

Reference Committee G

BOT Report(s)

- 14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

CMS Report(s)

- 01 Council on Medical Service Sunset Review of 2013 House Policies
- 05 Prescription Drug Dispensing Policies
- 08 Impact of Integration and Consolidation on Patients and Physicians
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- 717* Improving Patient Access to Supplemental Oxygen Therapies
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- 722* Expanding Protections of End-Of-Life Care

**Contained in the Handbook Addendum*

REPORT 14 OF THE BOARD OF TRUSTEES (A-23)
Advocacy of Private Practice Options for Healthcare Operations in Large Corporations
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting of the House of Delegates, Policy D-160.912, “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations,” was adopted. The policy directs the American Medical Association to (1) study the best method to create pilot programs which advance the advocacy of private practice and small business medicine within the rapidly growing area of internal health care within Fortune 500 corporations in America with a report back at the 2023 Annual Meeting, (2) use proposals for the advocacy of small business medicine and private practice models in health care as a pilot project in the development of advocacy programs within major leading corporations like Amazon and Walmart which are currently entering the health care service market with internalized models of health care in the complete absence of more diverse private practice (small business) options, and (3) prioritize advocacy efforts that emphasize small private practice utilization within the investment and business efforts of Fortune 500 corporations that are currently seeking to enter into the health care industry (Directive to Take Action).

To study potential pilots to advance the advocacy of private practice within corporate health care, the AMA conducted a market landscape assessment based on publicly available news articles and studies. Confidential informational interviews were undertaken among a small sample of national corporate entities with individuals directly responsible for each organization’s strategy in care delivery. These interviews were conducted with a series of pre-determined questions regarding their approaches and strategic thinking on care delivery and the role of private practices in the community. Three key themes emerged from this market analysis:

1. Corporate entities are increasingly investing in opportunities in care delivery and believe this strategy will increase value for their insured employees, their customers and shareholders.
2. Corporations believe “value-based” payment and delivery models will drive better patient outcomes and lower health care costs and are investing heavily in these models.
3. While acquisition of independent practices is accelerating in certain markets, some corporate entities, particularly among vertically integrated health insurers, have a strategy of working with independent practices in communities. These companies express a goal of supporting integrated networks of practices, with the aim of providing more enhanced, coordinated care for patients and preventing practice acquisition by larger health care systems or hospitals that can lead to consolidation and attendant price increases. Newer corporate retail and technology entrants will continue experimenting with various arrangements subject to market conditions and shareholder priorities.

Based on the market assessment, the AMA identified vital opportunities to (1) inform corporations about the value of private practices in successfully implementing new “value-based” models; (2) identify and work with a specific corporate entity advancing these models to explore a two-year pilot with independent private practices in which the AMA will: (a) convene practices in a community; (b) provide educational resources and technical assistance to practices to support participation in a pilot; and (c) formally evaluate the pilot for outcomes; and (3) continue advocacy that improves “value-based” models to ensure that physicians can succeed in these models with adequate payment, infrastructure and data.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-23

Subject: Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee G

1 INTRODUCTION

2
3 At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Policy D-160.912,
4 “Advocacy of Private Practice Options for Healthcare Operations in Large Corporations.” This
5 policy directs our American Medical Association (AMA) to: (1) study the best method to create
6 pilot programs which advance the advocacy of private practice and small business medicine within
7 the rapidly growing area of internal healthcare within Fortune 500 corporations in America with a
8 report back at the 2023 Annual Meeting; (2) use proposals for the advocacy of small business
9 medicine and private practice models in healthcare as a pilot project in the development of
10 advocacy programs within major leading corporations like Amazon and Walmart which are
11 currently entering the healthcare service market with internalized models of healthcare in the
12 complete absence of more diverse private practice (small business) options, and (3) prioritize
13 advocacy efforts that emphasize small private practice utilization within the investment and
14 business efforts of Fortune 500 corporations that are currently seeking to enter into the healthcare
15 industry.

17 BACKGROUND:

18
19 Over the last two decades, large corporations have increasingly entered health care delivery—a
20 trend that has accelerated following the onset of the COVID-19 pandemic. These entities include
21 Walmart, CVS, Walgreens and Amazon, as well as national health insurance corporations such as
22 UnitedHealth Group. Even unexpected corporate retailers like Dollar General are offering health
23 care delivery models. These corporations have assumed various roles within health care, such as in-
24 person and virtual health care delivery, pharmaceuticals, wellness and employer-sponsored health
25 insurance.

26
27 Following blocked mergers of Aetna-Humana and Anthem-Cigna in 2017, these large national
28 insurers, along with United Healthcare, accelerated acquisitions of other types of health care
29 companies.¹ This represented a shift from horizontal integration (two health insurers merging) to
30 vertical integration (different parts of the health care delivery system merging). These acquisitions
31 and mergers include retail pharmacies (e.g., Aetna-CVS), pharmacy benefit managers (e.g., Cigna-
32 Express Scripts) and data/analytic companies (e.g., United-Change Healthcare). In addition, these
33 organizations are acquiring a broad spectrum of health care delivery organizations, from physician
34 practices to home health companies to mental health care companies. For example, UnitedHealth
35 Group's Optum Health is now the largest employer of physicians in the country.²

1 In addition to traditional health insurers, new entrants such as large retailers (e.g., Walmart) and
 2 new and established technology companies (e.g., Amazon) are entering the health care delivery
 3 space. These organizations are entering health care delivery as a new revenue source to drive
 4 shareholder value, create synergy with other portions of their business (e.g., pharmacy) and help
 5 control employee health care costs.^{3,4,5,6} While these investments have not been as expansive as the
 6 large national health insurers, they will likely shake up health care delivery with new models of
 7 pricing, the integration of technology and alignment with their other offerings.

9 The consumerization of health care is one factor that has fostered opportunities for corporations not
 10 traditionally involved in health care delivery to enter these spaces and offer greater convenience at
 11 a lower cost.³ Occurring alongside this trend is the acquisition of independent physician practices
 12 by these large corporations, as well as by hospitals and payers. According to one estimate,
 13 corporate entities acquired over 30,000 additional physician practices between 2019 and 2021.⁷ The
 14 2020 AMA Physician Practice Benchmark survey found that less than half of patient care
 15 physicians worked in private practice, nearly five percent lower than two years prior.⁸

17 Some see this trend of corporate entry into health care as positive, believing it will make health
 18 care more sustainable and provide physicians greater access to capital, negotiating power and the
 19 latest technology. However, others view it as disruptive to high-quality, coordinated care delivered
 20 by a physician-led team, believing it decreases access and competition.⁸ There is also limited
 21 scrutiny of the impact on market competition, as some proposed transactions involving the
 22 corporate acquisition of physician practices may not come to the attention of antitrust enforcers if
 23 the transaction is not sufficiently large enough to trigger statutory reporting obligations.⁹

25 Further, restrictive networks are commonly associated with these acquisitions. For instance,
 26 patients receiving care from a physician employed by a hospital or large corporation may only
 27 receive referrals to other clinicians employed by said hospital or corporation. This can lead to less
 28 patient choice and arbitrary removal from networks of independent physicians.¹⁰ As these large
 29 corporations continue their entry into the health care market, this can result in more harm than good
 30 if the voices of patients and community-based private practice physicians are not integrated into
 31 their plans.

33 *The Role of Large Corporations in Health Care: Recent Examples*

35 Amazon

37 Amazon's entry into health care predominantly consists of health care services, such as in-person
 38 care, telehealth, and pharmaceuticals. For example, the company launched a telehealth service,
 39 Amazon Care, after first piloting it to its employees.³ Designed to address high employee health
 40 care costs, the app-based platform partnered with One Medical to offer members in-person and
 41 virtual primary, urgent, and preventive care services, including COVID-19 and flu testing,
 42 vaccinations, and treatment for illnesses and injuries.^{3,11} One Medical places medical offices near
 43 the workplace, and its members use an app to book appointments and track health records.¹² The
 44 platform reported a membership of 790,000 customers at the end of June 2022.¹³ In June 2022,
 45 Amazon announced its intent to purchase OneMedical for \$3.9 billion.^{14,15} After an eight month
 46 review, the Federal Trade Commission (FTC) declined to challenge the acquisition and the deal
 47 was finalized on February 22, 2023.^{12,16}

CVS

Perhaps the most established in health care of the mentioned corporations, CVS, is focused on journeying further into primary care.^{4,5} The company has offered walk-in health care services since the early 2000s. Today, consumers may take advantage of routine physicals, screenings, vaccinations, treatment for illnesses and minor injuries, mental health counseling and services that address social determinants of health, such as wellness and health education classes, tobacco cessation support and sleep assessments.⁴ In addition to the company's 10,000 pharmacy locations, CVS recently amassed a 10,000-clinician-network that makes in-person and virtual home visits through its Signify Health acquisition.⁶

A key part of its strategy to deliver on its goal, announced in 2021, to facilitate 65 billion health care interactions over the next decade, is to transform the number of stores converted to the HealthHUB model. With over 20 percent of the store dedicated to these HealthHUBs, this concept is designed to provide patients with chronic disease management consultations and other health and wellness services such as sleep apnea assessments and blood draws. Further, the concept will offer an array of durable medical equipment and other medical supplies¹⁷. As the HealthHUBs are currently staffed by nurse practitioners, CVS aims to hire physicians to staff the primary care sites. In addition to offering convenience to customers, the company also believes these efforts will reduce health care costs.⁵

Most recently, CVS acquired Oak Street Health for \$10.6 billion. Oak Street's centers predominantly serve low- to middle-income patients aged 65 and older with Medicare Advantage plans. The company operates in 169 locations throughout 21 states, and its locations are expected to increase to 300 by 2026.¹⁸

Walmart

Walmart continues to disrupt the health care industry through low-cost health care services and insurance.¹⁹ The company opened comprehensive health clinics in 2019 that offer affordable services such as primary care, urgent care, dental care, mental health counseling, and vision and hearing services.⁵ In addition to the 20 clinic locations that the company currently operates in Georgia, Walmart has over 5,000 pharmacy locations and aims to expand to Florida in 2023.^{11,12} Walmart now also offers virtual care through its telehealth platform, MeMD, and recently procured an agreement with UnitedHealth Group, the world's largest insurer.^{5,6} Through this partnership, Walmart and UnitedHealth Group will offer a Medicare Advantage plan. UnitedHealth Group will provide data analytics and decision support tools to Walmart clinicians, and Walmart Health's virtual care services will be included as part of one of UnitedHealth's commercial PPO plans.⁴

Walgreens

Walgreens is also focused on offering health care services, as demonstrated by its recent launch of Walgreens Health. The company currently owns 70 VillageMD primary care clinics. Walgreens continues to provide in-store services such as health tests, screenings and help with medications. The company also created an online marketplace where users may schedule appointments.⁵

Elevance Health

Elevance Health, formerly Anthem, combines care delivery tools and technology in its Carelon Division with its health insurance companies, with aspirations of growing beyond providing health insurance to become a "lifetime partner" in the delivery of healthcare to its members.²⁰ Unique

among other insurance companies that have purchased physician practices as part of their delivery network, Elevance is investing in an “Aggregator Strategy.” Through this strategy, Caredon, with other third-party partners, provides infrastructure and data analytics to independent primary care physician practices to enable them to effectively participate in value-based contracts so they can remain independent in local communities.^{20,21}

UnitedHealth Group

UnitedHealth Group is an example of a large vertically-integrated health care corporation that comprises a health insurance company, UnitedHealthcare, a solutions service, Optum, and a provider group subsidiary, Optum Health. Optum Health owns physician practices inclusive of approximately 60,000 physicians who treat over 20 million patients annually. Much of this growth is derived from the group’s focus on value-based care. Optum’s CEO, Andrew Witty, expects that the company will have four million patients in accountable care arrangements in 2023.²¹ The company plans to continue its expansion of value-based services—Witty informed investors that Optum Health intends to integrate further behavioral and home health offerings into its health care strategy.²³

Dollar General

In January 2023, Dollar General announced a partnership with DocGo, a publicly traded company that offers “last-mile care” via mobile health care clinics with trained providers, a transportation and logistics network, and an advanced data analytics network to deliver quick and easy health visits outside Dollar General stores. DocGo onsite care is provided by certified medical assistants, emergency medical technicians, licensed practical nurses, paramedics and physicians via remote technology. Services offered at Dollar General locations will include preventive visits and chronic care management. Dollar General, with over 18,000 stores nationwide—many in underserved rural and urban areas—seeks to make health care more accessible and convenient for its shoppers.²⁴

Others

Other companies, including National Public Radio (NPR), CHG Healthcare Services, USAA, Goldman Sachs, CustomInk, Anthrex, JM Family Enterprises and QuikTrip, have begun providing their employees with on-site health care services. NPR’s and CHG’s health clinics are available at no cost to all employees regardless of their enrollment status within the companies’ health plans. USAA offers its employees cancer screenings, flu shots, blood pressure checks, massages and physical rehabilitation. Goldman Sachs’ and QuikTrip’s health care benefits are available to all enrolled employees and their families. Further, many physicians employed by QuikTrip work exclusively for the company.²⁵

Investments and Support of Private Practices

Also accelerating is private sector investment in small- to medium-sized physician practices for the purpose of providing infrastructure to transition to value-based models. There has been significant growth in companies specifically designed to help independent practices succeed in value-based models, including Aledade, Emergence Healthcare Group, Redesign Health and Privia. Representing a shift from the 2010s, wherein founders of venture capital-backed health tech mainly pursued large payers and employers, as well as hospitals, there has been recent interest in selling to small- to medium-sized businesses which include private practices. Owners of private practices are increasingly seeking to remain independent, and these opportunities provide them with the agency

1 and revenue to do so.²⁶ Private equity firms see significant opportunities in investing in physician
2 practices across specialties to offer administrative support.²⁷

3
4 *AMA Market Analysis*

5
6 The AMA conducted confidential informational interviews to better understand the evolving
7 market landscape and identify opportunities to create pilot programs to advance the advocacy of
8 private practice and small business medicine within the rapidly growing area of health care
9 delivery within Fortune 500 corporations in America.

10
11 To better understand the best method to explore the creation of potential pilots, the AMA: (1)
12 conducted (1) a market landscape assessment based on publicly available news articles and studies;
13 and (2) qualitative informational interviews among a sample of national corporate entities. The
14 confidential informational interviews were conducted between Fall 2022 and Winter 2023 with
15 individuals directly responsible for each organization's strategy in health care delivery. The
16 interviews were conducted with a series of pre-determined questions regarding corporate entities'
17 approaches and strategic thinking on health care delivery and the role of private practices in the
18 community. Interviews included a selection of large national insurers vertically integrating into the
19 delivery of care through acquisitions, along with national retailers and large technology companies
20 entering the health care delivery marketplace.

21
22 Three key themes emerged from this market analysis:

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24 1. Corporate entities are increasingly investing in opportunities in care delivery and believe
25 this strategy will increase value for their insured employees, their customers and
26 shareholders.
27 2. Corporations believe "value-based" payment and delivery models will drive better patient
28 outcomes and lower health care costs and are investing heavily in these models.
29 3. While acquisition of independent practices is accelerating in certain markets, some
30 corporate entities, particularly among vertically integrated health insurers, have a strategy
31 of working with independent practices in communities. These companies express a goal of
32 supporting integrated networks of practices, with the aim of providing more enhanced,
33 coordinated care for patients and preventing practice acquisition by larger health care
34 systems or hospitals that can lead to consolidation and attendant price increases. Newer
35 corporate retail and technology entrants will continue experimenting with various
36 arrangements subject to market conditions and shareholder priorities.

37
38 *AMA POLICY*

39
40 The AMA supports preserving the value of the private practice of medicine and its benefit to
41 patients. AMA will:

- 42
43 a. Utilize its resources to protect and support the continued existence of solo and small group
44 medical practice and to protect and support the ability of these practices to provide quality
45 care. They will also advocate in Congress to ensure adequate payment for services
46 rendered by private practicing physicians.
47 b. Work through the appropriate channels to preserve choices and opportunities, including the
48 private practice of medicine, for new physicians whose choices and opportunities may be
49 limited due to their significant medical education debt. The organization will work through
50 the appropriate channels to ensure that medical students and residents during their training
51 are educated in all of medicine's career choices, including the private practice of medicine.

- c. Create, maintain and make accessible to medical students, residents and fellows, and physicians resources to enhance satisfaction and practice sustainability for physicians in private practice.
- d. Create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.
- e. Issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices (Policy D-405.988, “The Preservation of the Private Practice of Medicine”).

The AMA also supports the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles, as well as the following principles to support physicians who choose to participate in prospective payment models:

- a. The AMA, state medical associations and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allows independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.
- b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.
- c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
- d. Governance within the model must be physician-led and autonomous.
- e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
- f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
- g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians (Policy H-385.904, “Prospective Payment Model Best Practices for Independent Private Practice”).

The AMA will identify financially viable prospective payment models and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice (Policy H-385.904, “Prospective Payment Model Best Practices for Independent Private Practice”).

Additionally, the AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

- a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
- b. Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
- c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
- d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.

- 1 e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and
- 2 patients. Educational materials should be made available to help patients and physicians
- 3 understand the incentives and disincentives built into the plan design.
- 4 f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to
- 5 target specific services or treatments but should not otherwise limit patient care choices.
- 6 g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs
- 7 that include higher cost-sharing or other disincentives to obtaining services designated as low-
- 8 value must include an appeals process to enable patients to secure care recommended by their
- 9 physicians, without incurring cost-sharing penalties.
- 10 h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation
- 11 and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure
- 12 VBID coverage rules are updated in accordance with evolving evidence.
- 13 i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines
- 14 (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or
- 15 restricted networks (Policies H-450.941 and D-285.972) (Policy H-185.939, “Value-Based
- 16 Insurance Design”).
- 17

18 The AMA will also study and clarify the ethical challenges and considerations regarding physician
19 professionalism raised by the advent and expansion of private equity ownership or management of
20 physician practices and report back on the status of any ethical dimensions inherent in these
21 arrangements, including consideration of the need for ethical guidelines as appropriate. Such a
22 study should evaluate the impact of private equity ownership, including but not limited to the effect
23 on the professional responsibilities and ethical priorities for physician practices (Policy D-140.951,
24 “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices”).

25
26 Moreover, the AMA encourages physicians who are contemplating corporate investor partnerships
27 to consider the following guidelines:

- 28 a. Physicians should consider how the practice’s current mission, vision and long-term goals
- 29 align with those of the corporate investor.
- 30 b. Due diligence should be conducted that includes, at minimum, review of the corporate
- 31 investor’s business model, strategic plan, leadership and governance and culture.
- 32 c. External legal, accounting and/or business counsels should be obtained to advise during the
- 33 exploration and negotiation of corporate investor transactions.
- 34 d. Retaining negotiators to advocate for best interests of the practice and its employees should
- 35 be considered.
- 36 e. Physicians should consider whether and how corporate investor partnerships may require
- 37 physicians to cede varying degrees of control over practice decision-making and day-to-
- 38 day management.
- 39 f. Physicians should consider the potential impact of corporate investor partnerships on
- 40 physician and practice employee satisfaction and future physician recruitment.
- 41 g. Physicians should have a clear understanding of compensation agreements, mechanisms
- 42 for conflict resolution, processes for exiting corporate investor partnerships, and
- 43 application of restrictive covenants.
- 44 h. Physicians should consider corporate investor processes for medical staff representation on
- 45 the board of directors and medical staff leadership selection.
- 46 i. Physicians should retain responsibility for clinical governance, patient welfare and
- 47 outcomes, physician clinical autonomy and physician due process under corporate investor
- 48 partnerships.
- 49 j. Each individual physician should have the ultimate decision for medical judgment in
- 50 patient care and medical care processes, including supervision of non-physician
- 51 practitioners.

- k. Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs (Policy H-160.891, “Corporate Investors”).

Further, the AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices, encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty and supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine (Policy H-160.891, “Corporate Investors”).

Additionally, AMA policy states that any individual, company, or other entity that establishes and/or operates worksite health clinics should adhere to the following principles:

- a. Worksite health clinics must have a well-defined scope of clinical services, consistent with state scope of practice laws.
- 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.
- 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.
- d. Worksite health clinics must clearly 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.
- 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.
- f. Worksite health clinics must use evidence-based practice guidelines to ensure patient safety and quality of care.
- 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.
- 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.
- 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.
- 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.
- k. Patient cost-sharing for treatment received outside of the clinic must be affordable and not prohibit necessary access to care.
- l. Worksite health clinics should allow the involvement of community physicians in clinic operations.
- m. Employers implementing worksite health clinics should communicate the eligibility for services of employees' family members.

- n. Worksite health clinics should be encouraged to use interoperable electronic health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities (Policy H-160.910, “Worksite Health Clinics”).

The AMA also acknowledges that the corporate practice of medicine: (1) has the potential to erode the patient-physician relationship; and (2) may create a conflict of interest between profit and best practices in residency and fellowship training (Policy H-160.887, “Corporate Practice of Medicine”).

Furthermore, (1) the AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine; (2) At the request of state medical associations, the AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings and physicians contracting with corporately-owned management service organizations; and (3) the AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues (Policy H-215.981, “Corporate Practice of Medicine”).

DISCUSSION

Opportunities for Corporation-Provided Health Care

Large corporations, equipped with large amounts of capital, massive active user bases, and data and technology capabilities, have the potential to offer greater options for how patients receive care and streamline and automate processes to potentially alleviate high costs, burnout and inefficiencies.

Additionally, large corporations, which collect and maintain significant amounts of customer data, claim to utilize this data to address social determinants of health. For example, Dollar General and Walmart plan to expand access to care in rural communities, and Walmart is prioritizing diversity in clinical trials, as 20 percent of drugs reportedly respond differently across ethnic groups.^{5,18}

Further, new venture capital-backed companies, of which many are physician-led, are specifically designed to provide opportunities to improve the care delivery and financial sustainability of underinvested-in small to medium-independent physician practices.

Challenges for Corporation-Provided Health Care

Trust and a lack of health care background remain significant barriers to success for large corporations, particularly Big Tech companies such as Apple, Google, Microsoft and Amazon. For example, consumers, regulators and privacy advocates have all raised concerns about the implications of Big Tech having access to patient’s health records, as well as a potential cybersecurity crisis.^{5,12} This concern has only further intensified following the overturning of *Roe v. Wade*, which sparked questions about the use of personal data to surveil people seeking reproductive health services.¹²

Others have pointed to the underperformance of large corporations’ investments in health care. For instance, Haven, an effort by Amazon, JPMorgan Chase and Berkshire Hathaway that sought to reduce health care costs and improve patient outcomes, failed after just two years. Additionally, margins in health care are small. As large corporations are used to high margins and rapidly scaled

businesses, some experts question their preparedness for the health care industry where profit margins are typically small.²⁸

Further, common adverse effects of mergers and acquisitions on physicians include workflow disruptions, organizational changes that may increase workloads and staff burden, technological transitions such as shifts in EHR implementation and even lower wages. Athenahealth's 2021 Physician Sentiment Index report demonstrated that physicians undergoing a merger or acquisition expressed less willingness to remain at their organization and were more likely to experience burnout. While 68 percent of physician respondents undergoing a merger or acquisition reported that they would recommend their health care organization to friends or family, 85 percent of physicians not undergoing a merger or acquisition reported that they would recommend their organization to loved ones. The National Institute for Health Care (NIHCM) Foundation found that after a hospital merger, skilled workers experienced a four percent decrease in wages, and nurses and pharmacy workers saw a 6.8 percent decrease.²⁹

Finally, value-based payment models have persistent and ongoing methodologic and implementation challenges for payers, large integrated health care systems and independent private practices alike, including designing adequate risk models, measuring quality, providing access to timely and actionable data, and imposing significant administrative burdens. These fundamental design and implementation challenges must be addressed to ensure sustainable success for any of these investments.^{30,31}

CONCLUSION

With the continued growth of corporate entrants in care delivery pursuing new practice ownership strategies and delivery models, particularly among small-to-medium-sized physician practices, this report highlights opportunities for the AMA to work directly with corporate entities to advocate for and support independent physician practices in communities. Health care costs continue to increase, and the quality of and access to care continues to erode in many local communities. Thus, we support corporate entities to work with and assist independent physician practices with the capabilities to deliver highly coordinated care that is critical to improving patient outcomes and competition in many markets.

RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm the following policies:
 - a. D-405.988, "The Preservation of the Private Practice of Medicine"
 - b. H-385.904, "Prospective Payment Model Best Practices for Independent Private Practice"
 - c. H-185.939, "Value-Based Insurance Design"
 - d. D-140.951, "Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices"
 - e. H-160.891, "Corporate Investors"; (Reaffirm HOD Policy) and
2. That our AMA will: (1) inform corporate efforts about the value of private practices to successfully participate in new "value-based" models; (2) identify and work with a corporate entity that is advancing these models to explore a two year pilot among independent private practices in which the AMA will: (a) convene physician practices in a

- 1 community; (b) provide educational resources and technical assistance to practices to
- 2 support their participation with the corporate entity and (c) formally evaluate the pilot for
- 3 outcomes; and (3) advocate with commercial payers and health plans and federal and state
- 4 payers and policymakers to support private practice through policies and models that
- 5 provide adequate payment, infrastructure and data to succeed in “value-based” models.
- 6 (Directive to Take Action)
- 7 3. That Policy D-160.912 be rescinded as having been accomplished by this report. (Rescind
- 8 HOD Policy)

Fiscal Note: \$274,962

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 01-A-23

Subject: Council on Medical Service Sunset Review of 2013 House Policies

Presented by: Lynn Jeffers, MD, Chair

Referred to: Reference Committee G

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.

1 RECOMMENDATION

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3 The Council on Medical Service recommends that the House of Delegates policies that are
4 listed in the appendix to this report be acted upon in the manner indicated and the
5 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	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. 2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if	Rescind. Superseded by Policies H-165.920 , H-165.865 , D-290.979 , H-165.823 , and H-165.904 . Individual Health Insurance H-165.920 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; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary

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

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

POLICY #	Title	Text	Recommendation
			<p>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-risk employees with a larger contribution and lower-risk employees with a lesser one;</p> <p>(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;</p>

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

POLICY #	Title	Text	Recommendation
			<p>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, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-</p>

POLICY #	Title	Text	Recommendation
			<p>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> <p>a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.</p> <p>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</p>

POLICY #	Title	Text	Recommendation
			<p>coverage that meets standards for minimum value of benefits.</p> <p>c. Physician payments under the 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>

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

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

POLICY #	Title	Text	Recommendation
			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.
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 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.</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.
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	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		applicable state law, on authentication of all medical record entries, including telephone and verbal orders, in their medical staff bylaws.	
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 the hospital; and (2) incorporate this	Rescind. MACRA repealed the SGR.

POLICY #	Title	Text	Recommendation
		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., GPCIs); 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.

POLICY #	Title	Text	Recommendation
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.
D-510.999	Veterans Health Administration Health Care System	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>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> <p>1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.</p>

POLICY #	Title	Text	Recommendation
			<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>

POLICY #	Title	Text	Recommendation
			10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.
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.</p> <p>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.</p> <p>Characteristics: (a) The criteria and standards should be derived through an evaluation of (i) the peer-reviewed clinical and scientific literature and compendia; (ii) relevant guidelines obtained from professional groups through consensus-derived processes; (iii) the experience of practitioners with expertise in drug therapy; (iv) drug therapy information supplied by pharmaceutical manufacturers; and (v) data and experience obtained from DUR program operations. (b) Criteria and standards should identify underutilization as well as overutilization and inappropriate utilization. (c) Criteria and standards should be validated prior to use.</p> <p>Principle 3: Criteria and standards for DUR must be nonproprietary and must be developed and revised</p>	Retain. Still relevant.

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

POLICY #	Title	Text	Recommendation
		<p>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> <p>Principle 7: The DUR program operations must be structured to achieve the principles of DUR.</p> <p>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</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.</p> <p>Characteristics: (a) While a</p>

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

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			<p>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> <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</p>

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			<p>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	<p>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.</p>	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</p>	Retain. Still relevant.

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		<p>consistent with state laws.</p> <p>d) Worksite health clinics must clearly 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</p>	

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		<p>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 health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities.</p>	
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-	Rescind. Accomplished through CMMI TCPI .

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		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.	
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	Amend Policy H-110.990 to include specification of medical exception process. Cost Sharing Arrangements for Prescription Drugs H-110.990

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		under a medical exceptions process.	<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. <p><u>5. payers should not establish a higher cost-sharing requirement exclusively for prescription drugs approved for coverage under a medical exceptions process.</u></p>

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.

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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; 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.	Rescind. ACA established EHBs and HHS Administrative Simplification Eligibility and Benefits Transaction covers inquiries and responses about a patient's eligibility for insurance benefits.
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	Retain. Still relevant. Suggest revising every iteration of "copayments" to "copayments and coinsurance."

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		the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society.	
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 electronic reconciliation prior to physicians being required to transmit electronic claims; (3) supports the acceptance of the ANSI 837 standard as a uniform, but not exclusive, standard for those physicians who wish to bill	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 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

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		electronically; and (4) will continue to monitor the cost effectiveness of EDI participation with respect to rural physicians.	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 services; (2) continues to encourage physicians to develop electronic data interchange

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			(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.
H-20.906	Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases	<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</p>	Retain. Still relevant.

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		<p>accordingly. The policy selected should contain a reasonable definition of “sickness” or “disability,” an own-occupation clause, and guaranteed 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,</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>

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		<p>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>	

H-190.992	Electronic Claims Submission	<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</p>

POLICY #	Title	Text	Recommendation
			improve the efficiency of electronic claims approval.
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.
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	Retain. Still relevant.

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		and neutral peer review body.	
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.
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.

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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	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	Retain. Still relevant.

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		<p>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 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</p>	Retain. Still relevant.

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		<p>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>	
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 Criminal Backgrounds	1. Our AMA encourages the long-term care provider and correctional care communities, including the American 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	Retain. Still relevant.

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		<p>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</p>	Retain. Still relevant.

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		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 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</p>

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			<p>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 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</p>

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			<p>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> <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>

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			<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 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,</p>

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			<p>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 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</p>

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			<p>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>

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			<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</p>

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			<p>physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.</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

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			<p>upon termination of the agreement.</p> <p>6. Payment Agreements</p> <p>a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.</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</p>	Retain. Still relevant.

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

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

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		<p>and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative.</p> <p>(10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice.</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</p>

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			<p>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>
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,</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)</p>

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		<p>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 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</p>	<p>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> <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>

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		<p>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>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 Eligibility Guidelines	<p>The AMA will continue to press for the release of all Medicare carrier screens nationwide, including local screens, frequency parameters, and computer edits to identify claims for medical review.</p>	<p>Rescind. Superseded by Policies H-320.948 and H-340.898.</p> <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</p>

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			<p>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 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</p>

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			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</p>	Retain. Still relevant.

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		process to determine federal payments to Medicare Advantage plans.	
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 not in any way be diminished by the operations of the Medicare Carrier Advisory Committee.	Retain. Still relevant.
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	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		to identify the reason for this exchange of information.	
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 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.	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
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>

POLICY #	Title	Text	Recommendation
			<p>procedures for medical review, quality assurance, grievance procedures, credentialing criteria, 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</p>

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

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

POLICY #	Title	Text	Recommendation
			<p>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	<p>(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 of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care.</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
H-390.884	Medicare Policy Change	<p>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>	<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> <p>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.</p> <p>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.</p> <p>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.</p>
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	<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</p>

POLICY #	Title	Text	Recommendation
		<p>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 schedules between participating and nonparticipating physicians</p>	<p>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 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	<p>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>	<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</p>

POLICY #	Title	Text	Recommendation
			<p>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 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	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	Rescind. (1) Addressed by PPI ; (2) Addressed by CMS .

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

POLICY #	Title	Text	Recommendation
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</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>shall be limited to practice parameters that conform to 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</p>	

POLICY #	Title	Text	Recommendation
		<p>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	<p>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 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.</p>	Retain. Still relevant.
H-440.840	Patient Access to Anti-Tuberculosis Medications	<p>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</p>	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		this airborne infectious disease.	
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.	<p>Rescind. Superseded by Policies H-480.943 and H-385.919.</p> <p>Integration of Mobile Health Applications and Devices into Practice H-480.943</p> <p>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 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</p>

POLICY #	Title	Text	Recommendation
			<p>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</p> <p>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	Rescind. Superseded by Policies H-510.983 and H-510.985 .

POLICY #	Title	Text	Recommendation
		<p>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).</p>	<p>Expansion of US 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. 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. 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

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

POLICY #	Title	Text	Recommendation
			(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.
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.
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 	Retain. Still relevant.

POLICY #	Title	Text	Recommendation
		<p>the existing codes and work with CMS to achieve a smooth transition for such codes.</p> <p>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.</p> <p>5. Our AMA strongly supports RUC recommendations and any cuts by CMS beyond the RUC recommendations will be strongly opposed by our AMA.</p>	
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.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 05-A-23

Subject: Prescription Drug Dispensing Policies
(Resolution 237-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee G

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

1 medications. For PBMs and payers, these points of intersection may be areas where requiring a
2 larger quantity of medication to be dispensed is advantageous. For example, when a larger quantity
3 of medication is being negotiated, it gives the PBM better negotiating power and can lead to lower
4 negotiated prices or larger rebates. For both PBMs and payers, dispensing greater supplies of
5 medication can lower the dispensing costs associated with the medication. Additionally, it is not
6 uncommon for PBMs and/or health insurers to own and operate automatic dispensing facilities,
7 such as mail order pharmacies, and dispensing greater quantities of a medication can lower
8 operating costs in these settings as well.⁵ One place of major PBM reform that is promoted by the
9 National Community Pharmacist Association, is centered around the mandatory use of these PBM
10 owned mail order pharmacies that often depersonalize the process. This is especially relevant to the
11 quantity of a medication dispensed as the safeguards of both physicians and pharmacists interacting
12 with the patient are removed in the automated process used with PBM-owned mail order
13 pharmacies.⁶

14
15 Overall, the insertion of payers and PBMs in the process of determining the quantity of a
16 prescription medication dispensed is opposed both by the AMA and community pharmacists, the
17 two entities that interact most directly with the patient. While there can be benefits to the
18 dispensing of a larger supply of medication, especially in the cost savings for the PBM and/or
19 payer, the decision is one that needs to be made on a patient level and under the supervision and
20 control of the prescribing physician.

21 22 POTENTIAL PATIENT RISKS OF A 90-DAY SUPPLY

23
24 Among the key concerns when a patient receives a quantity of a prescription drug that is greater
25 than what was prescribed include the risk of intentional overdose. While there is not a guarantee
26 that a physician will be aware of a patient's suicide risk, there is an opportunity for assessment,
27 both formal and informal, during a medical appointment. Pharmacists' interactions with patients
28 would not typically include this type of screening process and, thus, they may not be aware of a
29 potential risk. Unfortunately, even if a risk was recognized, PBMs, who are further removed from
30 direct patient engagement, may force pharmacists to fill larger quantities without the ability to
31 apply insurance coverage at lower quantities. Currently, there are strict regulations on the quantity
32 of controlled substances that can be dispensed as these medications are often seen in suicide
33 attempts or completions.^{7,8} However, other prescription medications are not regulated at the same
34 level and may still be used in suicide attempts or completions.^{8,9}

35
36 A second concern regarding patients receiving quantities of prescription medication greater than
37 prescribed is the oversupply of medications. Oversupply is a concern with regard to the potential
38 for increased cost to the patient and patient stockpiling. When a prescription is dispensed at a
39 greater quantity than prescribed, a patient may not need the full 90 days. For example, if a
40 medication is new and the physician is working with the patient to establish the correct dosage
41 there may be a change in the dosage prior to completion of the full 90 days. The oversupply of a
42 prescription drug can lead to a patient stockpiling a medication, which, even when unintentional,
43 can be dangerous and should be avoided.¹⁰ In addition to the potential for a medication to be
44 stockpiled, it is possible that this oversupply could place an undue financial burden on the patient.
45 For instance, should a patient be prescribed a medication with a substantial co-pay that is only
46 covered in a 90-day supply, but that prescription is altered before completion of the 90 days, the
47 patient may be responsible for an additional, expensive co-pay. The cost of prescription
48 medications in the United States is a major barrier for many to access the care they require and
49 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.” (New HOD Policy)
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.... (Amend AMA Policy)
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. (Reaffirm AMA Policy)
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. (Reaffirm HOD Policy)
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. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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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.

REPORT 08 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Impact of Integration and Consolidation on Patients and Physicians
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2022 Interim meeting, the Council presented CMS Report 3, which was an informational report that provided background on the issue of health system consolidation. The next report in the Council's ongoing series on this topic is presented here and 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.

This report specifically addresses the impact of hospital-hospital horizontal consolidation and hospital-physician practice vertical integration on physicians, patients, and local markets. 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. While this is also a prevalent issue in health care, it is not the focus of this report.

Both horizontally and vertically integrated health care entities may engage in a range of anticompetitive behaviors, including raising prices, excluding rivals, raising their costs, bargaining with health plans to demand higher prices for affiliated providers, and including anticompetitive terms in their contracts.

This report examines the shared jurisdiction between the FTC and the DOJ in the merger and acquisition process. 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.

When examining a potential health care merger or acquisition, the FTC focuses on four areas: price effects, clinical quality effects, patient access, and provider wages. While evidence of impacts on health care prices and spending is stronger and more consistent, data on effects on patient access, changes in quality outcomes, and physician wages and workforce are insufficient to draw meaningful conclusions at this time.

The Council recommends that the American Medical Association (AMA) continue to monitor the impact of hospital-physician practice integration and hospital-hospital consolidation on health care prices and spending, patient access to care, potential changes in patient quality outcomes, and physician wages and labor, as well as the impact of non-compete clauses on physicians. The Council also recommends that the AMA broadly support efforts to collect relevant information on mergers and acquisitions in their state and/or region and work with state attorneys general (AG) to ensure proper review of these transactions before they occur. Finally, the Council recommends that the AMA support and encourage physicians to share their own experiences with mergers and acquisitions with the FTC through their online submission process.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 08-A-23

Subject: Impact of Integration and Consolidation on Patients and Physicians

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee G

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

1 US antitrust law which prescribes the rule of free competition among those engaged in commerce.
2 Importantly, the Sherman Act does not prohibit every restraint of trade, only those that are
3 unreasonable. Certain acts are considered so harmful to competition that they are almost always
4 illegal under the Sherman Act. These include plain arrangements among competing individuals or
5 businesses to fix prices, divide markets or rig bids. The Clayton Act of 1914 addresses specific
6 practices that are not directly addressed by the Sherman Act, including mergers. Specifically,
7 Section 7 of the Clayton Act prohibits mergers and acquisitions where the effect “may be
8 substantially to lessen competition or tend to create a monopoly.” The Clayton Act was amended in
9 1976 by the Hart-Scott-Rodino Act, which purposely exempts small transactions (valued at less
10 than \$111.4 million as of February 27, 2023) from pre-merger notification to not increase the
11 regulatory burden on small enterprises in addition to avoiding generating unnecessary transactions
12 for FTC staff to review. This threshold is adjusted annually and results in many health system,
13 hospital and/or physician mergers proceeding without FTC and/or DOJ review.

14
15 Another hurdle contributing to increases in consolidation in recent years is FTC constraints on its
16 ability to enforce antitrust laws in the not-for-profit health care sector. Vertical integration is
17 particularly challenging for the FTC to monitor because it is often the result of hospitals acquiring
18 many smaller practices and each of those transactions may fall under the \$111.4 million threshold
19 of having to notify the FTC. Additionally, the FTC has raised concerns about its inability to
20 enforce antitrust rules on most non-profit organizations, including most non-profit hospitals. The
21 FTC can only enforce Section 5 of the FTC Act against persons, partnerships, or corporations.
22 “Corporations” are defined as those entities organized to carry on business for-profit. Accordingly,
23 the FTC Act does not give the FTC the ability to enforce Section 5 against most non-profit entities,
24 which constitute the vast majority of hospitals.

25
26 The Council met with representatives from the FTC to discuss the process of reviewing mergers
27 and acquisitions. When examining a potential merger or acquisition, FTC staff focus on four areas:
28 price effects, clinical quality effects, patient access, and provider wages. When a proposed merger
29 filing comes in, FTC staff have 30 days to decide whether or not to issue a challenge. If a challenge
30 is issued, the deal is prohibited from closing until further investigations are completed. During
31 these investigations, the merging entities may negotiate further to receive the approval of the FTC,
32 or the case could go to court. Alternatively, the two merging entities may decide to abandon the
33 deal altogether.

34
35 The representatives from FTC stressed the importance of physicians as the best advocates for
36 patients, especially regarding mergers between health care facilities. FTC staff time is limited,
37 especially given the quick timeline in which the FTC must decide whether or not to challenge a
38 merger, so input from impacted communities is helpful in flagging potential concerns. Information
39 shared by physicians is used by the FTC when evaluating potential mergers and acquisitions and is
40 immensely helpful in providing a voice for physicians and patients who would be impacted most.
41 The FTC encourages physicians to share their experience via email to the following address which
42 is monitored regularly by staff: antitrust@ftc.gov. Physicians are encouraged to work with their
43 state medical associations and/or state attorneys general (AG) to report mergers or acquisitions that
44 fall below the FTC threshold for review. Alternatively, physicians (or any member of the public)
45 are welcome to report potential antitrust violations to the FTC here:
46 <https://www.ftc.gov/enforcement/report-antitrust-violation>.

47
48 In 2020, the FTC and DOJ published, and the FTC subsequently withdrew, revised Vertical Merger
49 Guidelines. After withdrawing the guidelines because they cited “unsound economic theories” the
50 FTC stated that it will continue working with the DOJ Antitrust Division to update merger
51 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. (New HOD Policy)
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. (New HOD Policy)
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. (New HOD Policy)
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. (New HOD Policy)

- 1 5. That our AMA encourage physicians to share their experiences with mergers and
2 acquisitions, such as those between hospitals and/or those between hospitals and physician
3 practices, with the FTC via their online submission form. (New HOD Policy)
4
5 6. That our AMA rescind policy D-215.984. (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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REPORT 09 OF THE COUNCIL ON MEDICAL SERVICES (A-23)
Federally Qualified Health Centers and Rural Health Care
(Reference Committee G)

EXECUTIVE SUMMARY

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 American Medical Association (AMA) policy and provides recommendations to ensure that these clinics are maintained and that physicians are able to practice without undue burden.

The Council understands that FQHCs and similar clinics serving areas of medical need are a key aspect of the AMA's existing advocacy to reduce health care disparities in rural communities through increasing access to health care services. The AMA has a robust body of policy and advocacy efforts supporting general efforts to improve health care in rural communities. To fully support the health care services provided in these clinic settings, the Council discusses the importance of maintaining funding streams, reducing physician administrative burden, and ensuring that all care provided is overseen by a physician. In order to maintain the feasibility of FQHCs and similar health centers, it is important that a continued investment be made by the federal government as FQHCs receive a majority of funding through grants from the federal government. These grants allow these health services to be delivered to communities that would otherwise face significant barriers to access. In addition to ongoing funding, it is important that the regulating bodies of these health centers ensure that the certification and operating regulations do not place undue burdens on the physicians practicing in these settings. Physicians nationwide are faced with significant administrative work and those practicing in settings like FQHCs may face even more daunting administrative tasks. Finally, to ensure that these underserved communities receive high quality health care, it is important that all care be overseen by physicians. Oversight regarding physician supervision must be maintained to guarantee that all communities served by FQHCs, and similar health centers receive high-quality health care.

The Council recommends adoption of two new policies, one advocating for clear certification requirements and other policies that reduce the administrative burden on physicians practicing in FQHCs, and a second supporting federal funding to maintain costs associated with operating these health centers. In addition to these two new policies, the Council recommends reaffirming existing AMA policy that supports the implementation of programs to improve rural communities' health, H-465.994, advocates for the authorization of Chronic Care Management reimbursement for physicians, D-390.923, and limits the scope of practice for nonphysician providers without supervision of a physician, H-160.947 and H-35.965.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 09-A-23

Subject: Federally Qualified Health Centers and Rural Health Care

Presented by: Lynn Jeffers, MD, MBA Chair

Referred to: Reference Committee G

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

1 to working in an FQHC, such as student loan repayment programs and visas for foreign-born
2 physicians.

3
4 Although these specific benefits and the ability to serve communities that are desperate for quality
5 health care can provide physicians with a sense of fulfillment, there are significant challenges that
6 these physicians face working in FQHCs¹². For example, working in an FQHC does not relieve the
7 physician burden of administrative paperwork. Serving a patient base that has higher rates of public
8 insurance means that physicians are spending more time dealing with the rules, protocols, and
9 paperwork associated with payment. The voluminous amount of paperwork that patients are
10 required to complete to register as an FQHC patient can frequently lead to disruptions in
11 scheduling and physicians spending significant amounts of time reviewing and signing the
12 paperwork. In addition to the increased administrative and regulatory burdens, since physicians at
13 FQHCs are operating in underserved areas it is often difficult to find reasonable timely referrals
14 and coordinate care for patients who may need advanced or specialty care. Some physicians who
15 work in FQHCs report feeling that they are practicing medicine without the support of a medical
16 team or other physicians. For physicians in these settings, providing care to their patients, who are
17 often facing complex medical conditions, can be a significant undertaking. Physicians practicing in
18 FQHCs are frequently part of a limited network of providers in the area they serve, leading to
19 increased stress and working hours in order to attempt to provide quality care on a reasonable
20 timeline to the patients they serve.^{9,10}

21
22 Finally, physicians working in FQHCs often have additional duties related to the supervision of
23 nonphysician providers, which adds another set of tasks to already full schedules. FQHC
24 physicians report spending considerable time on weekends and evenings reviewing cases that are
25 handled by the non-physician practitioners in order to remain in compliance with federal
26 regulations and provide quality care. Notably, physicians working in FQHCs report 11 percent
27 higher burnout than their colleagues working in other practice settings.¹³

28 29 RELEVANT AMA POLICY

30
31 The AMA has a number of existing policies related to rural health and FQHCs. Many of the current
32 AMA policies related to rural health are centered around rural hospitals. Policies H-465.979 and
33 H-465.990 focus on the economic viability of rural hospitals. Each encourages efforts and
34 legislation to support these hospitals' efforts to stay open and serve their communities. Policy
35 D-465.998, established with Council on Medical Service Report 9-J-21, and Policies H-240.971,
36 H-465.978, and H-240.970, all deal with the payment challenges that are faced by many rural
37 physicians and hospitals. The policies both recognize and offer potential solutions for remedying
38 the payment differentials between rural and urban medical care. Finally, Policies H-465.984,
39 H-465.996, and H-465.999 focus on the certification and regulations of rural health care centers
40 and hospitals.

41
42 The Council believes that, in conjunction with FQHCs and RHCs, rural hospitals are another vital
43 strategy to deliver care to rural communities. Notably, the Council's recent 2021 report,
44 "Addressing Payment and Delivery in Rural Hospitals" (Council on Medical Service Report
45 9-J-21) included policy recommendations that remain informative and relevant as to the current
46 state of rural hospitals in America. As previously noted, in order to avoid confusion, this current
47 report has remained focused on health care in non-hospital settings, like FQHCs and RHCs.

48
49 The AMA also has policies related to rural health care that are not centered solely around hospital
50 centered care. Policies H-465.994 and H-465.982 are concentrated around improving the health of
51 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 1. That our American Medical Association (AMA) support certification requirements and
2 other policies that reduce the administrative burden for physicians practicing in Federally
3 Qualified Health Center (FQHCs). (New HOD Policy)
4
- 5 2. That our AMA support sufficient federal funding to maintain the operation and costs
6 associated with establishing and operating a FQHC, FQHC “Look-Alike”, or Outpatient
7 Tribal Facility. (New HOD Policy)
8
- 9 3. That our AMA reaffirm Policy H-465.994, which supports efforts to develop and
10 implement proposals and programs to improve the health of rural communities. (Reaffirm
11 HOD Policy)
12
- 13 4. That our AMA reaffirm Policy D-390.923, which advocates for the authorization of
14 Chronic Care Management reimbursement for all physicians, including those practicing in
15 FQHCs or Rural Health Clinics. (Reaffirm HOD Policy)
16
- 17 5. That our AMA reaffirm Policies H-160.947 and H-35.965, which both advocate for the
18 support of state and local medical societies in identifying and working to prevent laws that
19 may allow for non-physicians (e.g., nurse practitioners, physician assistants) to operate
20 without the supervision of a physician. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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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"> • <u>FQHC (Health Center Program Grantees)</u>: Organizations receiving grants under section 330 of the PHS Act. • <u>“Look-Alikes”</u>: Organizations that meet the eligibility requirements of an FQHC, but do not receive funding under section 330 of the PHS Act. • <u>Outpatient Tribal Facilities</u>: Organizations operated by a tribe, tribal organization, or urban Indian Organization. • <u>Examples</u>: 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"> • <u>Independent RHC</u>: Clinics that meet the designation for an RHC and are standalone. • <u>Hospital-Based RHC</u>: Clinics that meet the designation for an RHC and are housed at a hospital. • <u>Provider-Based RHC</u>: 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, OB/GYN 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 away due to a lack of ability to pay. Must encourage patients to participate in insurance programs and plans for which they are eligible.	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 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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-23)

Introduced by: Medical Student Section

Subject: Reconsideration of the Birthday Rule

Referred to: Reference Committee G

1 Whereas, Self-insured coverage is either a self-administered process or a third party
2 administrator where the employer collects premiums from enrollees and assumes
3 responsibility of paying employees' and dependents' medical claims¹; and
4

5 Whereas, The Health Insurance Portability And Accountability Act of 1996 (HIPAA),
6 established protections for "self-insured" and "insured" coverage, whereby newborns,
7 adopted children, and new parents not enrolled under a health plan could enroll under a
8 period of "special enrollment" upon the birth, adoption, or placement for adoption of a new
9 child²; and
10

11 Whereas, Under HIPAA, as long as enrollment occurs within 30 days of birth, health
12 insurance coverage is effective as of the date of birth and cannot be subject to pre-existing
13 condition exclusion²; and
14

15 Whereas, If a health plan's benefits are provided through an insurance company or Health
16 Maintenance Organization (HMO), state laws may amend HIPAA requirements to allow for
17 additional considerations; such as extending the enrollment period²; and
18

19 Whereas, The National Association of Insurance Commissioners (NAIC) is the U.S. standard-
20 setting organization governed by the chief insurance regulators from all 50 states, the District
21 of Columbia, and five U.S. territories to coordinate regulation of multistate insurers³; and
22

23 Whereas, Coordination of Benefits (COB) as defined by the NAIC is the provision to eliminate
24 over-insurance and establish a prompt and orderly claims payment system when a person is
25 covered by more than one group insurance and/or group service plan¹; and
26

27 Whereas, State law permits insurers to follow a COB to determine insurers' responsibilities
28 under an insurance claim in the event the "insured" is covered by more than one health plan,
29 in the identification of a "primary" and "secondary" benefit payer⁴; and
30

31 Whereas, Newborns of parents with separate insurance policies are subjected to a COB at
32 birth^{2,4}; and
33

34 Whereas, The birthday rule is a COB model regulation set by the NAIC in which a newborn
35 takes as primary coverage the plan of the parent whose birthday comes first in the calendar
36 year^{2,4}; and
37

38 Whereas, The recently publicized case of the Kjelshus family resulted in a \$200,000 bill for a
39 NICU stay because the parents were unaware of their coordination of benefits, specifically
40 the birthday rule, that resulted in the father's inferior policy determining their child's insurance

1 coverage solely due to the fact of having a birthday only 2 weeks earlier than his spouse in
2 the calendar year⁵; and
3

4 Whereas, The birthday rule has led to confusion and frustration of parents when a child is
5 automatically enrolled under the parent with the earlier birthday in the calendar year without
6 considering the quality of insurance coverage between both parents, showing that simple
7 awareness is not enough to address the problem⁵; and
8

9 Whereas, H.R.4636I, known as the Empowering Parents' Healthcare Choices Act of 2021,
10 currently in the House Subcommittee on Health, would give parents with dual policies 60
11 days before the birthday rule would take effect from the date of an infant's birth to choose
12 which plan is primary and to notify the insurer of their choice effectively reclaiming parental
13 choice⁶; therefore be it
14

15 RESOLVED, That our American Medical Association support evidence-based legislation that
16 support a parent, or guardian's, choice of their dependent's health insurance plan under the
17 event of multiple insurers (New HOD Policy); and be it further
18

19 RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in
20 Coordination of Benefits" by addition to read as follows:
21

22 **Delay in Payments Due to Disputes in Coordination of**
23 **Benefits, H-190.969**

24 Our AMA:

25 (1) urges state and federal agencies to exercise their authority
26 over health plans to ensure that beneficiaries' claims are promptly
27 paid and that state and federal legislation that guarantees the
28 timely resolution of disputes in coordination of benefits between
29 health plans is actively enforced;

30 (2) includes the "birthday rule" as a last resort only after
31 parents/guardians have been allowed a choice of insurer and
32 have failed to choose, and the "employer first rule" in any and all
33 future AMA model legislation and model medical service
34 agreements that contain coordination of benefits information
35 and/or guidance on timely payment of health insurance claims;
36 (3) urges state medical associations to advocate for the inclusion
37 of the "employer first rule", and "birthday rule" as a last resort only
38 after parents/guardians have been allowed a choice of insurer and
39 have failed to choose, in state insurance statutes as mechanisms
40 for alleviating disputes in coordination of benefits;

41 (4) includes questions on payment timeliness in its Socioeconomic
42 Monitoring System survey to collect information on the extent of
43 the problem at the national level and to track the success of state
44 legislation on payment delays;

45 (5) continues to encourage state medical associations to utilize
46 the prompt payment provisions contained in the AMA Model
47 Managed Care Medical Services Agreement and in AMA model
48 state legislation;

49 (6) through its Advocacy Resource Center, continue to coordinate
50 and implement the timely payment campaign, including the

1 promotion of the payment delay survey instrument, to assess and
 2 communicate the scope of payment delays as well as ensure
 3 prompt payment of health insurance claims and interest accrual
 4 on late payments by all health plans, including those regulated by
 5 ERISA; and
 6 (7) urges private sector health care accreditation organizations to
 7 (a) develop and utilize standards that incorporate summary
 8 statistics on claims processing performance, including claim
 9 payment timeliness, and (b) require accredited health plans to
 10 provide this information to patients, physicians, and other
 11 purchasers of health care services. (Modify Current HOD Policy)
 12

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

Received: 3/27/23

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RELEVANT AMA POLICY

Delay in Payments Due to Disputes in Coordination of Benefits H-190.969

Our AMA:

- (1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;
- (2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;
- (3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;
- (4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;
- (5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;
- (6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and
- (7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness,

and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.

Citation: (CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)

Health Insurance for Children H-185.948

Our AMA supports requiring all children to have adequate health insurance as a strategic priority.

Citation: Res. 610, I-08; Reaffirmed: CMS Rep. 01, A-18;

Multiple Coverage in Voluntary Health Insurance H-185.999

(1) Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar. (2) A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses. (3) Therefore, the AMA encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance.

Citation: CMS Rep. F, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98;

Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18;

Adequacy of Health Insurance Coverage Options H-165.846

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:

A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.

B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.

C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.

Citation: CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09;

Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep.

2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15;

Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19;

Increasing Coverage for Children H-165.877

Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support

federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

Citation: Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18;

Mitigating the Negative Effects of High-Deductible Health Plans H-185.918

Our AMA: (1) encourages ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients; (2) encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year; and (3) encourages state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.

Citation: CMS Rep. 2, I-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-23)

Introduced by: Medical Student Section

Subject: Providing Reduced Parking for Patients

Referred to: Reference Committee G

1 Whereas, In the United States, an estimated four million individuals fail to receive annual
2 medical care due to transportation barriers¹; and

3
4 Whereas, Many patients with common illnesses attend multiple outpatient appointments a
5 year, such as one study which showed 47% of patients with hypertension had four or more
6 visits in 2014²; and

7
8 Whereas, Parking prices at some of the country's largest medical centers can be as high as
9 \$20 to \$43 per day³⁻⁴; and

10
11 Whereas, The public transportation system in the United States varies greatly within the
12 country in terms of usage, location, and infrastructure, with most of the public transport
13 concentrated in the Northeast⁵; and

14
15 Whereas, Approximately only a third of patients are within walking distance to their nearest
16 public transportation in certain metropolitan medical centers⁶; and

17
18 Whereas, Public transport is not readily available in all locations, such as rural areas where
19 the scarcity of local physicians can still require patients to drive to urban areas for care⁷; and

20
21 Whereas, Programs such as non-emergency patient/medical transportation (NEMT) are often
22 limited to approved patients within Medicaid and can have many disadvantages, including
23 restrictions on the type and number of rides, the necessity of a social worker to coordinate
24 transportation, having to schedule days in advance, and carpooling with other patients
25 leading to longer travel and wait times⁸; and

26
27 Whereas, The average cost of an NEMT in 2014 was \$28, and this price rises in rural and
28 suburban areas that are farther from medical centers^{8,9}; and

29
30 Whereas, When surveying older Americans, the group that utilizes the most inpatient and
31 outpatient healthcare, rideshare services were not seen as a practical option, with 74% of
32 patients reporting no knowledge of these services and only 1.7% making use of them¹⁰; and

33
34 Whereas, In a study of patients with heart disease, individuals reported the high cost of
35 parking at healthcare facilities as a financial barrier to attending multiple specialist
36 appointments¹¹; and

37
38 Whereas, In a study of factors influencing family burden in pediatric hematology/oncology,
39 parking was cited as one of the most disproportionately distressing factors¹²; and

Whereas, Nonmedical costs, such as transportation, meals, and child care, have been reported to range from \$50 to \$165 a day, further contributing to a family's financial stress¹³; and

Whereas, The lower the financial burden a patient has, the less likely they are to miss appointments and adhere to treatment, preventing high cost emergent situations that would lead to hospitals losing money on patients who cannot pay¹⁴; and

Whereas, Reduced parking fees have been cited as an incentive for patients to travel to hospitals that can offer better treatment than local counterparts¹⁵; and

Whereas, A minority of hospitals rely on nonpatient care income to offset revenue losses, such that providing parking vouchers would only represent a minor loss in revenue while providing a major benefit to patients¹⁶; and

Whereas, Many hospitals have already implemented programs for patient parking such as reduced monthly rates and free validated parking¹⁷⁻¹⁹; and

Whereas, Several associations of healthcare facilities focus on developing solutions for and advocating improvements in social and economic aspects of healthcare, including the American Hospital Association, the Federation of American Hospitals, and the Children's Hospital Association²⁰⁻²⁷; and

Whereas, The American Hospital Association is a national organization of "5,000 hospitals, health care systems, networks, [and] other providers of care" and publishes standards and guidelines on various social and economic aspects of care^{20,21}; and

Whereas, The Federation of American Hospitals is a national organization of over 1,000 hospitals that are not tax-exempt, including for-profit hospitals, and advocates their priorities²²⁻²⁴; and

Whereas, The Children's Hospital Association is a national organization of over 220 pediatric hospitals and develops and shares solutions with its members on various social and economic aspects of care^{26,27}; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to recognize parking fees as a barrier to patient care and encourage mechanisms for reducing parking costs for patients and trainees. (New HOD Policy)

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

Received: 3/37/23

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

Our AMA: (1) supports the education of physicians, first responders, and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Citation: Sub. Res. 812, I-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed in lieu of Res. 101, A-12; Modified: CMS Rep. 02, I-18;

Controlling Cost of Medical Care H-155.966

The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to

emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.

Citation: Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmed: CMS Rep. 1, A-22;

Voluntary Health Care Cost Containment H-155.998

(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care.

Citation: Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22;

Health Promotion and Disease Prevention H-425.993

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and preferably clean-energy public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

Citation: Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 923, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-23)

Introduced by: Medical Student Section

Subject: Tribal Health Program Electronic Health Record Modernization

Referred to: Reference Committee G

1 Whereas, The Indian Health Service (IHS), an agency within the United States Department of
2 Health and Human Services, provides federal health care services to American Indians and
3 Alaska Natives¹; and
4

5 Whereas, As of 2019, all 122 IHS facilities and more than 300 Tribes and Urban Indian
6 (I/T/U) health facilities use the Resource and Patient Management System (RPMS), which
7 handles everything from patient registration to insurance billing, including the electronic
8 health record (EHR)^{2,3}; and
9

10 Whereas, Although the IHS regularly updates RPMS, it is built on outdated technology from
11 1985 that will become obsolete within the next decade, making new development more
12 difficult each year⁴; and
13

14 Whereas, RPMS exists in a decentralized database system at IHS facilities across the
15 country, making it difficult for patients to share their health information with new providers
16 when they seek care at an outside facility⁴; and
17

18 Whereas, RPMS uses software code and features from the U.S. Department of Veterans
19 Affairs (VA) "VistA" EHR system⁴; and
20

21 Whereas, In 2017, the VA made the decision to fully transition away from VistA to a
22 commercial EHR by 2028 due to limited interoperability with other EHR products, known
23 cybersecurity vulnerabilities, and costly maintenance⁴; and
24

25 Whereas, The IHS will stop receiving VA VistA updates making it more challenging and
26 costly to update RPMS⁴; and
27

28 Whereas, In 2019, the U.S. Government Accountability Office listed RPMS as a critical
29 federal legacy system in need of modernization, because its underlying code will be
30 unsupportable in the next 5 to 10 years⁵; and
31

32 Whereas, In 2019, the IHS did not have a Congressional appropriation or proposed budget
33 for health information technology (HIT) and electronic health record modernization⁵; and
34

35 Whereas, The VA serves 9 million patients per year and the IHS serves 2.2 million patients
36 per year^{6,7}; and
37

38 Whereas, In fiscal year (FY) 2020, the VA received \$1.5 billion to modernize their EHR, while
39 the IHS only received an appropriation of \$8 million to modernize their EHR⁸⁻⁹; and

Whereas, In FY21, the VA and IHS received an appropriation of \$2.6 billion and \$34.5 million to continue EHR modernization efforts, respectively, demonstrating a significant gap in federal health care expenditures per capita¹⁰⁻¹¹; and

Whereas, In 2021, after a period of Tribal consultations, the IHS announced the IHS Health Information Technology Modernization Program, through which they would fully replace RPMS at IHS facilities with commercially available solutions, with no estimated completion date due to funding challenges¹²; and

Whereas, Many Tribes and Urban Indian health facilities compact and contract with the IHS to assume full funding and control over all programs, services, and functions, and activities provided by the IHS¹³; and

Whereas, Non-IHS Tribal health facilities (79.4% of all I/T/U facilities) do not all use RPMS, minimizing their involvement in and potential benefit from any programs managed by and funds provided to the IHS for EHR modernization¹⁴; and

Whereas, A 2019 study of 21 Tribes in the Pacific Northwest found that over half used non-RPMS EHR and medical claims systems, and EHR modernization costs up to \$500,000 per Tribe with monthly maintenance costs up to \$3,000 per Tribe³; and

Whereas, The IHS National Tribal Budget Formulation Workgroup, representing all 12 IHS Service Areas, made FY23 funding recommendations for EHR modernization efforts ranging from \$282 million to \$1.76 billion¹⁶; therefore be it

RESOLVED, That our American Medical Association support adequate funding for electronic health record modernization and maintenance costs for Tribal and Urban Indian Health Programs with active self-governance compacts and contracts with the Indian Health Service. (New HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

Citation:(CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate

construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3)Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4)Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).

2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.

3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.

4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

Citation: BOT Rep. 1, I-15; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18;

Health Information Technology Principles H-478.981

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

1. Enhance physicians ability to provide high quality patient care;

2. Support team-based care;

3. Promote care coordination;

4. Offer product modularity and configurability;

5. Reduce cognitive workload;

6. Promote data liquidity;

7. Facilitate digital and mobile patient engagement; and

8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;

2. Advocate to federal and state policymakers to develop effective HIT policy;

3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;

4. Partner with researchers to advance our understanding of HIT usability;

5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and

6. Promote the elimination of Information Blocking.

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

Citation: BOT Rep. 19, A-18; Reaffirmation: A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-23)

Introduced by: Medical Student Section

Subject: Interrupted Patient Sleep

Referred to: Reference Committee G

1 Whereas, Sleep is critical for brain function and systemic physiology¹; and

2
3 Whereas, The most at-risk patients for poor sleep are categorized as acutely ill and
4 hospitalized²; and

5
6 Whereas, The American Academy of Sleep Medicine notes that hospital and long-term care
7 environments can negatively impact patients' sleep due to nursing care activities such as
8 frequent nocturnal vital signs and tests, and recommends greater focus on sleep health in
9 these populations^{3-6,16}; and

10
11 Whereas, Hospitalized patients experience disrupted and poor quality sleep with frequent
12 arousals, poor nocturnal sleep efficiency, an increase in stage 2 sleep, a reduction or
13 absence of deep or slow wave sleep, and a reduction or absence of rapid eye movement
14 (REM) sleep⁷; and

15
16 Whereas, Hospital noise is a common complaint amongst patients which results in impaired
17 sleep and is associated with adverse outcomes¹⁶; and

18
19 Whereas, Positive correlations were shown between the number of interruptions at night and
20 mean number of as-needed pain medications given, systolic blood pressure, and heart rate
21 at various times⁸; and

22
23 Whereas, Sleep disruption can lead to the development of delirium, hypertension,
24 dyslipidemia, cardiovascular disease, metabolic syndrome, type 2 diabetes mellitus,
25 colorectal cancer, lower physical functioning after release from the hospital, higher overall
26 mortality 1-year post discharge, delayed healing, and fatigue, which may hinder patients'
27 participation in recovery activities^{1,2,9,10}; and

28
29 Whereas, Among medical inpatients, shorter sleep duration and worse sleep efficiency were
30 associated with greater odds of hyperglycemia, which increases the risk of myocardial
31 infarction, stroke, likelihood of admission to the intensive care unit, longer lengths of stay,
32 decreased likelihood to be discharged home compared to patients with known diabetes and
33 those without hyperglycemia¹¹; and

34
35 Whereas, Interventions decreasing circadian disruptions resulted in shorter length of stay,
36 lower readmission rates, and improved self-reported emotional and mental health for
37 patients¹²; and

38
39 Whereas, Sleep intervention bundles which included reduced alarm volume, closing bedroom
40 doors at night, earplugs, eye masks, and light dimming in ICU units are associated with better

1 sleep, a reduced incidence, duration and risk of developing delirium, and, in 2021, a project
 2 aimed at reducing delirium through sleep promotion in 2 inpatient units found that delirium
 3 decreased by 33% and 45%, respectively, on the units over 1 year¹³⁻¹⁵; and

4
 5 Whereas, Sleep improvement projects increased the percentage of patients who self-
 6 reported five or more hours of uninterrupted sleep, improved patients' care and sleep
 7 experience, and included fewer room entries, fewer minutes of in-room activity, decreased
 8 sound during rest time, and empowered patients to ask their providers to minimize nighttime
 9 disruptions^{16,17,19,20}; and

10
 11 Whereas, Interventions to minimize sleep disturbances lead to fewer symptoms and
 12 significantly lower sleep disturbance scores in antepartum patients, decreased as-needed
 13 sedative use by 49%, and led to an increase in sleep-friendly orders, sleep promoting venous
 14 thromboembolism prophylaxis, and a decrease in night time disruptions^{18,21,22}; and

15
 16 Whereas, Decreasing nighttime vital sign measurement has been shown to increase patient
 17 satisfaction²³; and

18
 19 Whereas, A trial that utilized a risk stratification tool to classify patients into high or low risk
 20 categories to eliminate overnight vital sign monitoring for low risk patients reported no
 21 significant adverse events for low-risk patients²⁴; and

22
 23 Whereas, Our American Medical Association identifies adolescent insufficient sleep and
 24 sleepiness as a public health issue (H-60.930) and supports diagnosis and management of
 25 sleep and sleep disorders (H-295.894); and

26
 27 Whereas, Our AMA does not have policy that evaluates or supports current inpatient sleep
 28 guidelines to improve patient sleep; therefore be it

29
 30 RESOLVED, That our American Medical Association encourage physicians, trainees,
 31 inpatient care teams, and hospital administration to reduce the number of patient sleep
 32 interruptions as much as possible, including considering the impact of circadian and
 33 environmental factors on sleep, to only those interruptions which are necessary and cannot
 34 be performed at another time (New HOD Policy); and be it further

35
 36 RESOLVED, That our AMA support efforts to improve quality, duration, and timing of
 37 inpatient sleep. (New HOD Policy)

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

Received: 4/3/23

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RELEVANT AMA POLICY

Insufficient Sleep in Adolescents H-60.930

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Citation: Res. 503, A-10; Appended: CSAPH Rep. 06, A-16;

Medical Education on Sleep and Sleep Disorders H-295.894

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education.

Citation: Res. 310, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 01, A-18;

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932

Our AMA:

1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

Citation: CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-22;

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").
2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
 - a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.
 - b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.
 - c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules.
 - d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
 - a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.
 - b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
 - c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
 - d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.

7. Our AMA supports the following statements related to clinical and educational work hours:

- a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
- b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
- c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
- d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
- e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
- f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.
- g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
- h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.
- i) Scheduled time providing patient care services of limited or no educational value should be minimized.
- j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.
- k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.
- l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
- m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.
- o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-23)

Introduced by: Senior Physicians Section

Subject: Aging and Dementia Friendly Health Systems

Referred to: Reference Committee G

1 Whereas, The *AMA Principles of Medical Ethics* encourages participation in activities to improve
2 community and public health as well as access to medical care for all people”¹; and
3

4 Whereas, Dementia and related diagnoses affect inexorably growing numbers of American
5 seniors; and
6

7 Whereas, Immediately addressing long-term care services and support systems for seniors
8 would allow for adjustments to best accommodate future demographic shifts; and
9

10 Whereas, Documentation on relative costs of home care versus facility-based nursing care for
11 patients with dementia indicates that home care is more cost effective²; and
12

13 Whereas, AMA policies address health care in the home as well as cost-effectiveness/cost-
14 benefit of assisted in-home versus nursing home care for Alzheimer’s disease and related
15 disorders; and
16

17 Whereas, The John A. Hartford Foundation and the Institute for Healthcare Improvement have
18 released comprehensive evidence-based guidance for healthcare professionals entitled: *Age-
19 Friendly Health Systems: A Guide to Using the 4Ms While Caring for Older Adults*, which
20 highlights, “What Matters,” “Medications,” “Mentation,” and “Mobility,”³; and
21

22 Whereas, Cost-effective, equitable, and quality health care for all may be achieved by
23 comprehensive education, community grants for long-term home-care services, and appropriate
24 support systems for seniors; and
25

26 Whereas, Development of dementia friendly communities may permit patients and families living
27 with dementia to improve health outcomes; therefore be it
28

29 RESOLVED, That our American Medical Association lobby Congress, state legislatures and
30 appropriate organizations to expand community and home-based services to promote and
31 support “aging in place” (Directive to Take Action); and be it further
32

33 RESOLVED, That our AMA develop educational resources for all health care professionals
34 about ways that successful outcomes have been achieved to appropriately support patients as
35 they age including those with dementia both in their homes as well as in health care systems.
36 (Directive to Take Action)

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

Received: 4/26/23

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RELEVANT AMA POLICY**Physicians and Family Caregivers: Shared Responsibility H-210.980**

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;

(2) continues to support health policies that facilitate and encourage health care in the home;

(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;

(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.

Citation: Res. 308, I-98; Reaffirmation A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17;

Alzheimer's Disease H-25.991

Our AMA:

(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;

(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;

(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;

(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;

(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;

(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and

(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.

Citation: CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-23)

Introduced by: Medical Student Section

Subject: Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis

Referred to: Reference Committee G

1 Whereas, A 2018 study from the Centers for Disease Control and Prevention (CDC)
2 estimated the prevalence of autism spectrum disorder (ASD) among adults aged 8 years to
3 be 1 in 44¹; and

4
5 Whereas, Applied Behavioral Analysis (ABA) is currently the most widely available and
6 commonly used state-funded form of autism therapy in Canada and the United States^{2,3}; and

7
8 Whereas, Autism treatment represents a fragmented industry that consists of a mixture of for-
9 profit and nonprofit organizations, with the top nine for-profit chains estimated to have a
10 combined revenue of \$547 million and a market value close to \$2 billion with future growth
11 expected⁴; and

12
13 Whereas, An ABA software company reports over 3 billion in claims processed annually for
14 about 1,300 practices highlighting the prevalence of ABA use as an intervention for
15 individuals with autism⁵; and

16
17 Whereas, Autism Speaks lists 3,194 centers across the United States who offer ABA therapy
18 as of 2022⁶; and

19
20 Whereas, ABA was conceived in 1961 by Dr. Ole Ivar Lovaas to condition neurotypical
21 behaviors in children he viewed as “incomplete humans”^{7–10}; and

22
23 Whereas, Desired behavior is often defined by the adult or behaviorist without input or
24 requirement of consent from the child and may include non-harmful stimming or coping
25 behaviors^{2,3,8,11,12}; and

26
27 Whereas, ABA uses behavior modification techniques to eliminate behaviors deemed
28 undesirable^{2,8,11–14}; and

29
30 Whereas, ABA practices are historically based in abuse such as holding autistic children's
31 communication hostage through the use of their devices as leverage, and denying basic
32 rights such as food and toileting privileges^{2,3,8,11,14–18}; and

33
34 Whereas, Modern ABA still abides by the founding principle of making a child appear
35 “normal” or “indistinguishable from one’s peers”, which serves to separate the humanity of
36 the individual with autism from desired behaviors^{2,8,15}; and

37
38 Whereas, A 2018 study found that Adults with autism who have received ABA are more
39 prone to suicide¹⁹; and

Whereas, ABA has been repeatedly linked to Post Traumatic Stress Disorder (PTSD), with 46% of 460 ABA participants meeting the diagnostic threshold for PTSD in an online survey²⁰; and

Whereas, Adults with autism have been continuously outspoken about the trauma incurred by ABA practices experienced in their childhood^{2,14,16-18}; and

Whereas, A 2012 literature review found the evidence base for services for adults with an ASD to be underdeveloped²¹; and

Whereas, A 2018 Cochrane review recommend further research after reporting very weak evidence in support of ABA²²; and

Whereas, A 2022 informal online community survey found that 71% of adults with autism responded “disagree” or “strongly disagree” to the statement “Generally speaking, I support ABA therapy for autistic children”²³; and

Whereas, A 2020 Department of Defense report demonstrated a lack of correlation between improvement in symptoms and hours of direct ABA services, found that the improvements recorded were due to reasons other than ABA services, and ABA services did not meet the TRICARE hierarchy of evidence standard for medical and proven care²⁴; and

Whereas, A 2021 study on conflicts of interest (COIs) in autism early intervention research found COIs to be prevalent and under-reported, with 70% of studies containing a conflict of interest and less than 6% declaring them as such²⁵; and

Whereas, Current research supports alternatives to ABA such as the Developmental, Individual Differences, and Relationship-based (DIRTM) program, the PLAY Project, individualized Early Social Interaction (ESI) and, Social Communication, Emotional Regulation, and Transactional Support (SCERTSTM)^{24,26-29}; and

Whereas, Current AMA policy supports the use of ABA through its advocacy of coverage of ABA and the evidence-based treatment for autism and fails to recognize its harms or controversial nature within the community at large; therefore be it

RESOLVED, That our American Medical Association support research towards the evaluation and the development of interventions and programs for autistic individuals (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" by addition and deletion as follows:

**Standardizing Coverage of Applied Behavioural Analysts
Therapy for Persons with Autism Spectrum Disorder, H-
185.921**

Our AMA supports coverage and reimbursement for evidence-
based ~~treatment of services for Autism Spectrum Disorder~~
~~including, but not limited to, Applied Behavior Analysis Therapy.~~
(Modify Current HOD Policy)

Fiscal Note: Not yet determined.

Received: 4/3/23

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RELEVANT AMA POLICY

Early Intervention for Individuals with Developmental Delay H-90.969

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17;

Community-Based Treatment Centers H-160.963

Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.

Citation: BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-23)

Introduced by: American Academy of Physical Medicine & Rehabilitation
American Association of Neuromuscular & Electrodiagnostic Medicine

Subject: Expediting Repairs for Power and Manual Wheelchairs

Referred to: Reference Committee G

1 Whereas, Patients with neuromusculoskeletal weakness or other disabilities, such as
2 amputations, paralysis, cerebral palsy, stroke, traumatic brain injury, multiple sclerosis,
3 muscular dystrophy, arthritis, and spinal cord injury, who are unable to walk must use wheeled
4 mobility devices in their homes and in their communities; and
5

6 Whereas, Power and manual wheelchairs are medically necessary specialized equipment used
7 by individuals with mobility disabilities and designed to help individuals perform activities of daily
8 living (ADLs) to the fullest extent possible; and
9

10 Whereas, The process of qualifying for power and manual wheelchairs is well established and
11 requires physician certification of medical necessity, and for more complex wheelchairs,
12 requires a comprehensive evaluation of long-term need for the device; and
13

14 Whereas, The Medicare program and many other payors will not replace a power or manual
15 wheelchair unless it is more than five years old; and
16

17 Whereas, Medicare and most other payors currently do not cover preventative maintenance of
18 power and manual wheelchairs; and
19

20 Whereas, There are more than five million wheelchair users in the United States and of those
21 users, many will require some type of wheelchair repair during the five-year useful life of the
22 mobility device^{1,2}; and
23

24 Whereas, Prompt action is needed when the patient's power or manual wheelchair is in need of
25 repairs in order to operate safely, return to work or school, enable the patient to get out of bed,
26 move about the home, perform activities of daily living, or participate in community activities;
27 and
28

29 Whereas, Prolonged bedrest or inactivity due to lack of a safely operating power or manual
30 wheelchair can result in multiple medical complications for the patient including, but not limited
31 to, pressure sores, pneumonia, increased weakness, depression; and
32

33 Whereas, The wheelchair repair process is currently flawed and causes delays in repairs due to
34 multiple factors including payors' requirements for unnecessary documentation, such as prior
35 authorization and new prescriptions, inadequate reimbursement policies to compensate
36 suppliers for the costs of repairs, such as uncompensated labor and costs of travel to the
37 patient's home to repair the wheelchair and the replacement or repair parts, and delays in
38 availability of replacement or repair parts due to supply chain issues; and

Whereas, Most payors, except Medicare and the Veterans Administration, do not pay for a substitute rental wheelchair while the patient's own wheelchair is being repaired; therefore be it

RESOLVED, That our American Medical Association encourage all payors to improve the process of and reduce barriers to patients obtaining wheelchair repairs for patient-owned power and manual wheelchairs, to ensure that repairs and services are safe, affordable, and timely, and support mobility and independence for those who utilize power and manual wheelchairs (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all payors to eliminate unnecessary paperwork including requiring prior authorization for basic repairs and proof of continuous need for patient-owned power and manual wheelchairs (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all payors to add coverage and payment for

- (1) temporary rental of a substitute wheelchair when repairs require the primary wheelchair to be taken out of the home;
- (2) preventive maintenance; and
- (3) travel to and from the patient's home when the patient cannot transport the wheelchair to a repair facility (New HOD Policy); and be it further

RESOLVED, That our AMA encourage all suppliers of power and manual wheelchairs to service wheelchairs they supply to patients and to permit consumers to perform simple self-repairs and have access to necessary parts. (New HOD Policy)

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

Received: 5/2/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-23)

Introduced by: American College of Gastroenterology
American Gastroenterological Association
American Society for Gastrointestinal Endoscopy

Subject: UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal
Endoscopy Procedures

Referred to: Reference Committee G

1 Whereas, As of June 1, 2023, UnitedHealthcare (UHC) requires prior authorization for all
2 diagnostic and surveillance colonoscopies, esophagogastroduodenoscopies (EGDs), and
3 capsule endoscopies; and
4

5 Whereas, This policy is contradictory to UHC's announced plans to eliminate 20% of its current
6 prior authorizations starting the summer of 2023 and introduce a "Gold Card" program in 2024;
7 and
8

9 Whereas, The American Medical Association 2021 Prior Authorization Physician Survey
10 revealed that¹;

- 11 • 93% of physicians report care delays as a result of your authorization.
- 12 • 82% of physicians report prior authorization can lead to treatment abandonment.
- 13 • 34% of physicians reported prior authorization has led to a serious adverse event.
- 14 • 51% of physicians report prior authorization has interfered with a patient's ability to
15 perform their job responsibilities; and
16

17 Whereas, The AMA 2021 Prior Authorization Physician Survey also reveals that physicians
18 complete an average of 45 prior authorizations a week¹; and
19

20 Whereas, The AMA's current position is that prior authorization, if used at all, must be used
21 judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians and
22 other providers² and discourages volume reduction solutions such as the elimination of prior
23 authorization requirements for regularly approved care, gold-carding programs, and other
24 exemption programs³; and
25

26 Whereas, The Office of Inspector General (OIG) review of Medicare Advantage Organizations
27 (MAOs) appealed preauthorization and payment denials, MAOs overturned 75 percent of their
28 own denials. The OIG also found that beneficiaries and providers appealed only 1 percent of
29 denials to the first level of appeal⁶; and
30

31 Whereas, A 2022 American College of Gastroenterology survey found that more than 50% of
32 members surveyed reported that prior authorization led to a serious adverse event in patients⁴
33 and a 2022 American Gastroenterological Association survey found that 56% of members
34 reported that prior authorization restrictions have "significantly" impacted patient access to
35 clinically appropriate treatments and patient clinical outcomes¹⁸; and

1 Whereas, It also revealed that the alternative treatments were less effective, more costly to
2 patients, less tolerable and/or supported by a lower level of clinical evidence⁴; and
3

4 Whereas, 2022 AMA data reveal 46% of respondents reported that prior authorization policies
5 led to urgent or emergency care for patients and 86% reported prior authorization led to higher
6 utilization of healthcare resources⁵; and
7

8 Whereas, All of the procedures flagged for prior authorization by UHC have robust multi-society
9 clinical guidelines and quality indicators that can be used with a directed utilization review
10 policy^{7,8,9,10,11,12,13,14,15}; and
11

12 Whereas, This UHC policy is a blanket obstruction to the practice of diagnostic and therapeutic
13 endoscopy rather than a directed utilization review of suspected outliers. AMA Prior
14 Authorization and Utilization Principle #19 states "Health plans should restrict utilization
15 management programs to "outlier" providers whose prescribing or ordering patterns differ
16 significantly from their peers after adjusting for patient mix and other relevant factors" ¹⁶; and
17

18 Whereas, The AMA, AHA, AHIP, BCBS, MGMA and the APhA have agreed to a Consensus
19 Statement on Improving the Prior Authorization Process including an agreement to "Encourage
20 the use of programs that selectively implement prior authorization requirements based on
21 stratification of health care providers' performance and adherence to evidence-based
22 medicine" ⁷; and
23

24 Whereas, UHC has failed to provide, and denied access to, any documentation showing recent
25 evidence of overutilization or to identify specific CPT procedure codes of concern in spite of
26 multiple requests; and
27

28 Whereas, A coalition of over 90 patient advocacy groups, national and state medical
29 associations urged UHC not to move forward with these prior authorization rules, due to the
30 significant impact on access to care and to the patient-physician relationship; therefore be it
31

32 RESOLVED, That our American Medical Association strongly advocate with all state and federal
33 agencies for the cancellation of UHC's 2023 blanket prior authorization policy directed at
34 endoscopic procedures in favor of a directed utilization review of presumed outliers (Directive to
35 Take Action); and be it further
36

37 RESOLVED, That our AMA redouble its efforts to promote state laws such as the AMA's
38 example "Ensuring Transparency in Prior Authorization Act" (Directive to Take Action); and be it
39 further
40

41 RESOLVED, That our AMA communicate with the various state insurance commissioners
42 concerning UHC's prior authorization policy change, which has the potential to adversely affect
43 access, quality, and equity of G.I. patient care. (Directive to Take Action)

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

Received: 5/2/23

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RELEVANT AMA POLICY

Approaches to Increase Payer Accountability H-320.968

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

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

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical

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

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

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20; Reaffirmation: A-22;

Payer Accountability H-320.982

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

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

(3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

Citation: CMS Rep. O, A-89; Reaffirmation A-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation A-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, I-14; Reaffirmation: I-17; Reaffirmation: A-22;

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior

Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.

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

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

4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22;

Fair Reimbursement for Administrative Burdens D-320.978

Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Citation: Res. 701, A-22;

Promoting Accountability in Prior Authorization D-285.960

Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21;

Managed Care H-285.998

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

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

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

financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

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

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

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

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

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

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

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

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

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

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

the time services requiring prior authorization are recommended by the physicians.

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

Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 04, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22;

Remuneration for Physician Services H-385.951

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

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

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

Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22;

Require Payers to Share Prior Authorization Cost Burden D-320.980

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

Citation: Res. 811, I-19; Reaffirmation: A-22;

Administrative Simplification in the Physician Practice D-190.974

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

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

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

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

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

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

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmation A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation: I-17; Reaffirmation: A-19; Modified: CMS Rep. 09, A-19; Reaffirmation: A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-23)

Introduced by: Medical Student Section

Subject: Hospital Bans on Trial of Labor After Cesarean

Referred to: Reference Committee G

1 Whereas, Trial of labor after cesarean (TOLAC) is a procedure where women who have
2 undergone a previous cesarean section undergo trial of vaginal birth; and
3

4 Whereas, Many hospitals ban the practice of TOLAC¹⁻³; and
5

6 Whereas, Hospital bans on TOLAC increase the number of unnecessary cesarean sections
7 because women eligible for vaginal birth are not given the opportunity for TOLAC⁴; and
8

9 Whereas, Women may have to travel far distances to find a hospital or provider that is willing to
10 let them attempt TOLAC⁵; and
11

12 Whereas, Cesarean section rates are at a medically unjustifiable level, reaching 32% of all
13 United States births in 2017⁶⁻⁸; and
14

15 Whereas, Cesarean sections are major surgeries that have inherent risks for the mother not
16 associated with vaginal birth, such as increased risk of blood loss, hysterectomy, and preterm
17 delivery for future pregnancies⁹; and
18

19 Whereas, Vaginal births result in decreased rates of respiratory distress and other complications
20 for newborns as compared to cesarean section births^{10,11}; and
21

22 Whereas, While relative risk of uterine rupture is higher for women undergoing TOLAC than
23 elective repeat cesarean deliveries (ERCD), the absolute risk remains low at 0.47%¹²; and
24

25 Whereas, There are no significantly different rates of hemorrhage, hysterectomy, or infection
26 between women undergoing TOLAC versus ERCD¹²; and
27

28 Whereas, TOLAC is associated with lower risk of maternal mortality at 3.8 deaths per 100,000
29 deliveries than ERCD at 13.4 deaths per 100,000 deliveries, showing it to be a safe option for
30 women with no contraindications¹³; and
31

32 Whereas, The American College of Obstetrics and Gynecology recommends TOLAC at
33 hospitals that provide at least basic maternal care^{14,15}; and
34

35 Whereas, TOLAC is a viable alternative to cesarean section that should be considered during
36 the antepartum course of care and be part of the physician-patient decision process¹⁶; and
37

38 Whereas, Opinion 1.1.3 in the AMA Code of Medical Ethics states that choice in treatment
39 allows patient control and autonomy over their healthcare decisions; and

Whereas, Hospital bans on TOLAC infringe on patient autonomy by preventing providers from respecting patient choice; and

Whereas, Hospital policies regarding TOLAC are not always easily accessible to patients^{3,17}; and

Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making between patient and physician in order to help patients make informed decisions about their health care; therefore be it

RESOLVED, That our American Medical Association support the elimination of broad hospital-based restrictions that prevent physicians from offering a trial of labor after cesarean to their patients when medically appropriate (New HOD Policy); and be it further

RESOLVED, That our AMA encourage hospitals to establish clear and transparent policies on trial of labor after cesarean in order to improve the process of patient-physician shared decision-making. (New HOD Policy)

Fiscal Note: Not yet determined.

Received: 5/1/23

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RELEVANT AMA POLICY

E-1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

- (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
- (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
- (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

Issued: 2016

E-1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example.

Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

- (a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
- (b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
- (c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
- (d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
- (e) To have the physician and other staff respect the patient's privacy and confidentiality.
- (f) To obtain copies or summaries of their medical records.
- (g) To obtain a second opinion.
- (h) To be advised of any conflicts of interest their physician may have in respect to their care.
- (i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

Issued: 2016

Obstetrical Delivery in the Home or Outpatient Facility H-420.998

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives.

Citation: Res. 23, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

Shared Decision-Making H-373.997

Our AMA:

1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.

Citation: CMS Rep. 7, A-10; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 06, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-23)

Introduced by: Michigan

Subject: Protect Patients with Medical Debt Burden

Referred to: Reference Committee G

1 Whereas, It is estimated that the percentage of American adults with medical debt range from
2 17.8 percent to 35 percent; and
3

4 Whereas, The Consumer Financial Protection Bureau reports \$88 billion in medical debt on
5 consumer credit records as of June, 2021; and
6

7 Whereas, It is estimated that approximately 23 million adults owe over \$250 in unpaid medical
8 bills; with more than 70 percent owing over \$1,000 and about half owing more than \$2,000; and
9

10 Whereas, People with medical debt are far less likely to fill a prescription, see a specialist when
11 needed, visit a doctor or clinic for a medical problem and more likely to skip a needed test,
12 treatment, or follow-up visit; and
13

14 Whereas, Out of every 100 people in the U.S., between 18 and 35 people have medical debt in
15 collections, with Black, Indigenous, and people of color and people with lower incomes having
16 higher rates of medical debt than the general population; and
17

18 Whereas, The COVID-19 pandemic brought renewed attention to medical debt, health
19 inequities, and public health; therefore be it
20

21 RESOLVED, That our American Medical Association work with the appropriate national
22 organizations to address the medical debt crisis by advocating for robust policies at the federal
23 and state level that prevent medical debt, help consumers avoid court involvement, and ensure
24 that court involved cases do not result in devastating consequences to patients' employment,
25 physical health, mental wellbeing, housing, and economic stability. (Directive to Take Action)

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

Received: 5/8/23

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RELEVANT AMA POLICY

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Citation: Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20;

Health Plan Payment of Patient Cost-Sharing D-180.979

Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.

Citation: CMS Rep. 09, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-23)

Introduced by: Missouri

Subject: Doctors' Risk for Termination of Liability Coverage or Medical Privileges
Consequent to *Dobbs*

Referred to: Reference Committee G

Whereas, U.S. Supreme Court's decision in *Dobbs v Jackson Women's Health Organization* led to the enactment of previously passed state legislation (known as "trigger laws") in many states hindering the provision of abortion services; and

Whereas, Unlike federal law, many of these state statutes are ambiguous regarding the definition of "emergency condition" that allow a physician to render pregnancy-related care; and

Whereas, The federal Emergency Medical Treatment and Active Labor law (EMTALA) governs the obligations of physicians and facilities where pregnancy-related care is rendered and supersedes any state laws to the contrary due to the "Supremacy Clause" of the United States Constitution; and

Whereas, EMTALA codifies that an emergency medical condition is defined to exist *upon the recognition of the threat* of loss of life or loss of function of any bodily system, an event that often occurs before "unstable" vital signs have developed consequent to the emergency condition; and

Whereas, In some cases, physicians complying with EMTALA will be forced to violate the recently enacted "trigger laws" and can be charged with a crime; and

Whereas, Insurers typically terminate liability insurance coverage for physicians who have been charged with a criminal offense, especially if the alleged offense is classified as a felony; and,

Whereas, Hospitals, medical clinics, and other health care facilities typically terminate a physician's medical staff membership and clinical privileges when a physician has been charged with a criminal offense, especially if the alleged offense is classified as a felony; therefore be it

RESOLVED, That the American Medical Association work with medical liability insurers and medical care facilities to discourage the termination of liability coverage or clinical privileges of any physician who has been charged with a crime arising from the provision of evidence-based healthcare. (Directive to Take Action)

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

Received: 5/4/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 712
(A-23)

Introduced by: New Jersey

Subject: Medical Bankruptcy – A Unique Feature in the USA

Referred to: Reference Committee G

1 Whereas, In 2020, medical debt was \$429 million across the United States; and

2
3 Whereas, The United States is the only developed nation that has such an enormous medical
4 debt; and

5
6 Whereas, In this country medical bills are the most common reason for bankruptcy. 17% of
7 adults with health care debt had to declare bankruptcy or lose their home because of it in 2022;
8 and

9
10 Whereas, The United States already has the most expensive health care of any country, despite
11 the medical bankruptcies; and

12
13 Whereas, The average age of a medial bankruptcy filer is 44.9 years old and 66.5% of all
14 bankruptcies are caused directly by medical debt, making it the leading cause for bankruptcy;
15 and

16
17 Whereas, Projections by the Centers for Medicare and Medicaid Services project that
18 healthcare expenditures will increase 50% by 2028, to 6.2 trillion dollars; and

19
20 Whereas, In 2019 Americans borrowed an estimated \$90 billion to pay for health care; and

21
22 Whereas, On average, couples that retire at age 65 pay a total of \$275,000 in medical bills for
23 the remainder of their life; and

24
25 Whereas, About 51% of single-person households with private insurance reported they would
26 be unable to pay a \$6,000 medical bill. 32% reported they would be unable to pay a \$2000
27 medical bill; and

28
29 Whereas, Americans health care expenses account for nearly 20% of GDP, which is almost
30 double that of most other developed countries. From 2000 to 2019, annual health insurance
31 premiums increased by approximately 50%; and

32
33 Whereas, According to the Organization for Economic Cooperation and Development, higher
34 out-of-pocket costs have been shown to translate to worse health outcomes. These costs cover
35 everything paid for directly by an individual, including prescription drug and physician visit
36 copays, health insurance deductibles and medical goods for personal use. Higher out-of-pocket
37 medical costs can deter someone with a medical problem from seeking treatment; and

Whereas, Americans had a life expectancy at birth of 78.6 years, which is lower than nearly all developed countries. For example, France has a life expectancy at birth of 82.6 years, four years longer than the United States; and

Whereas, In 2018 America's total healthcare bill, including spending on government programs, private health insurance, and patients' out-of-pocket costs exceeded \$10,000 per person, which was more than twice what governments, insurers, and patients in the Netherlands, Canada, France, and the United Kingdom spent, and almost twice Germany's healthcare costs; and

Whereas, In the rest of the developed world, medical costs are rarely or never cited as a driver behind personal bankruptcy; therefore be it

RESOLVED, That our American Medical Association study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such report to include recommendations to the House of Delegates to severely reduce the problem of medical debt. (Directive to take action)

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

Received: 5/4/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713
(A-23)

Introduced by: American Academy of Hospice and Palliative Medicine

Subject: Redesigning the Medicare Hospice Benefit

Referred to: Reference Committee G

1 Whereas, The population of terminally ill patients enrolled under the Medicare hospice benefit
2 today is very different than in 1983 when the benefit was established, with Alzheimer's disease
3 and related dementias (ADRD) representing a growing portion of hospice enrollees. And with
4 changing primary diagnoses, the care needs for these patients are also much different today¹;
5 and
6

7 Whereas, It has been shown that patients with ADRD can derive significant benefits from
8 hospice care, yet a 2022 study published in *JAMA Health Forum* found that current Medicare
9 policies aimed at reducing hospice misuse and long lengths of stay pose concerns for reduced
10 utilization by patients with ADRD – given the unpredictable trajectory of dementia – which may be
11 associated with poorer end-of-life experience and outcomes for these patients²⁻⁵; and
12

13 Whereas, Electing the hospice benefit means waiving access to all other Medicare services
14 related to the terminal condition, consequently the desire to continue disease-directed care or
15 certain intensive palliative treatments outside the usual scope of hospice care results in too
16 many patients who do not access hospice services until the last hours or days of life – or not at
17 all – depriving them and their families/caregivers of the supportive care to which they are
18 entitled; and
19

20 Whereas, For many patients belonging to historically minoritized or marginalized groups, a
21 history of discrimination, structural inequities, and substandard service delivery has resulted in a
22 lack of trust in the medical system associated with a reduced willingness to forgo life-sustaining
23 care and lower enrollment in hospice, as confirmed by a 2020 study published in *JAMA Network*
24 *Open* showing “despite the increase in the use of hospice care in recent decades, racial
25 disparities in the use of hospice remain, especially for noncancer deaths”^{1,6}; and
26

27 Whereas, Some aspects of the Medicare hospice benefit drive disparities in access to vital
28 services that can improve care and quality of life for seriously ill beneficiaries. For example, the
29 benefit was designed with the assumption that a patient has caregivers available at home; thus,
30 patients who lack home resources, transportation, and/or caregiver availability, or are otherwise
31 socially isolated, simply may not elect the benefit⁷; and
32

33 Whereas, The payment structure of the Medicare hospice benefit contributes to reduced access
34 to hospice care in rural settings given that rural providers receive lower payments compared to
35 urban hospice providers, despite facing increased costs due to travel distances and greater
36 difficulties in maintaining staff, remaining capitalized, and overcoming economic disadvantages;
37 and
38

39 Whereas, Council on Medical Services Report 4-I-16 recommends “that our AMA support
40 continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a

variety of models for providing and paying for concurrent hospice, palliative and curative care”;
and

Whereas, In light of the above, policymakers should reconsider the hospice benefit, and pursue efforts to redesign, establish, and implement an equitable, anti-racist benefit utilizing a process that is inclusive, transparent, and iterative; therefore be it

RESOLVED, That Our American Medical Association advocate for a 21st century evolution of the Medicare hospice benefit that meets the quadruple aim of health care; advances health equity; and improves access, support, and outcomes for seriously ill patients across all geographies, including underserved and low-resource communities (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for a reformed Medicare hospice benefit that incorporates the following components:

- 1) Hospice eligibility should not be based solely on a specified prognosis or life expectancy but rather on patients’ needs; patients with unclear prognoses should be able to access hospice services if their need is otherwise established.
- 2) Patients must continue to have an open choice of hospice providers.
- 3) Hospice services, including telehealth or telemedicine, should be provided by a full, physician-led interdisciplinary team.
- 4) Patients and their caregivers should receive adequate support using home- or facility-based hospice services, identified by a thorough assessment of their social determinants of health. This would incorporate 24-hour a day care for beneficiaries with very limited life expectancy who lack around-the-clock caregivers.
- 5) Patients should have concurrent access to disease-directed treatments along with palliative services.
- 6) Payments to hospices should be sufficient to support the quality, experience, scope, and frequency of care that beneficiaries deserve throughout the later stages of serious illness as dictated by their physical, psychological, social, spiritual, and practical needs.
- 7) The hospice benefit should be consistent, including with regard to the quality and intensity of services, regardless of which Medicare program or entity pays for services.
- 8) Metrics for health provider accountability should focus on those aspects of care and experience that matter most to patients, families, and caregivers.

(Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Concurrent Hospice and Curative Care H-85.951

1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.
3. Our AMA encourages physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.

Citation: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18;

Hospice Care H-85.955

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and (7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19;

Reaffirmation: A-22;

Hospice Coverage and Underutilization H-85.966

The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.

Citation: Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21;

End-of-Life Care H-85.949

Our AMA supports: (1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit; (2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition; and (3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.

Citation: CMS Rep. 1, I-21;

Planning and Delivery of Health Care Services H-160.975

(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.

Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07;

Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714
(A-23)

Introduced by: American Academy of Hospice & Palliative Medicine

Subject: Improving Hospice Program Integrity

Referred to: Reference Committee G

1 Whereas, Recent investigations show disproportionate hospice growth in some states with no
2 clear correlation to need, along with unusual billing and operational activity – including to
3 indicate some hospices are being established primarily for the purpose of selling them for profit
4 – suggesting willful fraud or abuse of the hospice benefit; and

5
6 Whereas, Medicare data has shown excessive geographic clustering of hospices (in one case,
7 120 separately licensed agencies in California are located in the same building, 75 of which are
8 Medicare certified); and

9
10 Whereas, After a statewide moratorium on new hospice licenses was enacted in California in
11 2022, similar troubling activity is shown to have spread to nearby states, including Arizona,
12 Nevada, and Texas; and

13
14 Whereas, Medicare beneficiaries nearing the end-of-life need – and deserve – all the valuable
15 services that good hospice delivers; and

16
17 Whereas, Patients and families who engage with fraudulent hospices can suffer real and lasting
18 consequences, including not receiving the types or level of care they need, or in some cases,
19 any care at all; and

20
21 Whereas, The many hospice audits currently in place have no bearing on care quality, nor have
22 they been shown to significantly curtail inappropriate organizational behavior; and

23
24 Whereas, Policy interventions aimed at ensuring hospice program integrity and quality should:

- 25 • Center on the needs of hospice patients and their families to ensure an optimal care
26 experience.
- 27 • Ensure timely and equitable access to hospice care across all geographies and
28 communities.
- 29 • Focus on integrity and quality indicators that impact patient care rather than focusing on
30 technical errors.
- 31 • Target non-operational and low-performing programs while avoiding blunt instruments
32 that could unnecessarily burden high-performing programs.
- 33 • Promote education and training of hospice professionals and support the free exercise of
34 reasonable, independent judgment in clinical decisions made in good faith, including
35 certification of terminal illness; and

36
37 Whereas, Current AMA policy calls to “ensure the availability and the coordination of a
38 continuum of supportive health care services for special populations in senior citizen centers,
39 day care and home care programs, supervised life-care centers, nursing homes, hospitals,

hospices, and rehabilitation facilities (H-160.975, *Planning and Delivery of Health Care Services*); therefore be it

RESOLVED, That Our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) use its existing authority to limit certification of additional hospices in counties where growth in hospice programs is out of line with established need by implementing a temporary targeted moratorium based on federal and state data, allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS strengthen investigation prior to approval of initial hospice certification applications and, for those new hospices approved but identified as high risk, require enhanced scrutiny and/or survey frequency (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that CMS use its existing authority to prohibit the sale or transfer of Medicare hospice certification numbers for a specified timeframe (similar to the 36-month change of ownership prohibition in the Medicare home health program), allowing for appropriate exceptions to ensure continued access to care (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS restrict Medicare privileges for non-operational hospices, including through voluntary termination of the provider agreement, deactivation of billing privileges, and revocation of Medicare enrollment (Directive to Take Action); and be it further

RESOLVED, That Our AMA advocate that CMS regulatory efforts aimed at weeding out fraud, waste, and abuse be refocused on integrity and quality indicators that impact patient care – rather than technical errors and retrospective chart audits focused on questioning eligibility – and avoid blunt instruments that burden high-performing programs, divert time and resources from patient care, and risk driving smaller providers from the market and/or putting rural or frontier hospice programs at a disadvantage. (Directive to Take Action)

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

Received: 5/10/23

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RELEVANT AMA POLICY

Concurrent Hospice and Curative Care H-85.951

1. Our AMA supports continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent **hospice**, palliative and curative care.
2. Our AMA encourages CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services.

3. Our AMA encourages physicians to be familiar with local **hospice** and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly.

Citation: (CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18)

Hospice Care H-85.955

Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care;

(2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment;

(3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare;

(4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program;

(5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers;

(6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure; and

(7) will advocate through all appropriate means to ensure that medications and other treatments used to stabilize palliative and hospice patients for pain, delirium, and related conditions in the hospital continue to be covered by pharmacy benefit management companies, health insurance companies, hospice programs, and other entities after patients are transitioned out of the hospital.

Citation: (CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 212, A-19;

Reaffirmation: A-22)

Hospice Coverage and Underutilization H-85.966

The policy of the AMA is that:

(1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy;

(2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease;

(3) Appropriate active palliation should be a covered hospital benefit; and

(4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life.

Citation: (Res. 515, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 04, I-16; Reaffirmed: Res. 119, A-18; Reaffirmed: CMS Rep. 1, I-21)

End-of-Life Care H-85.949

Our AMA supports:

(1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's **hospice** benefit;

(2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's **hospice** and skilled nursing facility (SNF) benefits for the same condition; and

(3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.

Citation: (CMS Rep. 1, I-21)

Planning and Delivery of Health Care Services H-160.975

(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser

and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms.

Citation: (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: BOT Rep. 23, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715
(A-23)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Published Metrics for Hospitals and Hospital Systems

Referred to: Reference Committee G

1 Whereas, American health care has witnessed an explosion in the number of hospital
2 administrators; and

3
4 Whereas, Studies have shown hospital boards are largely devoid of clinicians;¹ and

5
6 Whereas, The number of physicians who have become employed by hospitals has grown in
7 recent years, with 74% of physicians now employed by a hospital, health system or corporate
8 entity;² and

9
10 Whereas, While the C-Suite has significantly expanded, physicians have faced many negative
11 changes to the practice of medicine, including Medicare cuts, increased regulatory burdens and
12 crushing “burnout,” which have driven many to leave practice or curtail the hours they devote to
13 patient care; and

14
15 Whereas, While physicians are subject to scrutiny and oversight, these same requirements are
16 not placed on hospitals and health systems; and

17
18 Whereas, Hospital administrators are increasingly responsible for contributing to the high
19 turnover of talented, well-trained clinicians; and

20
21 Whereas, While hospitals are subject to publicly available measures citing such data as
22 infection rates, physicians do not have access to measures about the hospital as a workplace
23 environment, such as how physician-friendly the environment is; and

24
25 Whereas, Existing employee-based websites, such as GlassDoor.com, do not have the ability to
26 provide physicians the granular information needed to evaluate the hospital environment
27 relevant to physicians; therefore be it

28
29 RESOLVED, That our American Medical Association identify transparency metrics, such as
30 physician retention and physician satisfaction, that would apply to hospitals and hospital
31 systems and report back with recommendations for implementing appropriate processes to
32 require the development and public release of such transparency metrics. (Directive to Take
33 Action)

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

Received: 5/10/23

REFERENCES

1. Gondi, S., Kishore, S. & McWilliams, J.M. Professional Backgrounds of Board Members at Top-Ranked US Hospitals. *J GEN INTERN MED* (2023). <https://doi.org/10.1007/s11606-023-08056-z>.
2. Physicians Advocacy Institute. 2022. COVID-19's Impact On Acquisitions of Physician Practices and Physician Employment 2019-2021

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716
(A-23)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Referred to: Reference Committee G

Whereas, There has been tremendous health care consolidation over the last several years, with hospital systems acquiring multiple hospitals and physician practices; and

Whereas, The size of these transactions has been increasing, with \$1 billion deals involved;¹ and

Whereas, According to the Medicare Payment Advisory Commission, by 2017, in most markets, a single hospital system accounted for more than 50 percent of inpatient admissions; and

Whereas, As hospital systems grow, the bureaucracy and administration of these systems grow while competition decreases; and

Whereas, Burdens placed upon physicians, such as non-compete clauses, limit the ability of physicians to leave or challenge the system's dominance; and

Whereas, There have been several high-profile examples of physicians who have raised patient care concerns and have been targeted by the hospital system;² and

Whereas, Regulatory bodies, such as The Joint Commission, do not currently track or hold accountable hospital systems for the mistreatment of physicians; therefore be it

RESOLVED, That our American Medical Association identify options for developing and implementing processes — including increased transparency of physician complaints made to the Equal Employment Opportunity Commission and The Joint Commission — for tracking and monitoring physician complaints against hospitals and hospitals systems and report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act of 1986 to include monetary penalties for institutions performing bad-faith peer reviews. (Directive to Take Action)

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

Received: 5/10/23

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1. Singh, Anu. 2021 M&A in Review: A New Phase in Healthcare Partnerships. Kaufman Hall. <https://www.kaufmanhall.com/insights/research-report/2021-ma-review-new-phase-healthcare-partnerships>.
2. Geoff, Kelly. Yet another Roswell lawsuit alleging bias. Investigative Post. Feb. 27, 2023. <https://www.investigativepost.org/2023/02/27/yet-another-roswell-lawsuit-alleging-bias/>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717
(A-23)

Introduced by: American College of Chest Physicians

Subject: Improving Patient Access to Supplemental Oxygen Therapies

Referred to: Reference Committee G

1 Whereas, More than 1.5 million Americans use supplemental oxygen, a therapy that can
2 improve the quality of life for adults living with chronic lung diseases¹⁻³; and
3

4 Whereas, Advocacy groups, health care professionals, and patients report with alarming
5 frequency inaccurate coverage denials related to home oxygen; and
6

7 Whereas, The burden of these implementation gaps, and denials falls on the patients and their
8 providers; and
9

10 Whereas, The Centers for Medicare and Medicaid Services (CMS) in September 2021
11 published a new National Coverage Decision Memo on Home Use of Oxygen and Oxygen Use
12 to Treat Cluster Headaches which replaced the Certificate of Medical Necessity with medical
13 record review for documentation of necessity of supplemental oxygen; and
14

15 Whereas, During the COVID related public health emergency, CMS suspended physician
16 medical record review in recognition that hospital surges made it impossible for physician's
17 records to accurately reflect all the information required by Medicare Recovery Audit
18 Contractors; and
19

20 Whereas, During the period of suspension of medical record review no significant increase in
21 fraud and abuse was recognized; and
22

23 Whereas, In the opinion of our organization, relying on medical review to establish supplemental
24 oxygen medical necessity will introduce complexity, inconsistency, delays, and unneeded costs
25 to the system without benefit; therefore be it
26

27 RESOLVED, That our American Medical Association advocate for the adoption of a CMS-
28 crafted, patient- and provider- endorsed, clinical template in lieu of medical record review to
29 maintain patient access to supplemental oxygen (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA, to ensure predictable reimbursement and establish medical
32 necessity, advocate for CMS to establish a CMS-crafted, patient- and provider- endorsed,
33 clinical template as the national standard documentation for supplemental oxygen suppliers.
34 (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. Doherty DE, Petty TL, Bailey W, Carlin B, Cassaburi R, Christopher K, et al. Recommendations of the 6th long-term oxygen therapy consensus conference. *Respir Care* 2006;511:519-525.
2. Nocturnal Oxygen Therapy Trial Group. Continuous or nocturnal oxygen therapy in hypoxemic chronic obstructive lung disease: a clinical trial. *Ann Intern Med* 1980;93:391-398.
3. Medical Research Council Working Party. Long term domiciliary oxygen therapy in chronic hypoxic cor pulmonale complicating chronic bronchitis and emphysema: report of the Medical Research Council working Party. *Lancet* 1981;1:681-686.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718
(A-23)

Introduced by: Georgia

Subject: Insurance Coverage of FDA Approved Medications and Devices

Referred to: Reference Committee G

1 Whereas, Health insurers are increasingly denying coverage per their policy letters claiming
2 medications and devices are experimental; and
3

4 Whereas, Physicians and staff are spending increasing time on peer to peer calls trying to
5 obtain approval for their patient's care; and
6

7 Whereas, Insurance companies are practicing medicine without a license by denying care
8 recommended by licensed physicians; therefore be it
9

10 RESOLVED, That our American Medical Association support prohibiting the use of the rationale
11 for denial that a medication or device is experimental by insurance companies where such
12 medication or device has been approved by the United States Food and Drug Administration for
13 one year or longer and has peer-reviewed evidence supporting its use in the manner in which it
14 was prescribed. (New HOD Policy)

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

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719
(A-23)

Introduced by: Illinois

Subject: Care Partner Access to Medical Records

Referred to: Reference Committee G

1 Whereas, Many people manage their health with the help of others including family members
2 and friends, who are often referred to as informal care partners (or caregivers), and the role of
3 these care partners can include arranging and attending medical appointments, participating in
4 medical decision-making, coordinating services and addressing various patient needs; and
5

6 Whereas, Despite the vital role played by care partners, they are often unable to access health
7 information in the electronic health record (EHR) that is necessary to coordinate and manage
8 care; and
9

10 Whereas, One study revealed that only two-thirds of the U.S. hospitals surveyed offered adult
11 patients the option of granting portal access to a care partner, and among hospitals that did, the
12 process for obtaining proxy credentials was often difficult and time consuming; and
13

14 Whereas, Shared access to a patient's medical portal can improve patient and family
15 satisfaction with care, improve agreement with goals of care and treatment decisions, care
16 partner confidence in managing care and can help reduce care partner burden; and
17

18 Whereas, Few healthcare organizations have a convenient and straightforward procedure for
19 granting proxy access, and even when EHR vendors offer mechanisms for access, healthcare
20 organizations appear to give little thought to the information needs of this group; and
21

22 Whereas, Using secure patient portals to link care partners to the healthcare team should be a
23 priority for healthcare organizations; therefore be it
24

25 RESOLVED, That our American Medical Association advocate that electronic health records
26 (EHR) vendors offer simplified procedures for granting proxy access to care partners (or
27 caregivers) to the electronic health record, including online registration with multifactor
28 authentication to promote security, rather than requiring in person registration (Directive to Take
29 Action); and be it further
30

31 RESOLVED, That our AMA advocate that vendors develop a simple mechanism for noting and
32 displaying care partner names and contact information in the Electronic Health Record (EHR),
33 along with privacy settings that allow patients to grant proxy access to selected portions of their
34 records, including easy to understand information on use of this information and a user-friendly
35 consent mechanism (Directive to Take Action); and be it further
36

37 RESOLVED, That our AMA support and encourage Congress to modernize Health Insurance
38 Portability and Accountability Act (HIPAA) laws to ensure that HIPAA rules for preserving the
39 privacy of patient and associated data also cover third party applications' access to electronic
40 health records (EHRs). (New HOD Policy)

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

Received: 5/5/23

RELEVANT AMA POLICY

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.
2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Citation: BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-12; Reaffirmed: BOT Rep. 17, A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res. 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21; Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22;

Confidentiality of Computerized Patient Records H-315.990

The AMA (1) reaffirms the importance of confidentiality of patient records regardless of the form in which they are stored; and (2) will study and incorporate into its model legislation, Confidentiality of Health Care Information, a provision regulating third parties' use of computerized patient records in physicians' offices. Citation: Res. 813, I-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Modified: CMS Rep. 01, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 720
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Prior Authorization Costs, AMA Update to CMS

Referred to: Reference Committee G

1 Whereas, The impact of prior authorization costs is becoming excessive as an unfunded
2 mandate on practices; and
3

4 Whereas, The study by our American Medical Association has shown that practices must
5 complete 41 prior authorizations per physician each week on average, which consumes almost
6 two business days of physician and staff time, with 40% of physicians reporting that they have
7 hired staff who work exclusively on prior authorizations¹; and
8

9 Whereas, ASCO conducted a survey of members and found that nearly all survey participants
10 report patient harm including disease progression (80%) and loss of life (36%)²; and
11

12 Whereas, Our AMA will submit practice expense data and methodology information collected
13 via a physician practice expense survey to begin in June 2023 to the Centers for Medicare &
14 Medicaid Services (CMS) as they make updates; therefore be it
15

16 RESOLVED, That our American Medical Association include the costs associated with prior
17 authorization in the practice expense data and methodology information submitted to the
18 Centers for Medicare & Medicaid Services. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. Robeznieks A. Why prior authorization is bad for patients and bad for business. American Medical Association. February 18, 2022. <https://www.ama-assn.org/practice-management/prior-authorization/why-prior-authorization-bad-patients-and-bad-business>
2. Nearly All Oncology Providers Report Prior Authorization Causing Delayed Care, Other Patient Harms. *The ASCO Post*. December 25, 2022. <https://ascopost.com/issues/december-25-2022/nearly-all-oncology-providers-report-prior-authorization-causing-delayed-care-other-patient-harms/>

RELEVANT AMA POLICY

Update Practice Expense Component of Relative Value Units D-406.992

Our American Medical Association will conduct a pilot study to determine the best mechanism for gathering physician practice expense data, including the feasibility of fielding a new physician practice expense survey, and work with the Centers for Medicare & Medicaid Services (CMS) to update the resource-based relative value practice expense methodology.

Citation: BOT Action in response to referred for decision Res. 131, A-19;

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.

(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.

(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.

(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.

Citation: Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 721
(A-23)

Introduced by: American Society for Gastrointestinal Endoscopy, American Academy of Physical Medicine and Rehabilitation, American College of Gastroenterology, American Gastroenterological Association, American Society for Surgery of the Hand Professional Organization, American Society of Echocardiography, North American Spine Society, Society for Cardiovascular, Angiography & Interventions

Subject: Use of Artificial Intelligence for Prior Authorization

Referred to: Reference Committee G

-
- 1 Whereas, Health insurers are adopting artificial intelligence technology to speed up prior
2 authorization decisions; and
- 3 Whereas, Health insurance companies are increasingly relying on artificial intelligence as a
4 more economical way to conduct prior authorization for a greater number of health care
5 services; and
- 6 Whereas, *ProPublica* revealed that over a period of two months in 2022, Cigna doctors denied
7 more than 300,000 claims as part of a review process that used artificial intelligence, with Cigna
8 doctors spending an average of 1.2 seconds on each case¹; and
- 9 Whereas, As of June 1, 2023, UnitedHealthcare (UHC) requires prior authorization for all
10 diagnostic and surveillance colonoscopies, upper endoscopies, and capsule endoscopies —
11 roughly 47 percent of all gastrointestinal services; and
- 12 Whereas, UHC has stated it uses technology that allows it to make “fast, efficient and
13 streamlined coverage decisions”²; and
- 14 Whereas, the use of artificial intelligence to review requests for prior authorization raise
15 questions about whether insurance companies are in compliance with state and federal
16 insurance regulations; and
- 17 RESOLVED, That our American Medical Association advocate for greater regulatory oversight of
18 the use of artificial intelligence for review of patient claims, including whether insurers are using
19 a thorough and fair process that includes reviews by doctors and other health care professionals
20 with expertise for the service under review, and that such reviews include human examination of
21 patient records prior to a care denial. (Directive to Take Action)

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

Received: 5/10/23

REFERENCES

1. https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims?utm_medium=social&utm_source=twitter&utm_campaign=TwitterThread
2. Ibid.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 722
(A-23)

Introduced by: New York

Subject: Expanding Protections of End-Of-Life Care

Referred to: Reference Committee G

Whereas, Despite clinical practice guidelines recommendations of ongoing assessments of pain, other symptoms, side effects of treatment, and functional capacity pain and other distressing symptoms are often undertreated and inadequately controlled¹; and

Whereas, The medical profession increasingly recognizes the growing need to educate physicians in palliative care, however, trainee and physician awareness of and comfort with palliative care management is highly variable²⁻⁵; and

Whereas, Medical students receive varied training in palliative and end of life care ranging from 2 hours to weeks and most residents (81%) reported little to no classroom training on EOL care during residency^{6,7}; and

Whereas, Palliative care is underutilized in the United States and the National Inpatient Sample showed that palliative care consultations were recorded in only 9.9% of 4,732,172 weighted advanced cancer hospitalizations⁸; and

Whereas, The need for palliative care and end of life symptom relief has been largely ignored as healthcare systems and medicine have focused on extending life, but not to the same extent on dignity and quality of life when curative treatment is no longer possible⁵; and

Whereas, The AMA Code of Ethics also states that “the duty to relieve pain and suffering is central to the physician’s role as healer and is an obligation physicians have to their patients”⁹; and

Whereas, There are many ethical and legal considerations in end of life care in a climate where physicians have faced civil and criminal liability for providing standard of care end of life symptom control to patients as recently as 2022^{10,11}; and

Whereas, Standard of care end of life treatment can include treatments that can decrease the level of alertness and a patients remaining hours¹²; and

Whereas, There is variability in how prosecutors, juries, and judges interpret the law in relation to medical treatment of distressing symptoms therefore it is imperative the house of medicine take a strong stance to preserve the patient physician relationship^{13,14}; therefore be it

RESOLVED, That our American Medical Association:

(1) recognizes that healthcare, including end of life care like hospice, is a human right;

(2) supports the education of medical students, residents and physicians about the need for physicians who provide end of life healthcare services;

- (3) supports the medical and public health importance of access to safe end of life healthcare services and the medical, ethical, legal and psychological principles associated with end-of-life care;
- (4) supports education of physicians and lay people about the importance of offering medications to treat distressing symptoms associated with end of life including dyspnea, air hunger, and pain;
- (5) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to end-of-life care;
- (6) supports shared decision-making between patients and their physicians regarding end-of-life healthcare;
- (7) opposes limitations on access to evidence-based end of life care services;
- (8) opposes the imposition of criminal and civil penalties or other retaliatory efforts against physicians for receiving, assisting in, referring patients to, or providing end of life healthcare services. (New HOD Policy)

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

Received: 5/10/23

REFERENCES

1. Thomas J. Optimizing opioid management in palliative care. *Journal of Palliative Medicine*. 2007;10(Supplement_1):S-1-S-18.
2. Langan E, Kamal AH, Miller KE, Kaufman BG. Comparing palliative care knowledge in metropolitan and nonmetropolitan areas of the United States: Results from a National Survey. *Journal of Palliative Medicine*. 2021;24(12):1833-1839.
3. Rubio L, López-García M, Gaitán-Arroyo MJ, Martín-Martin J, Santos-Amaya I. Palliative care undergraduate education: Do medical and nursing students need more skills in ethical and legal issues? *Medical Hypotheses*. 2020;142:110138.
4. Sutherland R. Focus: death: dying well-informed: the need for better clinical education surrounding facilitating end-of-life conversations. *The Yale journal of biology and medicine*. 2019;92(4):757.
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RELEVANT AMA POLICY

Good Palliative Care H-70.915

Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good

care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them.

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