Physicians should educate and encourage their patients on lower cost hearing aids that are now available over the counter for mild to moderate hearing loss. Additionally, the AMA can encourage the USPSTF to re-evaluate its decision not to recommend screening for hearing loss in asymptomatic adults over age 65, especially considering the new evidence that exists about the connection of hearing loss and dementia. Hearing loss caught and treated early could prevent the onset of dementia and improve quality of life for the aging population.

Finally, the Council believes that AMA policy on vision coverage could be strengthened, and we recommend amendments to Policy H-25.990 to encourage programs and outreach efforts for affordable prescription eyeglasses.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of the referred Resolve clause of Alternate Resolution 113-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
2. That our AMA encourage the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia.
3. That our AMA amend Policy H-25.990 by addition to read as follows:

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

4. That our AMA reaffirm Policy D-160.925, which recognizes the importance of managing oral health and the importance of dental care to optimal patient care and supports the exploration of opportunities for

collaboration with the American Dental Association (ADA) on comprehensive strategy for improving oral health care and education for clinicians.

5. That our AMA reaffirm Policy H-330.872, which supports the American Medical Association's continued work with the ADA to improve access to dental care for Medicare beneficiaries and supports initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.
6. That our AMA reaffirm Policy H-185.929, which supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit and policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly and supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.
7. That our AMA reaffirm Policy D-390.946, which supports the American Medical Association's work towards the elimination of budget neutrality requirements within Medicare Part B.

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APPENDIX - Policies Recommended for Amendment or Reaffirmation

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians. (Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19)

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (CMS Rep. 03, A-19)

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. (Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15)

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.

5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. (CMS Rep. 6, I-15; Appended: Res. 124, A-19)

Sequestration D-390.946

Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services. (Res. 212, I-21; Reaffirmed: Res. 240, A-22)

3. PRIVATE INSURER PAYMENT INTEGRITY (RESOLUTION 110-A-22)

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 110-A-22
REMAINDER OF REPORT FILED**

See Policies D-185.986, D-460.967, H-165.856, H-185.915, H-185.986 and H320.995

At the June 2022 Annual Meeting, the House of Delegates referred Resolution 110, which was sponsored by the New York Delegation. Resolution 110-A-22 asked the American Medical Association (AMA) to advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare and seek legislation or regulation to ensure that private insurers shall not be allowed to deny payment for treatment options as “experimental and/or investigational” when they are covered under government plans. Testimony at the June 2022 Annual Meeting regarding the resolution was generally opposed, highlighting the complex issues surrounding private insurer versus governmental coverage, specifically regarding benefit mandates and the differential drivers utilized in making medical coverage determinations. This report focuses on the need for transparency of medical coverage determinations, studies how ‘investigational’ diagnosis and treatment options are determined, highlights essential AMA policy, and presents new policy recommendations.

BACKGROUND

Coverage Determinations by Private Insurers

Private insurers are a fragmented group of commercial plans operating under a broad range of federal regulations as well as insurance and coverage rules and regulations that vary by state. Some private insurers operate nationally. While they may look to governmental precedent in certain situations, they each make their own medical coverage determinations, which can vary across their product lines. Access to private insurers’ medical coverage decisions is limited, but not entirely restricted. For example, on the UnitedHealthcare (UHC) web site, the UHC commercial policy on coverage of “Off-Label/Unproven Specialty Drug Treatment” includes a Food & Drug Administration (FDA) section, noting that it is “to be used for informational purposes only...FDA approval alone is not a basis for coverage.”

Private insurers sometimes are able to deny coverage by labelling a diagnostic or treatment “investigational,” “experimental,” or “not medically necessary,” which may be exacerbated by the burdensome appeals process required to request reconsideration of a denial or adverse determination. Patients are typically not aware of their right to appeal or legal due process protections. This health insurance illiteracy is compounded among patients with

limited access to technology and other resources, leading to the potential for substantial health inequities across private plans.

Coverage Determinations by the Centers for Medicare & Medicaid Services

Of government payers, Medicare is typically considered the national benchmark, particularly since it is a federal defined benefit program, with decisions centralized within the Centers for Medicare & Medicaid Services (CMS). Title XVIII of the Social Security Act established Medicare with coverage that is limited to items and services that are:

- reasonable and necessary for the diagnosis or treatment of an illness or injury; and
- within the scope of a Medicare defined benefit category.

National Coverage Determinations

The vast majority of Medicare coverage is determined on the local level by clinician contractors (Medicare Administrative Contractors [MACs] making Local Coverage Determinations [LCDs]). However, in some cases, Medicare develops National Coverage Determinations (NCDs) that are applied for all Medicare beneficiaries meeting the coverage criteria.

The NCD process is a nine-month, evidence-based process with opportunities for public comment and supplemental technological assessment by the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC), which may include clinical studies. If the NCD determines coverage of an item or service only in the context of clinical study, it falls under the Coverage with Evidence Development (CED) program. NCDs in the CED program use available evidence to fit that item or service within that benefit category. As such, CMS can act as a coverage gatekeeper via the NCD process. This mechanism has been used over the past few decades and includes evidence-based guidelines for coverage.

Since it has been nearly eight years since the criteria for CED were last evaluated, MEDCAC is currently re-examining the requirements for clinical studies submitted for CMS coverage under CED, acknowledging that the update is needed since technologies have become more complex. MEDCAC also has conveyed “a commitment to greater transparency in decision-making, to making certain that study methodologies are ‘fit to purpose’ as determined by the topic, questions asked, health outcomes studied, and to making certain that the populations studied are representative of the diversity in the Medicare beneficiary population.”¹

The NCD process has been amended on several occasions (e.g., The Medicare Prescription Drug, Improvement, and Modernization Act of 2003), with updates made to the process for opening, deciding, or reconsidering NCDs under the Social Security Act. The 2013 update developed an expedited administrative process utilizing specific criteria to remove certain NCDs older than ten years, thereby enabling MACs to determine coverage under the Social Security Act for sunset NCDs. For 2023, CMS has updated Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force (USPSTF) and national medical specialty society recommendations.²

Transparency is a keystone to the process, as CMS issues an annual report listing the NCDs made in the previous calendar year in the form of a report to Congress. Additionally, there is an NCD dashboard, outlining the status of NCDs at each stage of the process (i.e., under review, reviewed but not yet opened, opened and undergoing national coverage analysis, and finalized). CMS houses all Medicare coverage determinations in the Medicare Coverage Database (MCD). The MCD includes LCDs as well as NCDs, along with reports on each.

The supposition that private insurers’ medical coverage determinations are more restrictive than Medicare’s may be based on the perception that traditional Medicare fee-for-service coverage is more robust due to its paucity of prior authorization requirements. Data indicates otherwise, such as with NCDs for medical devices. For each of the 47 medical devices considered for NCDs between February 1999 and August 2013, it was found that NCDs were equivalent to the corresponding private insurer policies roughly half of the time, more restrictive approximately a quarter of the time, and less restrictive about a quarter of the time.³

Food and Drug Administration

The notion that Medicare “adopts” diagnostic and treatment options once approved by the FDA is similarly problematic. Medicare does not automatically cover all FDA-approved devices and drugs. Between 1999 and 2011, Medicare covered FDA-approved drugs or devices only 80 percent of the time.⁴ Additionally, Medicare has been found to have more stringent requirements than the FDA, particularly for drugs or devices in patients with comorbidities.

The Medicare Benefit Policy Manual (Chapter 14 – Medical Devices) outlines that Medicare will cover FDA-approved and Institutional Review Board (IRB)-approved investigational devices “provided the investigational device meets certain requirements, including: (1) The device or services associated with the use of a device are provided to the beneficiary within the start and end dates contained in the master file; (2) There are no regulations, national coverage policies, or manual instructions that would otherwise prohibit Medicare coverage.”

Medicare Investigational Device Exemption

While Medicare normally does not cover experimental or investigational procedures, it does offer an exemption for investigational devices to allow for coverage under some circumstances. The Medicare Investigational Device Exemption (IDE) was developed as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and includes two categories:

- **Category A (Experimental):** An innovative/experimental device for which “absolute risk” of the device type has not been established (i.e., initial questions of safety and effectiveness have not been resolved and the FDA is unsure whether the device type can be safe and effective). There is no Medicare coverage for a Category A device but Medicare covers routine care items and services in the trial. An example is the CG-100 Intraluminal ByPass Device.
- **Category B (Non-experimental/non-investigational):** A device for which the underlying questions of safety and effectiveness of that device type have been resolved. Medicare allows for coverage of the Category B device as well as for routine care items and services in the trial. An example is the Viper Catheter System.

In 2015, CMS shifted responsibility for review and approval of IDE studies from the MACs to a centralized CMS process, which includes a publicly accessible, updated list of Approved IDE Studies.

Medicare Coverage of Innovative Technology and Definition of Reasonable and Necessary

In January 2021, CMS released a final rule on The Medicare Coverage of Innovative Technology and Definition of “Reasonable and Necessary,”⁵ which established pathways to payment for innovative technologies supported by high-quality, validated clinical data. The rule automatically provided four years of coverage for all Medicare beneficiaries for newly approved medical devices, in order to accelerate availability of medical devices approved through the FDA breakthrough pathway for innovative technologies.

As part of the rule, CMS proposed automatically transferring the coverage policy of commercial insurance to Medicare beneficiaries for new products. In two identical comment letters (November 2020 and April 2021), the AMA outlined several concerns with the proposal, namely the potential loss of transparency in Medicare coverage decisions if tied to commercial health insurer policies beholden to shareholder expectations. The independent, public comment process utilized by CMS to make coverage decisions appropriate for the Medicare population would be replaced with coverage decisions based on objectives such as litigation avoidance or competitive advantage. The AMA argued that the focus should remain on what is most suitable and safest for Medicare beneficiaries based on Medicare’s determination.

After considering these and other comments, CMS rescinded the rule in November 2021, citing concerns about lack of sufficient patient protections and lack of evidence of clinical benefit for the newly approved medical devices in the Medicare population. At the present time, CMS is working on a new proposed rule to create an accelerated Medicare coverage pathway, building on prior initiatives such as CED.⁶

AFFORDABLE CARE ACT BENEFIT MANDATES

The Patient Protection and Affordable Care Act (ACA) requires non-grandfathered health plans in the individual and small group markets to cover the following essential health benefits (EHB): (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. The Department of Health and Human Services (HHS) regulations define EHB using state-specific benchmarks. Since 2020, states have been granted greater flexibility in establishing new standards for their EHB benchmark plans. Non-grandfathered health plans cannot refuse coverage or limit benefits for pre-existing conditions.

Since the passage of the ACA in 2010, there have been more than 2,000 state and federal actions attempting to limit, alter, or repeal it.⁷ Most recently, in *Braidwood Management Inc. et al. v. Becerra et al.*, a federal judge ruled that insurers are no longer required to provide preventive services recommended by USPSTF at no cost. While some states have challenged parts or all of the ACA through legislation, others have acted to preserve the ACA by codifying certain provisions into state law.

Private ACA marketplace insurers have demonstrated hesitancy in fully embracing the ACA EHB benefit mandate, even as it continues to be challenged. For example, while insurers were initially required to cover preexposure prophylaxis (PrEP), a medication that prevents the transmission of human immunodeficiency virus in high-risk populations (e.g., gay and bisexual men of color) without cost sharing, not all insurers extended the benefit to the ancillary services (e.g., venipuncture, office visits) required to provide PrEP. HHS had to issue subsequent guidance to clarify that insurers were required to cover PrEP ancillary services under their EHBs. As decisions such as *Braidwood Management Inc. et al. v. Becerra et al.*, erode the ACA EHB benefit mandate, it will become increasingly important that private ACA marketplace insurers are held accountable for covering all current ACA EHB benefit mandates.

AMA POLICY

The AMA's longstanding goals to allow markets to determine benefit packages in order to permit a wide choice of coverage options and to refrain from jeopardizing coverage to currently insured populations are reflected in numerous AMA policies as well as in the AMA Proposal for Reform, which is grounded in AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. AMA policy supports the minimization of benefit mandates to allow markets to determine benefit packages, permitting a wide choice of coverage options.

Among the most relevant policies are those that:

- Oppose new health benefit mandates unrelated to patient protections (Policy H-185.964);
- Advocate for the minimization of benefit mandates (Policy H-165.856);
- Support maximization of patient choice (Policy H-165.839) and free market choice of plans (Policy H-330.912);
- Encourage payers to utilize transparent and accountable processes for developing and implementing coverage decisions and policies (Policy D-185.986);
- Assure reasonable payment levels for mandated benefits in health insurance policies (Policy D-385.966); and
- Call for the AMA to develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies (Policy D-185.986).

While AMA policy opposes blanket benefit mandates, there is policy on coverage of specific conditions and services. For example, Policy H-185.967 supports that treatment of pediatric congenital or developmental deformities or disorders due to trauma or malignant disease should be covered by all insurers, Policy H-185.957 supports legislation that requires all third party payers that cover surgical benefits to cover all strabismus surgery where medically indicated, and Policy D-185.973 encourages insurance coverage of and payment for reconstructive services for the treatment of physical injury sustained from intimate partner violence. The AMA defended Policy D-

185.979 by filing an amicus brief in *Braidwood Management Inc. et al. v. Becerra et al.*, which challenged support for first dollar coverage of preventive services.

The AMA definition of “medical necessity” (Policy H-320.953), urges payers to share third party methodologies for determining medical necessity, and advocates for the opportunity for treating physicians to provide medical evidence toward those determinations (Policy H-320.995). The AMA’s definition of medical necessity is included in state model legislation and has been enacted in several states as a required definition, rather than allowing plans to develop their own definitions. Policies H-320.968 and H-320.982 support that denial of medical necessity of services or request for prior authorization be recommended by a physician of the same specialty as the treating physician.

Finally, there is AMA policy to protect patients and physicians and encourage innovation in the context of experimental or investigational treatments. Policy D-460.967 calls for the AMA to study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models to increase access to investigational therapies. Policy H-460.965 states that the AMA should pursue legislation and regulatory reform to mandate third party payer coverage of patient care costs of nationally approved scientifically based research protocols. Policy H-480.996 supports that regulations be promulgated or interpreted so as to not interfere with the patient/physician relationship or impose regulatory burdens that may discourage creativity and innovation in advancing device technology.

DISCUSSION

While maintaining a commitment to minimizing benefit mandates is essential, there is clearly a need for transparency of coverage determinations, specifically regarding disparities across insurer product lines. An insurer may cover something considered preventive under one product line yet fail to cover the same thing under another product line. Such arbitrary coverage decisions not only question payer integrity but also introduce superfluous physician administrative burdens, such as prior authorization requirements.

While the AMA advocates for market-based solutions for coverage, there is presently a floor of benefits nationally as ACA plans must cover certain conditions. ACA coverage decisions for non-elective care at a basic level is necessary so that essential care is not determined by a patient’s socioeconomic status. While it would be helpful for private and governmental insurers to be cognizant of each other’s coverage decisions, it may not be ideal for them to be perfectly aligned given that Medicare is sometimes more restrictive and sometimes less restrictive. However, to encourage innovation, the process for gaining coverage must be transparent and expeditious. It would be beneficial to continue to expand the ability of CMS to proactively engage coverage of breakthrough therapies and devices at product launch – rather than having to wait for an NCD to be established. When CMS requires additional studies prior to coverage, this feedback should ideally be provided during the product development phase, not after the product is approved and available to the public, when finding patients to enroll in trials is more difficult.

The NCD process is very robust and might serve as a template for establishing a comprehensive, evidence-based process to allow for consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages. The process could include online tools to allow physicians to easily check coverage status rather than requiring completion of a prior authorization form and waiting for a response. Implementation of such a process would not preclude private insurers from offering additional or alternative benefits that would distinguish their products in the marketplace, allowing for a wide choice of coverage options in keeping with AMA policy. In following established precedents, it may amend the base level for what is considered medically necessary care (e.g., USPSTF grade A or B recommendations are covered without cost-sharing under the ACA).

Use of such a process would eliminate seemingly arbitrary decisions by private insurers to deem a diagnosis and treatment option as “experimental/investigational” in order not to have to cover it. There is considerable variation in how “experimental/investigational” diagnosis and treatment options are determined, which only escalates concerns regarding subjective and inequitable decisions. While some insurers may define experimental/investigational services as an intervention that has not yet been determined to be medically effective for the condition being treated, others describe it as something that has undergone basic laboratory testing and received approval from the FDA to be tested in human subjects. The definition of experimental/investigational is a continuum rather than a standard as

it is contingent upon discrete, independent evaluations that vary from insurer to insurer. While insurers may profess applying reasonable interpretation of their policy provisions, those are also variable and lacking a standard.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 110-A-22, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development of a comprehensive, evidence-based process to establish consistency in determinations of experimental/investigational status and transparency in coverage determinations from which insurers can develop benefit packages.
2. That our AMA support voluntary programs that expedite review for coverage by private and governmental insurers when requested by either the manufacturer or third parties such as national medical specialty societies.
3. That our AMA amend Policy D-185.986 by the addition of one new clause, as follows:
 4. Our AMA will advocate that when clinical coverage protocols are more restrictive than governmental payers, that private insurers and benefit managers should include the clinical rationale substantiating their coverage policies.
4. That our AMA reaffirm Policy H-185.964, which opposes new health benefit mandates unrelated to patient protections.
5. That our AMA reaffirm Policy H-165.856, which advocates for the minimization of benefit mandates.
6. That our AMA reaffirm Policy H-320.995, which urges payers to share third party methodologies for determining “medical necessity,” and advocates for the opportunity for treating physicians to provide medical evidence toward those determinations.
7. That our AMA reaffirm Policy D-460.967, which calls for study of the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models to increase access to investigational therapies.

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4. BUNDLED PAYMENTS AND MEDICALLY NECESSARY CARE (RESOLUTION 111-A-22)

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 111-A-22
REMAINDER OF REPORT FILED**

See Policies D-385.952, H-385.907, H-385.913 and H-390.849

At the 2022 Annual Meeting, the House of Delegates referred Resolution 111, which was cosponsored by the American Academy of Physical Medicine and Rehabilitation and the Ohio delegations. Resolution 111-A-22 asked the American Medical Association (AMA) to 1) advocate that coverage rules for Medicaid "episodes of care" be carefully reviewed to ensure that they do not incentivize limiting medically necessary services for patients to allow better reimbursement for recipients of the bundled payment; 2) study the issue of bundled payments and medically necessary care with a report back to explore the unintended long-term consequences on health care expenditures, physician reimbursement, and patient outcomes; and 3) advocate that functional improvement be a key target outcome for bundled payments.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report adds to the body of reports developed by the Council on alternative payment models (APMs) by providing background information specific to bundled/episode-based payment models, summarizing the literature on prominent Medicare and Medicaid models, reviewing relevant AMA policy and advocacy, and making policy recommendations.

BACKGROUND

Bundled or episode-based payments are a type of APM in which a single comprehensive payment amount covers services delivered by multiple providers during an episode of care. An episode of care is the care delivery process for a certain condition or procedure delivered within a defined period of time. State Medicaid programs use the term episodes of care to describe payment models in which a single bundled payment is made for services associated with the treatment of a condition or procedure. The models aim to lessen variations in cost and quality by incentivizing providers (e.g., physicians, hospitals, post-acute care facilities, and others providing services during the episode) to work together and manage costs without compromising care quality. Providers able to keep costs below a risk-adjusted target price for an episode may share in any savings and, conversely, those exceeding that threshold may incur financial penalties. Savings can be generated if, as is often the case, the target price is a discount of what has historically been paid, or if lower-cost facilities and providers are utilized during the episode. To guard against underserving patients, some models impose limits on gainsharing payments and/or require that certain quality metrics be met.

Medicare, state Medicaid programs, and many private insurers have adopted bundled or episode-based payment models to varying degrees with perinatal and joint replacement models increasingly prevalent across multiple payers. Although Medicare has administered bundled payments for many years, provisions in the Affordable Care Act (ACA) accelerated their use, along with other APMs, by establishing the Center for Medicare & Medicaid Innovation (CMMI) and authorizing it to develop and test new payment models without the need for Congressional approval. In 2015, the Department of Health and Human Services announced national goals for transitioning to value-based medicine and APMs; the same year, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which among other things established incentive payments for physicians to participate in advanced APMs. Centers for Medicare & Medicaid Services (CMS) and a handful of states continue to experiment with episode-based payment approaches, such as lengthier and more inclusive episodes and those that span multiple providers and/or sites of service. Importantly, there is substantial variance among bundled/episode payment designs,

with larger and more widely implemented models including Medicare's Bundled Payments for Care Improvement (BPCI) Advanced initiative and the Comprehensive Care for Joint Replacement (CJR) model. Medicare bundles have informed some Medicaid episodes of care although states have generally adapted APMs to suit the unique needs of their Medicaid enrollees and health care in their states.¹ Notably, state Medicaid programs and Medicaid providers are at various stages of implementation of value-based payment reforms and, to address ongoing budget pressures, many states have pursued APMs to reduce cost growth in Medicaid while improving care quality. Because 70 percent of Medicaid enrollees are enrolled in managed care,² states often use contracting strategies with managed care organizations (MCOs) to leverage the use of value-based payments, including episodes of care. For example, more than half of states (20 of 37) that contract with MCOs to manage care delivered to Medicaid enrollees require those plans to make a certain percentage of provider payments through APMs, while some states require MCOs to adopt specific models. Several states use financial incentives—and/or penalties—to compel MCOs to pursue value-based payment models. To date, the use of episode-based payments has generally been limited to those states that prescriptively define and require such models, including for joint replacement and perinatal episodes of care.³ In a 2021 Kaiser Family Foundation survey, eight states (CO, NM, NY, OH, PA, TN, VT, and VA) reported implementing episodes of care in Medicaid, although this number changes as states implement new models while sunsetting others.⁴

Most, but not all, bundled payment models are voluntary; the CJR initiative, which is mandatory in certain areas and voluntary in others, and Medicaid models in some states, are exceptions. Beyond that, bundled payment initiatives differ from each other in terms of duration, payment rules, and the types of services included. Episodes can range from shorter durations to lengthier periods, as for perinatal models that span the prenatal through postpartum periods. Although payments for episodes of care can be determined prospectively or based on fee-for-service with retrospective adjustments, most of the models discussed in this report adjust payments retrospectively. Additionally, add-on payments covering high-cost or outlier cases may be made available to varying degrees, depending on the model design. With respect to outliers, Policy H-385.907 advocates that bundled payments should recognize the differences in patients' needs and payment amounts should be risk stratified to reflect patients who need more resource-intensive services. The menu of services paid for in a bundle also varies significantly across models and affects the types of providers that participate. Notably, the CJR model includes most Part A and Part B services, except for hospice and a few other carve-outs, while other models pay for a narrower set of services.

Physician participation in bundled payment models has increased steadily over the past decade, as evidenced by data from the AMA's Physician Practice Benchmark Surveys, which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. According to recent Benchmark surveys, 32.0 percent of physicians were in practices involved in bundled payments in 2012. This increased to 34.8 percent in 2016 and topped 40 percent in 2020 and 2022 for a cumulative increase of eight percentage points. Additionally, in 2022, an average of 10 percent of practice revenue (at the physician level) came from bundled payments.⁵

The main obstacles to effective bundled payments are accurately defining care episodes, pricing the bundles, and ensuring adequate payment for care provided by all team members across all sites of service. Physicians have expressed concerns regarding both the financial arrangements and administrative burdens incurred, including the degree of financial risk required to participate, the potential for financial strain if the fixed payment amount does not accurately reflect the costs of the episode, the potential for decreased payments, and administrative hurdles, especially when participating in more than one APM. Additional concerns include high dropout rates among hospitals participating in some models, the potential for some models to become mandatory, and the ability of small physician practices to participate. In the Whereas clauses, the authors of Resolution 111-A-22 highlighted concerns about the occurrence of unrelated—and costly—events during a care episode, increased expenses for complex patients, the need for skilled nursing care by some patients, and possible incentives to lessen costs by decreasing patient access to services they may need.

Defining what is related and unrelated to a bundle can be problematic with episode models, yet decisions about covered services are critical to ensuring appropriate payment. Care for unrelated conditions and procedures that takes place within the duration of an episode can be costly and potentially increase spending beyond the target price of the bundle. Importantly, the AMA maintains that APMs should be designed by physicians or with significant input from physicians in part so they can influence decisions about covered services and advocate that care for unrelated events (e.g., cataract surgery during a 90-day lower extremity joint replacement (LEJR) episode) not be paid for out of the bundled payment. The AMA also advocates that financial risk requirements be limited to costs that physicians participating in an APM are able to influence or control.

An additional shortcoming of many of the larger Medicare bundled payment models is that they start with a hospitalization for a procedure. If, for example, episodes began with an evaluation for hip, knee, or back pain, or other condition, there would be more opportunities to save money and improve quality by, for example, engaging in patient-physician shared decision making strategies that could potentially prevent hospitalizations and procedures altogether. Specific to Medicaid, staffing, resource, and leadership capacity to develop and implement new models can be major obstacles to implementing payment initiatives and, for this reason, state Medicaid directors have asked CMS to provide upfront resources for states to engage in delivery system and payment reforms.⁶ Additionally, risk thresholds may dissuade some Medicaid providers, especially those practicing in states with particularly low payment rates, from participating in episode-based payment models if they feel they cannot take on financial risk. Importantly, Medicaid enrollees may have complex care needs and/or experience inequities in social determinants of health—such as housing instability, food insecurity, or lack of transportation—that impact their care and health outcomes. They also face unique barriers to care and may churn in and out of Medicaid, which could lead some Medicaid providers to believe they will be disproportionately penalized under APMs without sufficient risk adjustment.

Many of these obstacles have been addressed in previous reports and policy development by the Council on Medical Service. Council on Medical Service Report 9-A-16 established foundational policy on physician-focused APMs while Council on Medical Service Report 10-A-17 focused on reducing some of the barriers to participating in these models and the need for changes to risk adjustment systems, attribution methods, and performance target setting. AMA policy established by Council on Medical Service Report 10-A-19 addressed concerns raised by many that physicians serving people who are sicker or experiencing poverty are disproportionately penalized by APMs. Council on Medical Service Report 3-I-19 established new policy on improving risk adjustment in APMs, including that risk stratification systems should use fair and accurate payments based on patient characteristics, and that risk adjustment systems should use fair and accurate outlier payments if spending on an individual patient exceeds a predefined threshold. Concerns about APMs, and AMA advocacy to improve upon value-based payment models, were also discussed in Council on Medical Service Report 2-A-22, which focused on prospective payment model best practices for independent private practice.

EVIDENCE OF EFFECTIVENESS

Select Medicare Bundled Payment Models

Bundled/episode-based payments have been implemented for numerous surgical procedures and medical conditions and remain a leading value-based payment reform in Medicare. Lacking the capacity to thoroughly study the impact of all Medicare bundled payment models implemented over the years, the Council reviewed independent evaluations of the larger CMS initiatives and more recent analyses in the literature examining the impact of multiple bundles on Medicare spending, quality of care, and unintended consequences. Information on a unique episode program for non-hospital physicians developed as part of Maryland's statewide CMMI initiative is also provided.

BPCI: One of the largest Medicare models was the voluntary BPCI initiative—four model designs that offered episode-based payments to over 1,000 hospitals, physicians, and post-acute care providers for 48 different clinical episodes over five years (2013-2018).⁷ Consistent with previous findings, the final BPCI evaluation showed that the initiative reduced Medicare spending per episode due primarily to declines in institutional post-acute care utilization and decreases in the number of skilled nursing facility (SNF) days for those that needed SNF care. However, after accounting for reconciliation payments to eligible providers, BPCI did not increase net Medicare savings; instead, the initiative resulted in net increased Medicare spending beyond what it was estimated to be in absence of the model.⁸ Evaluations further demonstrated that BPCI generally did not affect quality of care as measured by emergency department visits, mortality, and hospital readmissions. The evidence was mixed and included both positive and negative associations between BPCI models and patient functioning,⁹ and fewer BPCI patients reported the highest level of satisfaction with their care.¹⁰ Importantly, two studies analyzing outcomes of high-risk patients found that participation in BPCI did not adversely impact their quality of care.^{11,12}

BPCI Advanced: Building on the experiences and lessons learned from BPCI, the BPCI Advanced initiative—which includes bundles with one risk track and a 90-day duration—was launched in 2018 and has been extended to run through 2025. BPCI Advanced links performance on select quality metrics to incentive payments and qualifies as an Advanced APM. Accordingly, participating physicians who meet certain cost thresholds may be eligible for a five

percent APM incentive payment. Participation in BPCI Advanced is currently voluntary and notably widespread, with 1,295 hospitals and physician groups participating in years one and two (2018 and 2019) and more than 2,000 participating in year three (2020).¹³ CMS continues to use results from its independent evaluations to refine the initiative, which reduced episode payments overall in 2018 and 2019 and produced greater savings (\$1,353 per episode) for surgical episodes than for medical episodes (\$564 per episode).¹⁴ After accounting for reconciliation payments made to BPCI Advanced providers in 2018 and 2019, the independent evaluator found that the initiative resulted in net Medicare savings for surgical episodes and net increased Medicare spending for medical episodes with an overall increase in Medicare spending of \$65.7 million.¹⁵ Consistent with BPCI and other bundles, episode savings were primarily attributed to lower payments to post-acute care sites, including SNFs and inpatient rehabilitation facilities. Importantly, quality of care was not adversely impacted; in fact, BPCI Advanced has been found by the evaluators to reduce readmissions for surgical episodes and to not worsen mortality rates.¹⁶ A separate study of BPCI Advanced, published in 2022, also found the initiative to be associated with a net increase in Medicare spending because bonuses paid to eligible hospitals exceeded episode payment reductions.¹⁷ This study further found that hospitals caring for historically marginalized populations received large bonuses under BPCI Advanced, possibly due to initial episode target pricing, which was subsequently adjusted by CMS.¹⁸

CJR: The CJR model pays for care episodes that extend through 90 days after discharge from both inpatient and outpatient settings for some of the most common surgeries among Medicare patients—hip, knee, and, more recently, ankle replacements, also referred to as LEJR.¹⁹ CJR began in 2016 and has been mandatory since 2017 for hospitals in 34 geographic areas where spending had been historically high.²⁰ Over CJR's first four years, payments across LEJR episodes in CJR's mandatory areas were 5.2 percent lower than the baseline, with payments averaging \$1,511 less per episode. An independent evaluation estimated small net savings for the Medicare program in earlier years but was unable to conclude definitively that Medicare realized net savings over the first four years of the initiative. Over the four-year period, independent evaluators estimated that, after accounting for reconciliation payments, net savings ranged from a possible \$15.3 million more in Medicare spending to \$167.2 million in savings.²¹ Similar to other surgical bundles, changes in post-acute care utilization drove the decrease in average episode payments, as fewer patients were discharged to SNFs and rehabilitation facilities, and patients who went to SNFs spent fewer days there. When compared to the control group, a larger proportion of CJR patients were discharged to home health agencies, which cost significantly less than institutional post-acute care.²² CJR patient care quality, as measured by unplanned readmissions, emergency department use, and mortality rates, was maintained over the four-year period. Furthermore, patients in the CJR and control groups reported similar functional status gains, pain levels, and overall satisfaction, although some CJR patients reported that they required more caregiving help at home and CJR hip replacement patients reported less improvement on three of eight functional status measures.²³ In terms of unintended consequences, evaluators identified a decrease in patient complexity that could indicate some level of risk selection but no evidence of increased LEJR volume.²⁴ Although a *New England Journal of Medicine* study of CJR's first two years did not find adverse effects on complications, hospital readmissions, or mortality, it did not look at functional status, pain, and patient satisfaction indicators. This study examined whether the CJR program incentivizes hospitals to 1) treat healthier rather than sicker patients (risk selection); and/or 2) reduce the use of SNF and inpatient rehabilitation. With regard to risk selection, the study noted inconsistent evidence in previous studies and no changes in patient selection in the current study other than some evidence that fewer disabled patients underwent procedures.²⁵ Because CJR did not negatively affect complications, readmissions, or mortality, the study authors concluded that hospitals may have correctly identified patients who could be appropriately discharged home with home health instead of being referred to institutional post-acute settings.²⁶

A systemic review of CMS's Acute Care Episode Demonstration (a three-year bundled payment model for inpatient cardiac and orthopedic surgeries), BPCI, and CJR initiatives found no associations between these Medicare models and 1) quality of care—as measured by readmissions, emergency department visits, and mortality—and 2) unintended consequences, such as increased utilization or risk selection.²⁷ This review further found that, in six out of 16 studies that evaluated spending, bundled payments significantly decreased episode costs; importantly, these six studies focused on orthopedic surgery and four of the six looked at LEJR episodes. Other clinical or medical episodes were not found to be associated with episode savings.²⁸ A separate review of 16 Medicare bundled payment initiatives similarly found that Medicare spending decreased for LEJR episodes but not for most other bundled payment models unless provider fees were heavily discounted.²⁹ This review found limited evidence of risk avoidance across models although the evidence was mixed.³⁰ The authors highlighted the association between bundled payments and post-acute care spending, with payments and service intensity more likely to decrease under bundles that included post-acute care services in the bundle and increased post-acute care utilization in models that

did not include post-acute care services in the bundle. Like other studies, no association was found between bundled payments and increased episode volume.³¹

Episode Programs in Maryland: Within its Total Cost of Care All-Payer Model, Maryland has several CMMI-approved advanced payment initiatives specific to that state, including the Episode Quality Improvement Program (EQIP) launched in 2022 for specialist physicians in Medicare.³² This program provides opportunities for more non-hospital providers to participate in bundles relevant to a range of specialties, including gastroenterology, cardiology, and orthopedics, which were implemented in year one, as well as additional episodes that have been rolled out since. As of January 2023, 43 medical specialties were represented in 45 episodes available under EQIP.³³

Select Medicaid Episodes of Care

Although Medicaid programs employ a range of value-based payment programs, including episodes of care for various conditions and procedures, they have not been as high profile as some Medicare-focused models. Furthermore, while there is a wealth of published studies of Medicare bundled payment initiatives, the research literature is less robust for Medicaid models and not all states implementing episodes of care make cost and performance data publicly available. Accordingly, the Council reviewed available data from select states that were early adopters of episodes of care, including Tennessee, Ohio, and Arkansas, as well as a Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of perinatal episodes implemented across three states.

Perinatal: Because Medicaid covers nearly half (42 percent in 2020) of all births in the U.S.,³⁴ several states have implemented episode-based payments for perinatal care. A 2021 MACPAC analysis reviewed perinatal episodes of care implemented in Arkansas, Colorado, and Tennessee. Although the Arkansas and Tennessee models were generally viewed positively in terms of reducing cost variations, Arkansas sunset its model, which had been mandatory, in 2021, due in part to administrative burdens on providers and diminishing returns as cost variations narrowed over time. The Tennessee and Arkansas models reduced costs per episode but produced mixed results on quality measures.³⁵ Because the Colorado model began later, in 2020, with only a few participants at the start, data on its impact on episode costs was not available at the time this report was written. Although high-risk pregnancies were excluded from episode-based payments in Arkansas and Tennessee, the Colorado model, which is voluntary, includes some high-risk patients, including those with substance use disorders. Importantly, while certain quality measures are tracked by states, there is no published evidence on the impact of perinatal episodes of care on maternal health or birth outcomes. Moreover, incentives are generally not tied to key metrics related to reductions in maternal morbidity and mortality, or impact on health disparities.³⁶

Tennessee: Aside from its perinatal model, Tennessee's Medicaid program, known as TennCare, has administered close to 50 episodes of care since 2013. TennCare reported that, in 2018, 22 of the 27 episodes of care tied to incentive payments saved the state an estimated \$38.3 million. The five that did not show savings were for acute percutaneous coronary intervention, non-acute percutaneous coronary intervention, gastrointestinal hemorrhage, bariatric surgery, and human immunodeficiency virus episodes, which the state described as low volume, making savings more difficult to achieve. Episodes producing the most savings in 2018 included the perinatal model (\$13.5 million in savings), respiratory infection episode (\$6.8 million), and the asthma acute exacerbation episode (\$4.2 million).³⁷ Quality of care, as measured by certain performance metrics, was mostly maintained or improved except for low-volume episodes in which quality metric performance declined.³⁸ Because TennCare waived all episodes of care incentives through 2021 due to the Covid-19 pandemic, more recent evaluation data was not available for review.

Ohio: Ohio's Department of Medicaid, which has administered 43 episodes of care since 2015, similarly suspended its episodes of care incentives between 2020 and 2022 due to Covid-19's impact on the state's providers. Data from 2019 showed that Ohio's episodes of care covered more than 1.5 million patients that year, or 51 percent of the state's Medicaid enrollees.³⁹ From 2013 to 2019, Ohio participated in CMMI's State Innovation Model (SIM) initiative, which helped facilitate the design and launch of the state's episodes of care as well as its comprehensive primary care program. Results from the first two years of Ohio's episodes of care program were generally positive and showed reductions in average episode costs overall with no adverse effects on care quality. For the nine episodes linked to incentives in 2017 (asthma exacerbation, chronic obstructive pulmonary disease exacerbation, perinatal, cholecystectomy, upper respiratory infection, gastrointestinal bleed, urinary tract infection, colonoscopy, and esophagogastroduodenoscopy), average non-risk-adjusted spending decreased by 0.9 percent annually, saving an estimated \$31.8-\$92.2 million.⁴⁰ That same year, providers received \$4 million in positive incentives and were accountable for \$4 million in negative incentives.⁴¹ In its final SIM report issued in 2019, the Ohio Department of

Medicaid identified several factors that were key to the successful design and implementation of its episodes of care, including ongoing provider engagement, addressing provider challenges, streamlining reporting burdens, engaging private insurers in the state, facilitating consistency across public and private health plans, and aligning episodes of care with population health priorities. The episodes of care initiative further benefited from strong leadership in the state, a dedicated innovation team, and alignment with federal models. In 2019, Ohio's episodes of care model was approved as an advanced APM.⁴²

Arkansas: Support from the federal SIM initiative also helped Arkansas develop new payment models and refine and expand episodes of care that were first implemented by the state's Medicaid program in 2011.⁴³ By the end of the SIM initiative in 2016, Arkansas had produced 14 episodes of care that were mandatory for Medicaid providers and voluntary for the state's two private payers.⁴⁴ Challenges early on ranged from a degree of provider hesitation and pushback to evidence that coding had been used by some providers to avoid triggering certain episodes. The state reported that average costs for attention-deficit/hyperactivity disorder and joint replacement episodes had decreased significantly while the costs of other episodes, and episodes of care overall, remained relatively constant.⁴⁵ One of the most prevalent models in Arkansas, for upper respiratory tract infections (URIs), showed significant quality improvements after two years, including greater reductions in antibiotic use and improvements in appropriate care for children, relative to a comparison group. However, emergency department visits increased during that time span and some physicians reported in focus groups using alternate coding to avoid triggering an episode.⁴⁶ Between 2011 and 2014, URI-related professional and outpatient spending increased while spending on prescription drugs (antibiotics and others) did not change. Over the same time period, the state's perinatal episode was found to decrease emergency department visits but increase inpatient hospital utilization and, importantly, perinatal expenditures declined, and improvements were made across most quality metrics.⁴⁷ A 2020 analysis of perinatal and URI episodes of care in Arkansas concluded that: linking incentives to performance metrics may help improve quality of care; episodes of care may successfully discourage the overuse of services; and unintended consequences are possible, including episode avoidance through coding, a shift of services to outside of the episode, and increased emergency department use.⁴⁸

A study of Arkansas' perinatal episode that included privately insured patients found that spending decreased 3.8 percent when compared to nearby states, with savings due primarily to decreased inpatient care prices.⁴⁹ Notably, although some states implementing episodes of care involve commercial payers in their program design and implementation, fewer published analyses have assessed the impact of bundled/episode-based payments among commercially insured patients or across multiple payers. Accordingly, much less is known about the impact of commercial models on spending and care quality. A 2022 meta-analysis looking at various value-based care models in the commercial sector, including nine studies of bundled/episode-based payments, found mixed results on spending and quality but cited significant savings incurred under UnitedHealthcare's cancer bundle.⁵⁰ A recent study of the use of bundled payments for certain surgical procedures among self-insured employers found considerable reductions in episode prices.⁵¹ As more research becomes available and models are refined, increased alignment of bundled/episode-based payments across Medicare, Medicaid, and private insurers may help expand successful models and align quality reporting.

AMA POLICY

The AMA has an abundance of policies addressing persistent concerns with value-based payment and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849). Under Policy D-385.963, the AMA works with CMS and other payers on evolving payment reforms and ensuring sufficient payments so that patients and families have access to care coordination supports that they need to achieve optimal outcomes. Policy H-385.913 supports goals that should be pursued as part of an APM, including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care their patients need, provide adequate and predictable resources to support the services physician practices need to deliver to patients (and include mechanisms for updating payment amounts), limit physician accountability to aspects of spending and quality that they can reasonably influence, and avoid placing physician practices at substantial financial risk. Policy H-385.913 also directs the AMA to continue to educate physicians about APMs and provide educational resources and support. Policy H-385.908 urges CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control and directs the AMA to work with stakeholders to improve risk adjustment systems, attribution methods, and performance target setting. Policy H-390.849 advocates for physician payment reforms that: promote improved patient access to high-quality, cost-effective care; are designed with input from

physicians; ensure that physicians have an appropriate level of authority over bonus or shared-savings distributions; and include ongoing evaluations to ensure the reforms are improving patient care and increasing value.

Policy H-390.849 also opposes bundling of payments in ways that limit care or otherwise interfere with a patient's ability to provide high quality care, while Policy H-385.913 supports the provision of flexibility under APMs so that physicians can deliver the care patients need. Policy H-385.908 focuses on reducing barriers to APMs, including limiting financial risk requirements to costs that physicians can control and working with stakeholders to improve attribution methods, risk adjustment systems, and performance target setting. Under Policy H-70.949, the AMA will take steps to ensure that public and private payers do not bundle services inappropriately; Policy D-390.961 directs the AMA to work with appropriate officials to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians. Additional policy on physician-focused payment reforms includes Policies D-390.953, H-390.844, H-450.931, and H-450.961. Policy H-450.931 directs the AMA to help physician practices address concerns about APMs and harmonize key components of APMs across multiple payers, including performance measures.

Improving risk adjustment across payment models is addressed by Policies H-385.907 and H-285.957, and D-385.952, which also support linking quality measures and payments to outcomes specific to high-risk populations and reductions in health care disparities. Policy H-385.907 supports: 1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors; 2) risk adjustment systems that use fair and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and accurate payments for external price changes beyond the physician's control; 3) risk adjustment systems that use risk corridors using fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments; 4) 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 5) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice. Policy H-165.837 advocates for protecting the patient-physician relationship in the context of bundled payments and affirms the obligation of physicians to prioritize patient care above financial interests.

AMA ADVOCACY

Many of the concerns about bundled/episode-based payment models have previously been addressed by AMA policy and advocacy on payment reform and APMs. Key characteristics of value-based care, including that new models and incentives must be tailored to the distinct characteristics of different specialties and practice settings, were also incorporated into the Medicare payment system principles crafted by the AMA in collaboration with 120 other physician and health care organizations. The AMA has worked diligently over the years to improve MACRA and advance the transition to value-based care and now leads the charge to reform Medicare's payment system to increase physician payment stability, reduce burnout, and improve the financial viability of physician practices. Although the Consolidated Appropriations Act of 2023 extended the five percent advanced APM incentive payment for 12 months, the AMA is advocating that it be extended for additional years.

The AMA continues to encourage and enable physician participation in physician-focused APMs, including bundled/episode-based payments. The AMA believes that well-designed, patient-centered APMs can provide significant opportunities to improve the quality and outcomes of patients' care in ways that also lower growth in health care spending. However, the AMA maintains that physicians must be involved in the design of APMs to ensure that models successfully remove certain barriers and do not require physicians to be accountable for spending or outcomes they cannot control. The AMA continues to carefully examine APMs that are proposed by CMS and provide feedback to the agency regarding needed modifications, including when APMs impose unreasonable requirements on physicians or require them to take on excessive financial risk. Because the AMA believes that APMs are significantly improved when physicians are directly and actively involved in their design, the AMA continually advocates for consideration of physician input on models and approval of APMs that have been designed by physicians.

The AMA works closely with national medical specialty societies to review proposed APMs, recommend model improvements, and comment on regulations governing APMs. A more recent example is the AMA's advocacy focused on Medicare's proposed Radiation Oncology (RO) Model, a bundled payment for cancer patients receiving radiotherapy, which the AMA urged be delayed so that CMS could work with radiation oncology specialty societies to redesign some of the model's key features.⁵² The RO Model that CMS had previously developed could have had

serious unintended consequences for patients because practices would have been mandated to participate and take steep payment cuts. Accordingly, the AMA expressed general support for the creation of a bundled payment model for radiation oncology but advocated that several changes be made to CMS's proposal, namely that payments be stratified based on patients' clinical characteristics, adjusted to account for the higher costs of delivering services in rural areas, and adjusted annually to reflect changes in evidence, technology, and inflation.⁵³ The AMA has further urged CMS to conduct a limited scale test of the RO Model on a voluntary basis rather than mandating participation in an untested model.

In 2015, the AMA recommended numerous changes to the proposed CJR model and urged CMS to make participation voluntary and available to physicians in all localities. Among other modifications to its original design, the AMA recommended that payments be risk-adjusted based on patients' functional status and other characteristics that affect the types of post-acute care they need so that physicians could assign patients to one of several acuity/risk levels and receive higher payments for higher-risk patients.⁵⁴ Additional advocacy on CJR and other episode-based payment models has repeatedly urged CMS to incorporate input from relevant national medical specialty societies in model design and revisions; listen to affected specialty societies that have experience with the different risks facing patients treated under the models; allow voluntary participation; begin episodes at the time of diagnoses of a condition instead of at hospital admission; and ensure that payment is adequate and predictable while limiting physicians' accountability to costs within their control. More recent AMA advocacy with CMS on episode-based payment models in Medicare included support for bundled payments for office-based management of patients with substance use disorders and bundled payments for chronic pain management.

To be successful, the AMA believes a physician-focused APM needs three key components:

1. Flexibility for physicians to deliver the most appropriate services to meet patients' needs;
2. Adequate payments to support the costs physicians incur in delivering high-quality care; and
3. Accountability by physicians for delivering high-quality services and avoiding unnecessary services, but without penalties for things that physicians cannot control.

The AMA has held educational seminars about APMs for physicians and organized several workshops in which physicians have shared their experiences in designing and implementing APMs. Physicians who want to learn more about episodes of care and other APMs are encouraged to read the following AMA resources: *Evaluating Medicaid Value-Based Care Models*, *Evaluating Bundled or Episode-Based Contracts*, and *Medicare Alternative Payment Models*.

DISCUSSION

Although the concerns highlighted in referred Resolution 111-A-22 focused primarily on Medicaid episodes of care, the Council reviewed available research on both Medicaid and Medicare bundled payment models. Evidence in the literature suggests that certain Medicare bundles may contain overall costs more effectively than fee-for-service payment but, after accounting for provider bonuses, aside from joint replacement models, most have not produced net Medicare savings. Additionally, although studies have been mixed and vary across initiatives, most bundled payment models have neither significantly improved nor worsened quality of care.⁵⁵ The Council found that LEJR bundles, and some perinatal episodes of care, have produced the most—but still modest—savings. LEJR episode savings have been driven by reductions in institutional post-acute care (e.g., SNFs and inpatient rehabilitation facilities) spending while hospital pricing contributed to reductions in perinatal episode spending. The Council was unable to locate published studies analyzing the impact of bundled/episode-based payment models on physician payment; however, we reviewed several studies looking at other possible unintended consequences of these models. For example, studies have found some evidence of risk selection across certain Medicare bundles, although the evidence has been mixed, and no evidence of increased episode volume, which had been an early concern among some stakeholders. A study of episodes of care in Arkansas revealed other possible unintended consequences, including episode avoidance through coding, a shift of some services outside of the bundles, and increased emergency department use.

Because the evidence is clear that the savings accrued under LEJR episodes has been due to decreased spending on SNFs and inpatient rehabilitation facilities, some physicians have questioned whether patient access to medically necessary care, including SNF services, could potentially be limited. The Council believes that performance metrics measuring key patient-centered outcomes, including functional improvements after orthopedic and other procedures,

are important and necessary checks on the risk that some models may underserve patients. Because the AMA already has extensive policy on APMs, we recommend amending Policies H-390.849[2, 3] and D-385.952[1, 2] to address this concern instead of crafting a separate policy statement specific to bundled/episode-based payments. Although evidence across models is limited, high-risk patients have not been found to be adversely impacted under the BPCI initiative; more research is needed on how historically marginalized patients fare, in terms of outcomes, under a broader range of episodes. One study we reviewed found that hospitals serving historically marginalized individuals performed well, and received large bonuses, under BPCI Advanced; however, more studies are needed to ensure that implementation of episode-based models is meaningfully supporting equity goals. The Council previously addressed concerns about the impact of APMs on high-risk populations and points to Policy D-385.952, which we recommend amending. To address other concerns and obstacles under bundled/episode-based payment models, the Council recommends reaffirmation of Policy H-385.907, which supports fair and accurate risk adjustment systems, and Policy H-385.913, which outlines goals to be pursued as part of physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, provide adequate and predictable resources, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue to work with national medical specialty societies and state medical associations to educate physicians on APMs.

As previously noted, one of the frustrations with episode-based payment models concerns the definition of related or unrelated services. For example, since some LEJR models include most Medicare Part A and Part B services, payment for seemingly unrelated procedures (e.g., eye, skin, or sinus surgeries) completed within 90 days of a joint replacement may be paid for out of the bundled payment. AMA policy addresses this concern by advocating that physician accountability be limited to aspects of spending and quality that they can reasonably influence or control. Notably, the services covered under joint replacement models can vary significantly across payers so that services included in a state Medicaid model may differ from CJR's list of covered services.

Although the Council discussed the need for bundled payment models to clearly define the services included and allow mechanisms for shifting unrelated services outside of the bundle, we believe this is best addressed at the design stage, with meaningful physician involvement, as highlighted by Policy H-385.913. The Council encourages physicians interested in participating in bundled payment models to determine ahead of time which services and Current Procedural Terminology codes are included and not included in an episode, and to review the AMA's Evaluating Bundled or Episode-Based Contracts for more information. Finally, the Council believes well-designed, patient-centered bundled payment models can improve care quality and patient outcomes in ways that also lower growth in health care spending. Designing these models to work effectively for patients, physicians, and payers remains challenging, and ongoing refinements to models may be needed to ensure optimal patient outcomes as these initiatives continue to expand.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 111-A-22, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-390.849[2, 3] by addition and deletion to read as follows:
 2. Our AMA opposes bundling of payments in ways that limit medically necessary care, including institutional post-acute care, or otherwise interfere with a physician's ability to provide high quality care to patients.
 3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, ~~verifiable, accurate, and based on current data~~ reliable, and consistent with national medical specialty society-developed clinical guidelines/standards.
2. That our AMA amend Policy D-385.952[1, 2] by addition and deletion to read as follows:

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations, ~~and~~ reductions in health care disparities, and functional improvements, if appropriate; (2) will continue to encourage the development and

implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations and safeguard patient access to medically necessary care, including institutional post-acute care.

3. That our AMA reaffirm Policy H-385.907, which supports risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors; risk adjustment systems that use fair and accurate outlier payments if spending on a patient exceeds a pre-defined threshold, and fair and accurate payments for external price changes beyond the physician's control; and accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence.
4. That our AMA reaffirm Policy H-385.913, which outlines goals for physician-focused APMs—including that models be designed by physicians or with significant input from physicians, provide flexibility to physicians to deliver the care patients need, limit physician accountability to aspects of spending and quality that they can reasonably influence, and avoid placing physician practices at substantial financial risk—and directs the AMA to continue working with national medical specialty societies and state medical associations to educate physicians on APMs.

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APPENDIX - Policies Recommended for Reaffirmation and Amendment

Improving Risk Adjustment in Alternative Payment Models H-385.907

Our AMA supports: (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications; (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost; (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost; (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control; (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19; Reaffirmed: CMS Rep. 2, A-22)

Physician-Focused Alternative Payment Models H-385.913

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; Reaffirmed: CMS Rep. 2, A-22)

Alternative Payment Models and Vulnerable Populations D-385.952

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations; and (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control. (CMS Rep. 10, A-19)

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
- a) promote improved patient access to high-quality, cost-effective care;
 - b) be designed with input from the physician community;
 - c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
 - d) not require budget neutrality within Medicare Part B;
 - e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
 - f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
 - g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
 - h) use adequate risk adjustment methodologies;
 - i) incorporate incentives large enough to merit additional investments by physicians;
 - j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
 - k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
 - l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
 - m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22)

5. PRESCRIPTION DRUG DISPENSING POLICIES (RESOLUTION 237-A-22)

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 237-A-22
REMAINDER OF REPORT FILED**

See Policies D-120.934, H-120-918, H-120.952, H-185.942 and H-320.953

At the June 2022 Annual Meeting, the House of Delegates referred Resolution 237-A-22, Prescription Drug Dispensing Policies, which was sponsored by the Ohio Delegation and asks that the American Medical Association (AMA) work with pharmacy benefit managers (PBMs) to eliminate any financial incentives that may exist for patients to receive a supply of medication that is greater than the physician prescribed. Resolution 237-A-22 also asks that the AMA create model state legislation to restrict dispensing a prescription drug in greater quantities than prescribed, and support legislation that supports removing financial barriers that favor dispensing of quantities greater than prescribed. This report provides background on the process of drug dispensing quantities, reviews relevant AMA policy, and makes policy recommendations.

BACKGROUND

When physicians write prescriptions and provide them to their patients, an insurance company and/or PBM may influence not only the cost of the medication, but also the amount that is dispensed to the patient¹. In certain situations, such as when a patient is taking a maintenance medication, the insurer or PBM, may be incentivized to require a 90-day supply to be dispensed, even if a 30-day supply was prescribed.² While this may not be an issue once the patient's medication and dosage are established, it can be a problem for patients and physicians when initially assessing medications, dosages, or making changes to either. When physicians write prescriptions with a set number of refills, some states allow pharmacists to dispense the total amount.² For example, a prescription for a 30-day supply of medication with two refills could result in these pharmacies dispensing the total 90-day supply at once.

PBM AND INSURER INFLUENCE ON DISPENSING QUANTITIES

To fully understand the pressures to dispense a 90-day supply it is important to understand the relationship between PBMs, health insurers, and the pharmacies that end up dispensing the medication. PBMs are considered an intermediary that works to manage prescription drug benefits for secondary entities, like health insurers. PBMs have the stated goal of working to lower drug prices through their work negotiating rebates and discounts off the list price of drugs. However, a lack of transparency and regulation into these efforts have yielded confusion and doubt as to if

this goal is being met.³ Current efforts by both the Federal Trade Commission (FTC) and Congress are being made to investigate and better understand the innerworkings of PBMs in the process.⁴

The process of dispensing medication has multiple intersections between PBMs, payers, and pharmacies. PBMs pay pharmacies a drug dispensing fee and negotiate rate prices with the manufacturer, while insurers pay the PBMs fees for administrative work and dispensing fees for medications. For PBMs and payers, these points of intersection may be areas where requiring a larger quantity of medication to be dispensed is advantageous. For example, when a larger quantity of medication is being negotiated, it gives the PBM better negotiating power and can lead to lower negotiated prices or larger rebates. For both PBMs and payers, dispensing greater supplies of medication can lower the dispensing costs associated with the medication. Additionally, it is not uncommon for PBMs and/or health insurers to own and operate automatic dispensing facilities, such as mail order pharmacies, and dispensing greater quantities of a medication can lower operating costs in these settings as well.⁵ One place of major PBM reform that is promoted by the National Community Pharmacist Association, is centered around the mandatory use of these PBM owned mail order pharmacies that often depersonalize the process. This is especially relevant to the quantity of a medication dispensed as the safeguards of both physicians and pharmacists interacting with the patient are removed in the automated process used with PBM-owned mail order pharmacies.⁶

Overall, the insertion of payers and PBMs in the process of determining the quantity of a prescription medication dispensed is opposed both by the AMA and community pharmacists, the two entities that interact most directly with the patient. While there can be benefits to the dispensing of a larger supply of medication, especially in the cost savings for the PBM and/or payer, the decision is one that needs to be made on a patient level and under the supervision and control of the prescribing physician.

POTENTIAL PATIENT RISKS OF A 90-DAY SUPPLY

Among the key concerns when a patient receives a quantity of a prescription drug that is greater than what was prescribed include the risk of intentional overdose. While there is not a guarantee that a physician will be aware of a patient's suicide risk, there is an opportunity for assessment, both formal and informal, during a medical appointment. Pharmacists' interactions with patients would not typically include this type of screening process and, thus, they may not be aware of a potential risk. Unfortunately, even if a risk was recognized, PBMs, who are further removed from direct patient engagement, may force pharmacists to fill larger quantities without the ability to apply insurance coverage at lower quantities. Currently, there are strict regulations on the quantity of controlled substances that can be dispensed as these medications are often seen in suicide attempts or completions.^{7,8} However, other prescription medications are not regulated at the same level and may still be used in suicide attempts or completions.^{8,9}

A second concern regarding patients receiving quantities of prescription medication greater than prescribed is the oversupply of medications. Oversupply is a concern with regard to the potential for increased cost to the patient and patient stockpiling. When a prescription is dispensed at a greater quantity than prescribed, a patient may not need the full 90 days. For example, if a medication is new and the physician is working with the patient to establish the correct dosage there may be a change in the dosage prior to completion of the full 90 days. The oversupply of a prescription drug can lead to a patient stockpiling a medication, which, even when unintentional, can be dangerous and should be avoided.¹⁰ In addition to the potential for a medication to be stockpiled, it is possible that this oversupply could place an undue financial burden on the patient. For instance, should a patient be prescribed a medication with a substantial co-pay that is only covered in a 90-day supply, but that prescription is altered before completion of the 90 days, the patient may be responsible for an additional, expensive co-pay. The cost of prescription medications in the United States is a major barrier for many to access the care they require and should be mitigated whenever possible.¹¹

POTENTIAL PATIENT BENEFITS OF A 90-DAY SUPPLY

While there are some substantial potential risks associated with dispensing larger supplies of medication than prescribed, there are some potential benefits as well. When allowed, pharmacists may be inclined or forced to dispense the larger supply due to the financial benefits and improved patient adherence to the medication regimen. Each year, a lack of medication adherence directly relates to approximately 10 percent of all health care spending in the United States⁷. Research has demonstrated that a larger supply of medication has been linked with greater medication adherence, which is especially true in patients who traditionally have the lowest levels of adherence.

This improvement in adherence is explained by reduction of barriers and improvement in convenience for the patient. For example, if a patient has difficulty finding transportation to and from the pharmacy, reducing the number of trips may boost adherence. Additionally, patients report greater satisfaction with a greater supply of medication, especially for those who have multiple prescriptions. Most importantly, adherence to medications, particularly medications for chronic diseases like hypertension and diabetes, significantly improves patient outcomes and reduces health care costs.⁷

In addition to greater medication adherence, there is the added benefit of cost savings with a larger quantity of medication for the pharmacy and the patient. Prescription drug cost reduction is typically centered around a lower distribution cost, negotiated drug cost, and potential rebates.⁵ These potential advantages can lead to cost-savings to the patient, as well as a reduction in the time spent obtaining their prescriptions. However, to ensure that patients are receiving lowered costs when appropriate, but not an oversupply of medication, it is important that the decision regarding amounts of dispensed medications remain within the context of the patient-physician relationship.

RELEVANT AMA POLICY

The AMA currently has policies that address the dispensing of prescription drugs. The most directly relevant AMA policies on the topic of medication dispensing are Policies H-120.962 and H-185.942. Each of these policies ensure that physicians can specify the appropriate quantity of a prescription drug and that insurers must have a specific process in place when exceptions to the typically dispensed amount needs to be altered due to a medical reason. Policy H-120.962 specifically addresses mail order pharmacies and outlines when a 90-day prescription may not be appropriate; during the initialization and dose stabilization of a new medication and when changing the dosage of a long-term medication. Policy H-185.942 outlines AMA support for working with insurers to ensure that there is an exceptions process for patients that may need a higher or lower dispensed amount of a medication due to a medical necessity and supports physician ability to limit quantities of a prescription drug during initialization and dose stabilization of a new medication or if the medication may pose a risk to patients.

In addition to policies related to the dispensing of prescription medications, the AMA has policy related to limiting the overreach of pharmacists into medical decision-making. Of specific relevance, Policy D-120.934 indicates AMA's intent to prohibit pharmacy actions that are unilateral medical decisions and directs the AMA to implement policies that ensure prescriptions are dispensed by pharmacists as ordered by the physician or prescriber, including the quantity ordered. Policies D-35.981 and D-35.987 more generally establish AMA's opposition to the inappropriate practice of medicine by pharmacists. Policy D-35.981 confronts the "intrusion" of pharmacy into medical practice. Policy D-35.987 outlines the AMA's intent to study, oppose, and educate about inappropriate scope of practice expansions that would allow pharmacists to perform services that constitute the practice of medicine, including opposition to laws that would allow pharmacists to prescribe medications or to dispense medication beyond the expiration date of the original prescription.

In addition, Policies H-115.967 and H-95.945 both outline the AMA's actions to promote education, tracking, and packaging that prevents addiction, misuse, and harm. Specifically, Policy H-115.967 focuses on introducing packaging for controlled substances that is more functional for patients, improves patient adherence, and reduces the risk for misuse and abuse. Policy H-95.945 supports the permanency of and funding for the National All Schedules Prescription Electronic Reporting and state/jurisdiction Prescription Drug Monitoring Programs. Additionally, the policy outlines support for the availability of these data and the education of physicians on how to reduce the misuse of prescription drugs.

Policies H-120.943 and H-120.952 state the AMA's work to ensure that the dispensed quantity of a prescription drug is adequate for the patient, not overregulated, and not an undue burden on the physician. Policy H-120.943 outlines the requirement for a medication that is dispensed for a month and three-month supply and indicates the AMA's opposition to the arbitrary prescription limits of medication for patients with pain related to cancer or a terminal illness. Similarly, Policy H-120.952 opposes restriction to legitimate and clinically appropriate refills and encourages the implementation of a prescription refill schedule.

DISCUSSION

In weighing the potential benefits and risks of dispensing a larger supply of medication, there is no one correct answer for all patients. However, it is clear that physicians and patients should be able to work collaboratively to

make the correct choice for each individual patient. Further complicating the issue are direction from PBMs and payers requiring or financially incentivizing the use of certain PBM owned mail order pharmacies that only dispense 90-day supplies of certain medications. These practices can lead to not only confusion and frustration for both physicians and patients, but also can be potentially dangerous and expensive for patients.

Although research has demonstrated benefits to dispensing 90-day supplies of medications to patients, the Council believes it is essential that the decision as to the quantity of medication dispensed is one that is made within the patient-physician relationship, not by insurers, pharmacies, or PBMs. The Council also believes that the benefits of a 90-day supply are most prevalent for maintenance medications that are stable and address chronic conditions. Although the AMA has policy to ensure that the patient is able to receive the prescribed amount of a medication, as well as policy that opposes the overreach of pharmacist practice, the Council believes that the language of existing policy can be strengthened to ensure that the quantity of a medication dispensed remains a decision made within the patient-physician relationship.

Therefore, the Council believes that the implementation of clear guidelines for physicians to indicate that a prescription should be dispensed only as written are warranted. These guidelines could follow what have been implemented in states where physicians are able to write “dispense quantity as written,” “no change in quantity,” or similar language to indicate the necessity of a prescription being dispensed in a specific quantity. Additionally, the Council believes that Policy H-185.942 which ensures that physicians are able to specify the quantity of a prescription dispensed, can be strengthened with the addition of PBMs as a regulated party. Finally, the Council believes that AMA policy on both ensuring the dispensing of adequate amounts of medication without undue burden on the physician or patient and restricting the influence of PBMs and payers are adequate and should be reaffirmed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 237-A-22, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support the development and implementation of clear guidelines and mechanisms to indicate that the quantity of a prescription should be dispensed only as written using such language as “dispense quantity as written” or “no change in quantity.”
2. That our AMA amend Policy H-185.942, to read as follows:
 1. Our AMA supports the protection of the patient-physician relationship from interference by payers and Pharmacy Benefit Managers (PBMs) via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
 2. Our AMA will work with third party payers and PBMs to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
 3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers or PBMs that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following....
3. That our AMA reaffirm Policy H-320.953, which defines the term “medical necessity” as referenced in the suggested amended policy H-185.942 (above) in recommendation two.
4. That our AMA reaffirm Policy H-120.952, which ensures that the quantity of a medication dispensed to patients is of adequate supply, not overregulated, and that receiving the medication is not an undue burden on the patient or the prescribing physician.

5. That our AMA reaffirm Policy D-120.934, which ensures that prescriptions must be filled as ordered, including the quantity, and that PBMs and payers restrict policies that impact patient access to prescription medications.
6. That our AMA support the development, implementation and/or use of electronic or other means of communication to provide cost and coverage information of various prescribing quantities at the point of care allowing physicians to make the best decisions with their patients regarding prescribed medication quantities.

REFERENCES

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- 6 PBM Reform. *National Community Pharmacists Association*. 2023.
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- 8 Miller TR, Swedler DI, Lawrence BA, et al. Incidence and Lethality of Suicidal Overdoses by Drug Class. *JAMA Network Open*. 2020;3(3):e200607. doi:10.1001/jamanetworkopen.2020.0607
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- 10 Kim J, Combs, K, Downs, J, et al. Medication adherence: The elephant in the room. *US Pharm*. 2018;43(1)30-34.
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Appendix - AMA Policies Recommended for Reaffirmation or Amendment

Policy H-185.942 “Third Party Payer Quantity Limits”

1. Our AMA supports the protection of the patient-physician relationship from interference by payers via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
 2. Our AMA will work with third party payers to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
 3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
 - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)
 - physicians can appeal adverse determinations regarding quantity limitations;
 - payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;
 - payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;
 - physicians with specialized qualifications may not be subject to quantity limits;
 - payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;
 - payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in non urgent situations and one working day in urgent cases; and
 - physicians or patients can submit any denied appeals to an independent review body for a final, binding decision.
- (BOT Rep. 12, A-12; Reaffirmation: I-17)

Policy H-320.953 “Definitions of “Screening” and “Medical Necessity””

- (1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.
- (2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term “medical screening examination”; “The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.”
- (3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.
- (4) Our AMA incorporates its definition of “medical necessity” in relevant AMA advocacy documents, including its “Model Managed Care Services Agreement.” Usage of the term “medical necessity” must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of “medical necessity”.
- (5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
- (6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.
- (7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.
- (8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations. (CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06; Reaffirmed: CMS Rep. 01, A-16)

Policy H-120.952 “Restriction on Prescription Refills”

1. Our AMA opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions including, but not limited to: (A) restricting refill hours to less than usual pharmacy hours; (B) restricting refills to limited pharmacies rather than all participating pharmacies; (C) restricting refills for chronic medications to a less than 90-day supply; and (D) restricting the date of refill.
2. Our AMA will encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the need for multiple renewal requests and travel barriers for prescription acquisition. (Res. 512, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 801, I-12; Modified: Sub. Res. 719, A-13; Reaffirmed: CMS Rep. 04, A-16)

Policy D-120.934 “Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care”

1. Our AMA will take steps to implement AMA Policies H-120.947 and D-35.981 that prescriptions must be filled as ordered by physicians or other duly authorized/licensed persons, including the quantity ordered.
2. Our AMA will work with pharmacy benefit managers, payers, relevant pharmacy associations, and stakeholders to: (a) identify the impact on patients of policies that restrict prescriptions to ensure access to care and urge that these policies receive the same notice and public comment as any other significant policy affecting the practice of pharmacy and medicine; and (b) prohibit pharmacy actions that are unilateral medical decisions.
3. Our AMA will report back at the 2018 Annual Meeting on actions taken to preserve the purview of physicians in prescription origination.

6. HEALTH CARE MARKETPLACE PLAN SELECTION

Informational report. No reference committee hearing.

HOUSE ACTION: FILED

At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, “Health Care Marketplace Plan Selection.” This policy directs the American Medical Association (AMA) to re-evaluate and study the effectiveness of the current plan options in the health care marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023 Annual Meeting. This report, which is presented for information to the House of Delegates, provides updated information on insurer competition in health insurance exchanges, insurer concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally, the report summarizes AMA policy that strongly supports competition and choice in the health insurance marketplace.

BACKGROUND

The intent of individual health insurance exchanges required under the Affordable Care Act (ACA) is to broaden coverage through a patient-friendly market and ensure healthy competition among plans. Products sold in the ACA marketplace are required to be certified as qualified health plans (QHPs); and as a condition of QHP certification, insurers—or issuers—must meet certain standards and requirements designed to protect patients while encouraging health plan competition and choice. Robust competition among issuers participating in the insurance exchanges is essential to health plan affordability and choice, as evidenced by research showing that the participation of additional insurers on an exchange is associated with lower premiums and, conversely, regions with fewer insurers have higher premiums.¹ Across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban areas.

INSURER PARTICIPATION IN HEALTH INSURANCE EXCHANGES

Insurer participation in the marketplace has been an ongoing concern since the ACA exchanges began operating and have gone up and down in the ensuing years in response to marketplace regulations and insurers entering and exiting the market. After a period of decreasing insurer participation between 2016 and 2018 (participation was at its highest in 2015), 2023 marks the fifth consecutive year of increases in the number of insurers offering ACA marketplace plans. In fact, most people shopping for coverage on an exchange must navigate through scores of offerings before choosing a health plan that best meets their needs and budget, a process that can be both daunting and confusing. This year, consumers using the federal exchange through HealthCare.gov will have, on average, more than 113 QHPs to choose from, up from over 60 plan options in 2021 and just over 25 options in 2019.² An issue brief released by the Office of Health Policy for the Assistant Secretary for Planning and Evaluation (ASPE) showed that, in 2021, nearly three-quarters of HealthCare.gov users had more than 60 plan options to choose from, and over a quarter selected from more than 160 plans.³ Within a specific metal tier (i.e., bronze, silver, gold, or platinum), or even within a particular metal tier and a specific issuer, consumers in many areas can still have an abundance of plan options from which to choose.

In the 33 marketplaces using the HealthCare.gov platform, the Centers for Medicare & Medicaid Services (CMS) has announced that there is greater choice of insurers in 2023 with only one percent of enrollees having access to a single QHP issuer, the lowest in marketplace history.⁴ The Center for Consumer Information and Insurance Oversight (CCIIO) has reported that, in HealthCare.gov states, 92 percent of enrollees have three or more insurers from which to choose this year compared to 89 percent of enrollees in 2022. There are 220 total insurers participating in HealthCare.gov states, an increase of seven from 2022, and the average enrollee has access to between six and seven issuers, and over 113 QHPs.⁵ A CCIIO map (<https://www.cms.gov/files/document/py2023-county-coverage-map.pdf>) of Plan Year 2023 exchange insurers, which includes federally-facilitated exchange data as well as self-reported data (updated as of October 2022) from the 18 states operating their own exchanges, shows that only three percent of counties (93) have a single insurer while 25 percent (771) have two insurers and remaining counties have three or more insurers on the exchange. This contrasts with 2018 when over half (51.3 percent) of counties had a single carrier, a percentage that decreased to just over 35 percent of counties in 2019, 24 percent in 2020, nine percent in 2021, five percent in 2022, and three percent in 2023 (see appendix). County level data is

important to measuring competition in the ACA marketplace because many insurers offer plans in some parts of a state but not others, and because health plans are priced and offered locally.

A brief from the Robert Wood Johnson Foundation explains that although insurer participation in the ACA marketplace increased significantly between 2019 and 2021, such increases were more moderate in 2022 and relatively small in 2023.⁶ This year, large increases in insurer participation were seen in only a small number of states, including a few non-expansion states, as insurers continue to focus on areas where more uninsured people live. Although Georgia had a large increase in new plan offerings in 2022, the increase in that state was much smaller in 2023 when Texas had the most new offerings.⁷ Importantly, the share of plans offered by large health insurers, including Blues plans, UnitedHealthcare, Cigna, CVS/Aetna, Centene, and Molina, increased in the marketplace while the share of smaller insurers, such as regional and provider-sponsored plans, decreased from 45 percent in 2022 to 40 percent in 2023.⁸ Furthermore, the large national insurers have tended to take over where smaller companies, including Bright Health and Oscar Health, have exited markets. It is also notable that the Medicaid managed care companies Centene and Molina have been steadily increasing their footprints on the exchanges.

INSURER CONCENTRATION IN EXCHANGE MARKETS

The 2022 edition of the AMA's *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* notes that there have been large changes over time in exchange market concentration and some volatility in exchange insurers' market shares and rankings. According to the study's analysis, there were large increases in average market concentration in the exchanges between 2015 and 2018, annual decreases thereafter, and a notably large decrease between 2020 and 2021 that was widespread across metropolitan statistical areas (MSAs). The AMA study found that, at the MSA level in 2021, at least one insurer had a market share of 30 percent in 98 percent of exchange markets; in 73 percent of markets, one insurer had a market share of 50 percent; and in 39 percent of markets, an insurer had a market share of 70 percent.⁹ Turning to the national level, Anthem had the largest share of the exchange market in 2014 and 2015 but fell to sixth largest in 2021 while Centene, which had a smaller share of the exchange market in earlier years, had the largest market share (15 percent) in 2021.¹⁰

Concerns over the years regarding insufficient competition in the individual health care marketplace have led some thought leaders, as well as state and federal policy makers, to put forward a range of proposals to ensure marketplace coverage options, including the creation of a public option. Concerns with public option proposals have previously been addressed at length by the Council on Medical Service in Council Report 3-A-18 and Council Report 1-Nov.-20. Policy experts have also suggested leveraging Federal Employees Health Benefits Program (FEHBP) health plan participation as a solution to prevent bare counties in the marketplaces, which is consistent with Policy H-165.825. In addition to discussing a public option and establishing policy that supports requiring the largest two FEHBP insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation, Policy H-165.825—established via Council on Medical Service Report 3-A-18—supports 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. This policy also opposes 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.

A primary purpose of regulations governing the health insurance marketplace has been to help ensure that insurers are competing and operating on an even playing field in which all insurers and plans must play by the same rules. The AMA advocates that exchanges need to offer choices to patients to spur competition and that mechanisms to facilitate competition in health insurance should ensure that critical patient protections remain in place, including the ban on pre-existing condition exclusions as well as critical cost protections guaranteed in the ACA (e.g., annual cap on out-of-pocket expenses). The AMA strongly believes that an important federal role remains to ensure that proposals to foster competition in health insurance also promote ACA marketplace stability and a balanced risk pool and do not lead to adverse selection in the marketplace.¹¹

NETWORK ADEQUACY

AMA policy and advocacy also underscores that a plan's provider network is an important factor in maintaining healthy competition and choice and, as such, the AMA consistently advocates for stronger network adequacy standards for QHPs, including those offered through federally facilitated exchanges. The AMA believes that state regulators should have flexibility to regulate their provider networks but also maintains that there is a critical need for a minimum federal network adequacy standard that includes quantifiable standards, especially in light of inaction in many states to update network adequacy requirements. The AMA has also advocated that CMS implement additional qualitative standards to measure network adequacy and better evaluate access to timely and appropriate care for enrollees in QHP plans.¹²

In response to CMS' proposed rulemaking on benefits and payment parameters under the ACA for 2024, the AMA strongly supported CMS' inclusion of wait time requirements into the measurement of network adequacy. The AMA believes this, and other quantitative standards are critical to determining if a network can serve the needs of its enrollees. Often network physicians may appear to be available but may not be accepting new patients at all or have a lengthy wait time for obtaining an appointment that makes it impossible to see them in a timely manner. Wait time requirements could help address these issues. The AMA also urged CMS to consider additional tools to measure compliance beyond insurer attestation, including audits, secret shopper programs, and patient surveys.¹³

SALE OF HEALTH INSURANCE ACROSS STATE LINES

The issue of permitting the sale of health insurance across state lines has been debated by the House of Delegates several times over the years, with proponents arguing that this would spur competition, choice, and affordability and others maintaining that any such allowances could motivate insurers to incorporate in states with less insurance regulation, putting important patient and provider protections at risk. Under AMA Policy H-180.946, established in 2017, the AMA would support the sale of health insurance across state lines, including multistate compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. These protections include not weakening any state's laws or regulations involving network adequacy and transparency; fair contracting and claims handling; prompt payment for physicians; regulation of unfair health insurance market products and activities; rating and underwriting rules; grievance and appeals procedures; and fraud. The sentiment of AMA policy is that patients purchasing an out-of-state policy should retain the right to bring a claim against an insurer in a state court in the state in which the patient resides.

Because a state's insurance regulator cannot enforce another state's laws or regulate beyond its borders, consumer protections and other regulations must be clearly defined when interstate health insurance sales are permitted. It is unclear whether insurers would even be interested in selling products in new markets across state lines where other carriers are already competing. When interstate health insurance sales were debated at the federal level in 2017, a handful of states had laws allowing such sales; however, out-of-state issuers were not drawn to these markets, primarily due to the costs and other challenges associated with developing provider networks in another state. Some stakeholders, including the American Academy of Actuaries and the National Association of Insurance Commissioners, have cautioned that interstate sales will neither increase competition nor decrease premium pricing but could have unintended consequences related to consumer protections and adverse selection.¹⁴

ADDITIONAL POLICIES IMPACTING THE MARKETPLACE IN 2023

Extension of Enhanced Premium Tax Credit Subsidies: The Inflation Reduction Act, signed into law in August 2022, extends through 2025 the enhanced premium tax credits that were made available to eligible consumers under the American Rescue Plan Act of 2021. This advanceable and refundable credit, which the AMA supports, reduces the premium contribution for families with incomes between 100 and 150 percent of the federal poverty level (FPL) to zero and provides subsidies to 90 percent of consumers selecting marketplace plans. Partly as a result, enrollment in marketplace plans has reached record highs, surpassing 16 million during the open enrollment period that ran until mid-January 2023 for most exchanges.¹⁵ Additionally, the enhanced subsidies significantly increase affordability of marketplace plans and will improve the stability of the exchange market if healthier people enroll.¹⁶

Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage: The Consolidated Appropriations Act of 2023 decoupled the Medicaid continuous enrollment requirement from the public health emergency (PHE) end date and permitted state eligibility redeterminations of Medicaid/CHIP enrollees to begin as

early as March 2023. Although it is not yet known how many individuals will be disenrolled as states undertake these mass redeterminations, major disruptions in coverage are anticipated and many people could become uninsured. Importantly, CMS established a SEP for consumers losing Medicaid/CHIP coverage due to the unwinding of the continuous enrollment requirement. This SEP, which allows individuals and families to enroll in marketplace plans, if eligible, outside of the annual open enrollment period, runs between March 31, 2023 and July 31, 2024 and presents a significant enrollment opportunity for the exchanges.¹⁷ The Council addressed the mass redeterminations and strategies for preventing coverage losses in Council Report 03-A-22.

Fixing the “Family Glitch:” The AMA long supported fixing the “family glitch” and was accomplished this year by regulations allowing family members of workers offered affordable self-only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it was anticipated that nearly one million Americans would see their coverage become more affordable.¹⁸

Requiring Standardized Plan Options: To address “choice overload” and increase transparency, in 2023, CMS began requiring issuers offering QHPs on HealthCare.gov to offer standardized benefit plans for every product, metal level, and geographic area. In comment letters to CMS, the AMA has supported this change which will help highlight clear and meaningful differences between plans, simplify consumer choice, and improve the plan selection process.¹⁹

AMA POLICY

As previously noted, Council on Medical Service Report 3-A-18 established Policy H-165.825, which added to the AMA’s strong body of policy on marketplace competition and health plan choice. Policy H-165.839 outlines principles for the operation of health insurance exchanges, including that: 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; and federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring protections for patients and physicians. Additionally, this policy supports using the open marketplace model for any health insurance exchange to increase competition and maximize patient choice of health plans.

Policy H-165.838 supports health reform initiatives that are consistent with long-standing AMA policies on pluralism, freedom of choice, freedom of practice, and universal access for patients. This policy also states 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. Support for fixing the ACA’s “family glitch” is addressed by Policy H-165.828, which also supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.

Principles to guide in the evaluation of the adequacy of health insurance coverage options are outlined in Policy H-165.846, including that: 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; existing federal guidelines regarding types of health insurance coverage should be used as a reference when considering if a given plan would provide meaningful coverage; and mechanisms must be in place to educate patients and assist them in making informed choices. This policy also opposes waivers of essential health benefits (EHB) requirements that lead to the elimination of EHB categories and their associated protections. Policy H-165.865 states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the U.S. Code.

Network adequacy is addressed in Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements. This policy supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy. Policy H-180.946 supports the selling of insurance across state lines that ensure that certain patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. Additionally, Policy H-180.946 states that patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

Policy H-165.856 supports greater national uniformity of market regulation across health insurance markets, geographic location, or type of health plan. Under this policy, state variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not hamper the development of multi-state group purchasing alliances or create adverse selection. Under Policy D-165.971, the AMA will support an association health plan that safeguards state and federal patient protection laws, including those state regulations regarding fiscal soundness and prompt payment. Policy D-180.986 encourages local, state, and federal regulatory authorities to aggressively pursue action against “sham” health insurers.

Policy H-180.947 opposes consolidation in the health insurance industry that may result in anticompetitive markets. Antitrust reform is an AMA priority under Policy D-383.990, which directs the AMA to continue to: aggressively advocate for a level playing field for negotiations between physicians and health insurers; advocate to the Federal Trade Commission and Department of Justice for more flexible and fair treatment of physicians and for greater scrutiny for insurers; continue to develop and publish objective evidence of the dominance of health insurers through its study, *Competition in Health Insurance*; and identify consequences of the concentration of market power by health plans.

DISCUSSION

Insurer participation in the ACA marketplace has increased for five consecutive years, although a smaller increase was seen in 2023. Additionally, record numbers of individuals have signed up for coverage in the exchanges, which seem to be functioning well. Enrollment is likely being influenced this year by 1) the Inflation Reduction Act’s extension of enhanced premium tax credit subsidies for marketplace plans, through 2025, and 2) the disenrollment of individuals no longer eligible for Medicaid/CHIP, some of whom may be eligible for subsidized ACA plans. Still, the Council recognizes that insurer participation in the marketplace remains lower today than in 2015, when it was at its highest, and the share of plans offered by large insurers has been steadily growing in recent years. Additionally, many insurer exchange markets remain highly concentrated, as evidenced by data compiled in the AMA’s most recent edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. Importantly, health insurance markets are local; across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban regions. The Council shares the sentiment of many physicians that insufficient competition in the ACA marketplace remains concerning in many areas.

The Council also recognizes that the AMA has been a longstanding advocate for health insurance coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice and universal access for patients. The AMA’s plan to cover the uninsured, updated annually with new policy and metrics on the uninsured, lays out key calls for action to not only maintain, but build upon, the coverage gains that have been achieved under the ACA. This plan guides ongoing AMA federal and state advocacy on health reform policy priorities. Importantly, increasing insurer competition, maximizing health plan choice, and strengthening and ensuring the sustainability of the ACA marketplace remain key AMA priorities. The Council has presented several reports in recent years to establish and update AMA policy on these issues, including:

- Council on Medical Service Report 4-I-17, Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients;
- Council on Medical Service Report 3-A-18, Ensuring Marketplace Competition and Health Plan Choice;
- Council on Medical Service Report 2-A-18, Improving Affordability in the Health Insurance Exchanges;
- Council on Medical Service Report 2-A-19, Covering the Uninsured under the AMA Proposal for Reform;
- Council on Medical Service Report 1-Nov.-20, Options to Maximize Coverage under the AMA Proposal for Reform; and
- Council on Medical Service Report 3-Nov.-21, Covering the Remaining Uninsured.

Additionally, the Council highlights the following AMA policies addressing the issues raised in Policy D-165.933 and exemplifying the AMA’s strong support for insurer competition and health plan choice:

- Policy H-165.825, which offers solutions to ensuring marketplace competition and health plan choice;
- Policy H-165.839, which supports using the open marketplace model for any health insurance exchange and states that exchanges should maximize health plan choice;

- Policy H-165.838, under which insurance coverage options offered in an exchange should be self-supporting and have uniform solvency and other requirements;
- Policy H-165.846, which outlines principles to guide in the evaluation of health insurance coverage options;
- Policy H-180.946, which supports the selling of insurance across state lines, including multistate compacts, when patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides;
- Policy H-165.856, which supports greater uniformity of market regulation across health insurance markets, geographic location, or type of health plan; and
- Policy H-180.947, which opposes consolidation in the health insurance industry that may result in anticompetitive markets.

CONCLUSION

During the development of this report, the Council did not identify gaps in existing AMA policy on competition and choice and, therefore, makes no policy recommendations at this time. However, the Council believes network adequacy, which is key to maintaining healthy competition and choice in the exchanges, is an issue that remains problematic and is worthy of additional study. Relatedly, the Council is concerned about the ability of patients to see certain physicians who are listed by plans as in-network but for whom, in reality, access is limited. Accordingly, the Council has begun looking at the need for stronger network adequacy standards for ACA, Medicare Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

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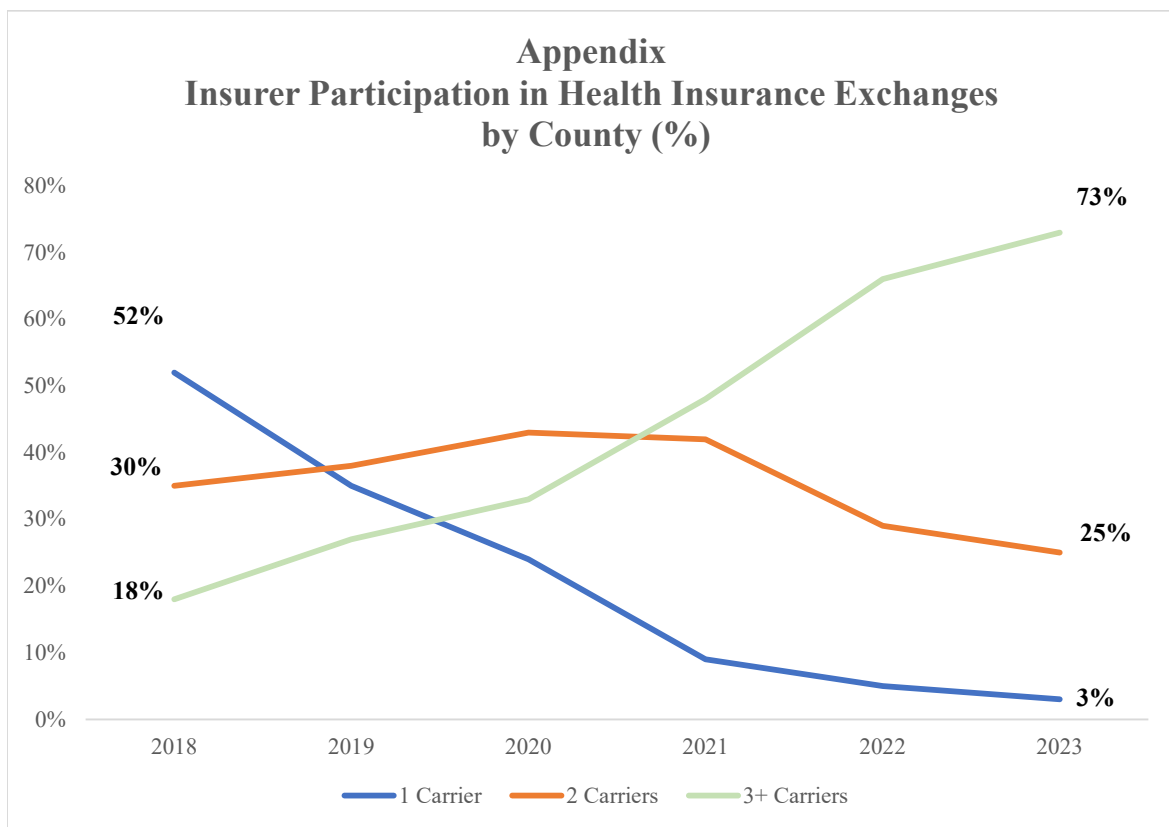
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Values may not add up to 100% due to rounding.

7. REPORTING MULTIPLE SERVICES PERFORMED DURING A SINGLE PATIENT ENCOUNTER (RESOLUTION 824-I-22)

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 824-I-22
REMAINDER OF REPORT FILED**

See Policies D-70.959, D-70.971, D-385.956 and H-385.944

At the November 2022 Interim Meeting, the House of Delegates referred Resolution 824-I-22, which was sponsored by the Private Practice Physicians Section. Resolution 824-I-22 asked the American Medical Association (AMA) to recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter. Testimony at the November 2022 Interim Meeting regarding the resolution was mixed, with some speakers offering vignettes to support the need for Resolution 824-I-22 and others questioning the need for it given recent revisions to Current Procedural Terminology (CPT®) Evaluation and Management (E/M) codes that allow physicians to report encounters involving multiple services during a single patient encounter. This report focuses on the need for education of physicians and payers on appropriate reporting of multiple services using CPT nomenclature, provides a snapshot of strategies insurers use to deny claims, highlights AMA advocacy efforts and essential policy, and presents new policy recommendations.

BACKGROUND

As outlined in Resolution 824-I-22, “multiple services” can refer to two E/M services, a procedure plus an E/M service, or two or more procedures provided by the same physician during a single patient encounter. CPT is the most widely accepted US medical nomenclature for reporting singular or multiple medical services and procedures under public and private health insurance programs. In addition to being the code set adopted under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) for outpatient services and procedures¹, CPT codes create a uniform language for reporting medical services and procedures to allow accurate and efficient claims processing and adjudication. In addition to codes, CPT includes two-digit modifiers, which are appended to codes to indicate that a service or procedure has been altered by a specific circumstance but not changed in its definition. The use of modifiers provides supplementary information for payer policy requirements.

While CPT provides a valid way to report multiple services, the resulting claims can result in high rates of denials. Payers may flag all multiple services claims for prepayment claim validation prior to payment or require submission of documentation with the claim, both of which create unjustifiable administrative burden for physicians, an incumbrance exacerbated in rural communities and other areas with limited health care resources. Addressing rural health inequities is a cornerstone of the Centers for Medicare & Medicaid Services’ (CMS) effort to improve health equity,² a goal that can be achieved by consistent application of CPT across all payers given its ability to promote health equity.³

Unfortunately, there is a disconnect between physicians and payers regarding the feasibility of providing, documenting, reporting, and paying for multiple services. This can be confounded further by use of electronic health records (EHR), which can make it difficult to ensure accurate data if codes and medical terms are not used consistently. Therefore, it becomes imperative that both physicians and payers are well educated on the appropriate way to report multiple services as well as the circumstances that justify such reporting. It is also important that the CPT guidelines used to recognize the validity of claims for multiple services are consistently applied, which may be facilitated by the development of EHR tools.

MODIFIER 25

CPT modifier 25 is appended to an E/M service code on a claim to indicate the code is a significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service.⁴ Its use allows two E/M services or a procedure plus an E/M service that are distinctly different but required for the patient’s condition to be appropriately reported and, therefore, appropriately paid. The CPT Professional Edition also states that 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.⁵ While CPT does not outline required documentation for modifier 25, its use indicates that documentation is available in the patient's record to support the reported E/M service as distinct and separately identifiable. Further, the E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.

There are two scenarios where modifier 25 is typically used:

- 1) A Preventive Medicine E/M service provided with a problem-oriented Office or Other Outpatient E/M service:

This is a common scenario in pre- or non-verbal patients. For example, a 2-year-old is seen for their well child visit and the physician finds otitis media during the physical examination. When a significant problem is encountered while performing a Preventive Medicine E/M service, requiring additional work to perform the key components of the E/M service, the appropriate Office or Other Outpatient E/M code also should be reported for that service with modifier 25 appended. Modifier 25 allows separate payment for these visits without requiring documentation with the claim form.

- 2) A minor surgical procedure provided with a problem-oriented Office or Other Outpatient E/M service:

CPT codes for minor surgical procedures include preoperative evaluation services (i.e., assessing the site or problem, explaining the procedure, risks, and benefits, and obtaining consent). Therefore, the E/M service has to involve work "above and beyond" the preoperative evaluation services. For example, when a patient presents with a head laceration, and the physician also performs a neurological examination before repairing the laceration, the neurological exam would merit a separate E/M service reported with modifier 25.

The CPT Professional 2023 codebook definition of a significant, separately identifiable service relies on satisfying the relevant criteria for determining the correct level of E/M service to be reported. The following questions can be used to determine whether an E/M service justifies use of modifier 25 according to CPT guidelines:

- Did the physician perform and document the level of medical decision making or total time necessary to report a problem-oriented Office or Other Outpatient E/M service for the complaint or problem?
- Could the work to address the complaint or problem stand alone as a billable service?
- Did the physician perform extra work that went above and beyond the typical pre- or postoperative work associated with the procedure code?

If all answers are "yes," then use of modifier 25 is consistent with CPT guidelines.

CMS requires that modifier 25 be used:

- Only on claims for E/M services and
- Only when the E/M service is provided by the same physician on the same day as another procedure or service.

While these two requirements are consistent with CPT guidelines, Medicare policy is more restrictive in that it will not pay for more than one E/M service provided by the same physician on the same day unless the visits are for unrelated problems and could not be provided during the same patient encounter. For example, Medicare will not pay separately when a patient is seen for their annual preventive checkup and the physician finds otitis media during the physical examination – even with the use of modifier 25. However, Medicare will pay for a patient who presents for blood pressure medication evaluation and then returns five hours later that same day for evaluation of leg pain following an accident – if modifier 25 is used.

Under certain circumstances, Medicare will allow use of modifier 25 when an E/M service is reported with a global procedure. Global procedures include visits and other physician services provided within 24 hours prior to the service, provision of the service, and visits and other physician services for a specified number of days after the service is provided.

CMS defines global surgical packages based on the number of postoperative days it assigns to the service:

- XXX: Global period does not apply

- 0-day global period: Includes procedure and visit on day of procedure
- 10-day global period: Includes procedure, visit on day of procedure, and visits 10 days immediately following the day of the procedure
- 90-day global period: Includes procedure, visit on day of procedure, and visits 90 days immediately following the day of the procedure

Modifier 25 may be appended to E/M services reported with minor surgical procedures (i.e., 0-day and 10-day global periods) or procedures not covered by a global period (i.e., XXX). Since minor surgical procedures and XXX-global procedures include pre-service, intra-service, and post-service work inherent in the procedure, the physician cannot report an E/M service for this work in most circumstances when the minor surgical procedure or XXX-global is the primary procedure. Furthermore, Medicare policy prevents the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure.

All E/M services provided on the same day as a procedure are considered part of the procedure and Medicare only makes separate payment if an exception applies. Modifier 25 is used to provide justification for a visit that is “generally not payable,” as Medicare payment is made only if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre-service and post-service work required on the day of the procedure. Modifier 25 may be used in the rare circumstance of an E/M service the day before a procedure which represents a significant, separately identifiable service; it typically is linked to a different diagnosis than the underlying reason for the procedure (e.g., evaluation of a cough that might contraindicate surgery).⁶ Medicare requires that the physician appropriately and sufficiently document both the medically necessary E/M service and the procedure in the patient’s medical record to support the claim for these services, even though the documentation is not required to submit with the claim.⁷

CMS has focused on the potential misuse of modifier 25 since 2005, when the Office of the Inspector General (OIG) published an analysis indicating that 35 percent of Medicare claims involving modifier 25 did not meet CMS requirements.⁸ Since that time, both Medicare and private payers have increased their scrutiny of claims submitted with modifier 25, which has led to substantial recoupment of physician payments. The OIG continues to maintain modifier 25 as a target of its work plan and is expected to release a report of modifier 25 use in dermatology in late 2023.

OTHER CPT MODIFIERS USED FOR REPORTING MULTIPLE SERVICES

In addition to modifier 25, CPT includes other modifiers to allow the reporting of multiple services:⁹

- Modifier 24: Unrelated E/M service provided by the same physician or other qualified health care professional during a postoperative period
- Modifier 51: Multiple procedures, non-E/M procedures provided by the same individual at the same session
- Modifier 57: Decision for surgery, an E/M service that resulted in the initial decision to perform surgery
- Modifier 58: Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period
- Modifier 59: Distinct procedural service, an independent non-E/M service performed on the same day
Modifier 59 is used to identify non-E/M procedures/services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Modifier 59 should only be used if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances.
- Modifier 78: Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period
- Modifier 79: Unrelated procedure or service performed by the same physician or other qualified health care professional during the postoperative period

CPT CODES AND GUIDELINES THAT FACILITATE THE REPORTING OF MULTIPLE SERVICES

Prolonged Service

There are Prolonged Service CPT codes that permit the reporting of time spent beyond the highest time in the range of total time of the primary E/M service. Prolonged Service CPT codes are reported in 15 minute increments, allowing physicians to be paid for providing extended services during a single patient encounter (even if the time on that date is not continuous) that contribute toward the total time of the visit.

The AMA is currently advocating to align CMS's interpretation of the Prolonged Service codes with the CPT definition as described above. Medicare, however, requires that the physician surpass the maximum time of the highest E/M level by 15 minutes. Until such time that CPT and CMS interpretations are reconciled, Medicare requires reporting of Healthcare Common Procedure Coding System Level II codes in lieu of CPT codes for reporting prolonged services.

Care Management

Care Management CPT codes are E/M codes reported monthly for physician oversight and management of clinical staff in the development and implementation of the care plan and care coordination in patients with one or more complex chronic conditions. Care Management codes can be reported in addition to other E/M codes (e.g., Office or Other Outpatient Services). Time that is spent providing services within the scope of the Care Management service on the same day as an E/M visit can be counted towards Care Management codes, as long as the time is not counted towards the other reported E/M code(s).

Total Visit Time Versus Medical Decision Making

E/M codes are selected based on either the total time spent or medical decision making (MDM) required. The decision of which component to use in selecting the appropriate E/M code is determined by the reporting physician or qualified health care professional based on the available criteria.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option.

There are three elements to MDM:

- Number and complexity of problems addressed at the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

Time is based on the total time spent on the date of the encounter. It includes both face-to-face time with the patient and non-face-to-face time spent on things such as care coordination, consulting with other health care professionals, and ordering medications, tests, and procedures.

Caring for a patient with multiple issues is likely to increase the total time of the encounter, which may allow the physician to report a single, higher level E/M code rather than two lower level E/M codes appended with modifier 25.

RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS)

CMS considers recommendations from the AMA/Specialty Society Relative Value Scale Update Committee (RUC) process to determine relative value units (RVUs) for the RBRVS. The RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it. Determining RVUs through the RUC ensures that potential overlap is eliminated from the physician work, practice expense, and professional liability insurance (PLI) for services that are frequently provided together. The physician work component accounts for an average of 51 percent of the total RVU for each service while practice expense accounts for 45 percent. PLI accounts for the remaining four percent. The factors used to determine physician work include the time it takes to perform the service, the technical skill and physical effort, the required mental effort and

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 95 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 policies. 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 care³. Additionally, those in rural areas are geographically further from hospitals and physicians, increasing barriers to access care³. 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 services, 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 FQHCs¹². 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.

The AMA also has policies related to rural health care that are not centered solely around hospital centered care. Policies H-465.994 and H-465.982 are concentrated around improving the health of rural communities through promoting access to medical care. Policy H-465.978 works to recognize and advocate for fixing the payment bias that is seen between rural and non-rural providers. The policy advocates specifically for payment equity in telehealth legislation. Finally, Policy H-465.980 supports the development and improvement of rural health networks to be centered around the needs of the communities they serve.

With respect to FQHCs, Policy D-390.923 acknowledges the need for Chronic Care Management payment for physicians who practice in FQHCs. Additionally, the AMA has existing policy surrounding issues of scope of practice for non-physician providers. Specifically, Policies D-35.989, H-160.947, and H-35.965 ensure the regulation of and appropriate scope (including physician supervision) of midwives/CNMs, PAs, NPs, and “related medical personnel.”

DISCUSSION

FQHCs are, by definition, located in areas where health care is hard to access. As previously discussed, FQHCs were key in meeting the needs of communities that arose during the peak of the COVID-19 pandemic. FQHCs also have a long history of working to reduce health care disparities and providing preventive and primary care to the underserved.^{8,9} Although the AMA has established policy on improving the health of rural Americans, the Council believes that strengthening our support of FQHCs is warranted.

One specific method to ensure the viability of FQHCs and RHCs is by reducing physician burnout, one of the core tenets of the AMA’s Recovery Plan for America’s Physicians. Burnout is reported at higher levels in physicians who practice in FQHCs,¹⁰ with significant time and resource burdens related to the administrative aspects of maintaining patient care.^{9,10} The Council believes that this is a potential point of intervention via the addition of AMA policy to ensure that administrative burdens placed on physicians practicing in these settings are not undue and do not influence levels of burnout.

In addition to ensuring that physicians are able to continue practicing in FQHCs the Council believes that it is also essential that the AMA advocate for continued federal support for these practices. Existing funding for FQHCs should be maintained and increased when feasible to support the expansion of existing clinics and founding of new clinics in underserved communities. The Council understands the importance of FQHCs in providing health care services for communities that have limited access and believes that it is essential to support these clinics and the physicians who practice in them.

Finally, in order to ensure that patients cared for in FQHCs are receiving high-quality medical care services, it is important to ensure that care is always performed under the supervision of a physician. While regulations for both FQHCs and RHCs allow for practitioners like PAs, NPs, and CNMs to provide care, they do require the supervision of a physician. The AMA does have existing policies that ensure support for state and local medical societies in identifying and advocating for the existing requirement of physician oversight. Each of these additions and reaffirmations of policy will ensure that the AMA works to support essential access points of care for rural communities and the physicians who provide this care.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support certification requirements and other policies that reduce the administrative burden for physicians practicing in Federally Qualified Health Center (FQHCs).
2. That our AMA support sufficient federal funding to maintain the operation and costs associated with establishing and operating a FQHC, FQHC “Look-Alike”, or Outpatient Tribal Facility.
3. That our AMA advocate for regular updates to the Medicaid FQHC Prospective Payment System that at least keep pace with inflation.

34. That our AMA reaffirm Policy H-465.994, which supports efforts to develop and implement proposals and programs to improve the health of rural communities.
45. That our AMA reaffirm Policy D-390.923, which advocates for the authorization of Chronic Care Management reimbursement for all physicians, including those practicing in FQHCs or Rural Health Clinics.
56. That our AMA reaffirm Policies H-160.947 and H-35.965, which both advocate for the support of state and local medical societies in identifying and working to prevent laws that may allow for non-physicians (e.g., nurse practitioners, physician assistants) to operate without the supervision of a physician.

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APPENDIX A: FQHC & RHC REQUIREMENTS

	FEDERALLY QUALIFIED HEALTH CENTERS	RURAL HEALTH CLINIC
SUMMARY	<i>Provide at least primary care services to rural and urban shortage areas.</i>	<i>Provide primary care services for patients who live in rural shortage areas.</i>
SUBTYPES	<ul style="list-style-type: none"> • FQHC (Health Center Program Grantees): Organizations receiving grants under section 330 of the PHS Act. • “Look-Alikes”: Organizations that meet the eligibility requirements of an FQHC, but do not receive funding under section 330 of the PHS Act. • Outpatient Tribal Facilities: Organizations operated by a tribe, tribal organization, or urban Indian Organization. • Examples: Community Health Centers, Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers 	<ul style="list-style-type: none"> • Independent RHC: Clinics that meet the designation for an RHC and are standalone. • Hospital-Based RHC: Clinics that meet the designation for an RHC and are housed at a hospital. • Provider-Based RHC: Clinics that meet the designation for an RHC and are owned and operated by a nursing home or home health agency participating in Medicare.
PRACTITIONERS	Services must be provided by a physician, NP, PA, CNM, CP, CSW, or furnished by the care of an aforementioned provider.	Must have a physician providing medical direction. A NP, PA, or CNM must provide care services at least 50 percent of the time.
FUNDING	Dependent on the subtype of FQHC. For official FQHCs they must receiving funding from grants under section 330 of the PHS Act. FQHC “look-alikes” may receive grants and funding from a variety of sources but <i>cannot</i> receive grants under section 330 of the PHS Act. Outpatient Tribal facilities are funded through the Indian Self-Determination Act or Title V of the Indian Health Care Improvement Act.	Funding is via Medicare reimbursement and patient co-pays.
RECORDS & REPORTING	Must demonstrate an effective procedure for compiling and reporting operations costs, patterns of service use, availability, accessibility, and acceptability of services offered. Must establish and maintain records and provide the authorities with access to examine, copy, and reproduce.	Clinics must file an annual cost report that includes payment rate, reconcile interim payments, graduate medical education adjustments, bad debt shots, and administrative payments.
AUDITING	Must provide an independent annual financial audit and file with the HHS secretary.	Must cooperate with audits done by oversight bodies.
REQUIRED SERVICES	Primary health services including family medicine, internal medicine, pediatrics, OBGYN care, diagnostic lab services, preventative health services, emergency medical services, referrals, case management services, services that enable access to the FQHC, and community education.	Must provide routine diagnostic and lab services, including chemical urine exams, hemoglobin or hematocrit tests, blood sugar tests, and occult blood stool specimen’s exam, pregnancy tests, and primary culturing onsite.
ADDITIONAL SERVICES	Pharmaceutical services, behavioral & mental health services, environmental health services, screening & control of infectious diseases, and injury prevention programs.	May provide care management services like Transitional Care Management (TCM), Chronic Care Management (CCM), General Behavioral Health Integration (BHI), Principal Care Management (PCM), and Psychiatric Collaborative Care Management.
POPULATIONS SERVED	Must serve a MUA or a MUP.	Must serve a non-urbanized community that is designated as a medical shortage area.
QUALITY IMPROVEMENT	Ongoing process that includes clinical services and management.	No specific quality improvement requirements.
PAYMENT & REIMBURSEMENT	Contracted agreement with the State for those eligible for medical assistance through a state plan. Collect appropriate reimbursement from patients who are insured and establish a prepared schedule of fees/payments from patients on a sliding scale, while ensuring no patient is turned	Reimbursement is paid via a bundled All-Inclusive Rate (AIR) per visit for all qualified primary and preventative care services. Dependent upon services and insurance status, patients may have a copay. For example, those with Part B coverage would

	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)

Policy D-390.923, “Chronic Care Management Payment for Patients Also on Home Health”

Our AMA will advocate for the authorization of Chronic Care Management (CCM) reimbursement for all physicians, including those practicing in Rural Health Clinics and Federally Qualified Health Centers, for patients in a home health episode. (Res. 801, I-17)

Policy H-160.947, “Physician Assistants and Nurse Practitioners”

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner’s authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician’s delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
- (8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
- (9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
- (10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care. (BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22)

Policy H-35.965 “Regulation of Physician Assistants”

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by organizations to board certify physician assistants in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification. (Res. 233, A-17; Modified: Res. 215, I-19)