RECOMMENDED FOR ADOPTION IN LIEU OF

(31)  RESOLUTION 214 - ADVOCACY AND ACTION FOR A SUSTAINABLE MEDICAL CARE SYSTEM
RESOLUTION 234 - MEDICARE PHYSICIAN FEE SCHEDULE UPDATES AND GRASSROOTS CAMPAIGN
RESOLUTION 257 - AMA EFFORTS ON MEDICARE PAYMENT REFORM

RECOMMENDATION: Alternate Resolution 214 be adopted in lieu of Resolutions 214, 234, and 257.

AMA EFFORTS ON MEDICARE PAYMENT REFORM

RESOLVED, That our American Medical Association declare Medicare physician payment reform as an urgent advocacy and legislative priority for our AMA; and be it further

RESOLVED, That our AMA prioritize significant increases in funding for federal and state advocacy budgets specifically allocated to achieve Medicare physician payment reform to ensure that physician payments are updated annually at least equal to the annual percentage increase in the Medicare Economic Index; and be it further

RESOLVED, That our AMA Board of Trustees report back to the House of Delegates at each annual and interim meeting on the progress of our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician payment is achieved.

RESOLVED, That AMA Policy D-390.922 be amended by addition and deletion to read as follows:

Physician Payment Reform and Equity, D-390.922
Our AMA will develop implement a comprehensive advocacy campaign, including a sustained national media strategy engaging patients and physicians in promoting Medicare physician payment reform, to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.
RESOLVED, That our AMA reaffirm AMA Policy H-390-849, “Physician Payment Reform,” which states, among other things, that our AMA will advocate for the development and adoption of physician payment reforms that are designed with input from the physician community, do not require budget neutrality within Medicare Part B, and are based on payment rates that are sufficient to cover the full cost of sustainable medical practice.

RESOLVED, That our AMA reaffirm AMA Policy D-390.946, “Sequestration,” which states, among other things, that our AMA will continue to seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs, ensure Medicare physician payments are sufficient to safeguard beneficiary access to care, and work towards the elimination of budget neutrality requirements within Medicare Part B; as well as our AMA advocate strongly to the Administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

HOD ACTION: Alternate Resolution 214 adopted in lieu of Resolutions 214, 234, and 257.

Resolution 214:

RESOLVED, That our American Medical Association continue to strongly advocate for fair reimbursement of all segments of health care, particularly physicians, to undo inadequate payment relative to inflation (Directive to Take Action); and be it further

RESOLVED, That our AMA seek ongoing reimbursement adjustments for fair physician payment at least on an annual basis in order to match that given to hospitals, extended and ambulatory care facilities, medical device and pharmaceutical companies for rising practice costs and inflation. (Directive to Take Action)

Resolution 234:

RESOLVED, That our American Medical Association’s top priority be to advocate for positive annual updates to the Medicare Physician Fee Schedule (PFS) to accurately account for annual inflation, cost of living, and practice expense increases (Directive to Take Action); and be it further

RESOLVED, That our AMA actively engage in an AMA-organized and sponsored national grassroots campaign that educates patients about how lack of sufficient positive updates to the physician fee schedule places physician practice survivability and access to quality health care at risk (Directive to Take Action); and be it further
RESOLVED, That this newly-created AMA grassroots campaign actively engage America’s patients, as constituents, to use their influence to lobby Congress in favor of positive Medicare PFS updates to help ensure the survivability of physician practices and access to quality health care for all. (Directive to Take Action)

Resolution 257:

RESOLVED, That our American Medical Association House of Delegates declare Medicare physician payment reform as both an urgent and a top advocacy and legislative priority for our AMA; and be it further

RESOLVED, That our AMA prioritize significant increases in funding for federal and state advocacy budgets specifically to ensure Medicare physician payment reforms are achieved and updated annually according to the Medicare Economic Index; and be it further

RESOLVED, That our AMA use the increased federal and state advocacy funding to:

1. Create and sustain a national media strategy and campaign promoting Medicare physician payment reform;

2. Fund Washington, D.C., fly-ins, with a white coat march promoting Medicare physician payment reform; and

3. Develop and implement any additional new strategies to accomplish this goal;

And be it further;

RESOLVED, That our AMA consider this policy the top advocacy priority until this goal is accomplished; and be it further

RESOLVED, That the next National Advocacy Conference be sharply focused upon reforming the Medicare payment system to create a more sustainable payment formula for physician practices with annual updates according to the Medicare Economic Index; and be it further

RESOLVED, That our AMA Board of Trustees report back to the house at each annual and interim session on the progress of our AMA staff and physicians until this goal is accomplished.

Your Reference Committee heard unanimous support for the goals of Resolutions, 214, 234, and 257. Your Reference Committee heard testimony expressing intense frustration with the current Medicare physician payment system and its lack of positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs. Testimony stated that the current physician payment system is in crisis and driving private practices out of business. Your Reference Committee heard passionate testimony arguing that achieving permanent physician payment reform should be our AMA’s highest advocacy priority and supporting the types of additional actions called for in Resolution 234 and 237, including a significant increase in funding to advocate for physician payment reform, creating a sustained media strategy, and enhancing our AMA’s grassroots efforts
by engaging patients in our AMA’s advocacy efforts. Your Reference Committee also
heard testimony that our AMA has already initiated a comprehensive advocacy campaign
to achieve enactment of reforms to the Medicare physician payment system consistent
with AMA policy and in accord with the principles (Characteristics of a Rational Medicare
Payment System) endorsed by over 120 state and medical specialty Federation of
Medicine members. Your Reference Committee heard testimony that our AMA, in
collaboration with Federation members, has successfully advocated for the introduction of
H.R. 2474, the “Strengthening Medicare for Patients and Providers Act,” a bipartisan bill
that provides for a payment update that is equal to the annual percentage increase in the
Medicare Economic Index (Federation sign-on support letter), and that our AMA is
collaborating with Federation members to secure additional bipartisan cosponsors for this
legislation and to educate Congress on why it is needed, as well as strongly advocating
for this bipartisan legislation to be introduced in the Senate. (Federation sign-on letter).
Testimony also highlighted a number of other recently enhanced AMA advocacy activities,
including: the relaunching of the FixMedicareNow.org campaign to build awareness and
support through a highly visible paid and earned media tactic, as well as a grassroots and
grassroots strategy to position our AMA as a go-to source for information about Medicare
payment reform and to establish a strong grassroots base of patients and physicians ready
to call on Congress to take action; a patient message testing initiative with patient focus
groups and polling that will begin this month; collaboration with Federation members in
drafting legislation to reform the budget neutrality policies that have been producing
across-the-board payment cuts; and developing several impactful advocacy resources,
which can be found here. Your Reference Committee also heard testimony that these
AMA advocacy efforts and our AMA’s collaboration with Federation members is not being
effectively communicated to AMA members in general, or to the media and patients,
despite AMA advocacy updates, press releases, and other communication efforts. Your
Reference Committee heard testimony in strong agreement that our AMA should improve
its communication and outreach, but that the specific strategy and tactics to implement
these advocacy efforts have been and should continue to be decided by the Board and
senior management. Your Reference Committee acknowledges the intense frustration of
those who testified in support of Resolutions, 214, 234, and 257. At the same time, your
Reference Committee acknowledges the significant advocacy efforts our AMA has
initiated based on recently adopted policy. Your Reference Committee considered an
alternate resolution offered during the hearing that captures the essence of these
resolutions while leaving the specific strategy and tactics to the Board. Your Reference
Committee agrees with this approach and believes the Alternate Resolution should be
further strengthened to capture some of the provisions in Resolution 237. In addition, your
Reference Committee alternate resolves reflect comments on the importance of
enhancing our AMA’s visible advocacy on this crucial issue. Therefore, your Reference
Committee recommends that Alternate Resolution 214 be adopted in lieu of Resolutions
214, 234, and 257.

Physician Payment Reform H-390.849
1. Our AMA will advocate for the development and adoption of physician payment
reforms that adhere to the following principles:
   a) promote improved patient access to high-quality, cost-effective care;
   b) be designed with input from the physician community;
   c) ensure that physicians have an appropriate level of decision-making
      authority over bonus or shared-savings distributions;
   d) not require budget neutrality within Medicare Part B;
e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
h) use adequate risk adjustment methodologies;
i) incorporate incentives large enough to merit additional investments by physicians;
j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Sequestration D-390.946

Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in MIPS with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.
(32) RESOLUTION 219 - REPEALING THE BAN ON
PHYSICIAN-OWNED HOSPITALS
RESOLUTION 222 - PHYSICIAN OWNERSHIP OF
HOSPITAL BLOCKED BY THE ACA
RESOLUTION 261 - PHYSICIAN OWNED HOSPITALS

RECOMMENDATION A:

The first Resolve of Resolution 219 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association advocate for policies that remove alleviate any restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type —in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment of physicians dedication to patient care (Directive to Take Action); and be it further-

RECOMMENDATION B:

The second Resolve of Resolution 219 be deleted.

RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to ensure that physician-owned hospitals are operating in the best interests of patients (Directive to Take Action); and be it further

RECOMMENDATION C:

The third Resolve of Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage further study and research into the benefits and drawbacks—impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, of physician-owned hospitals and their impact on patient care competition in highly concentrated hospital markets; as well as the potential impact of regulatory safeguards to ensure transparency and accountability in physician-owned hospitals (New HOD Policy); and be it further
RECOMMENDATION D:

The fourth Resolve of Resolution 219 be deleted.

RESOLVED, That our AMA work with policymakers to
develop regulations that promote transparency and
accountability in physician-owned hospitals, and protect
against any potential conflicts of interest, while also
fostering competition and innovation in the healthcare
market (Directive to Take Action); and be it further-

RECOMMENDATION E:

The seventh Resolve of Resolution 219 be amended by
addition and deletion to read as follows:

RESOLVED, That our AMA collaborate with other
stakeholders, including hospital associations, patient
advocacy groups, and government agencies, to develop
and promote policies that support physician ownership of
hospitals (Directive to Take Action); and be it further-

RECOMMENDATION F:

The eighth Resolve of Resolution 219 be deleted.

RESOLVED, That our AMA direct the appropriate
stakeholders to report back to the AMA on the progress
made in implementing these resolutions, with
recommendations for future action as appropriate.
(Directive to Take Action)

RECOMMENDATION G:

Resolution 219 be adopted as amended in lieu of
Resolutions 222 and 261.

RECOMMENDATION H:

The title of Resolution 219 be changed to read as follows:

PHYSICIAN-OWNED HOSPITALS

HOD ACTION: Resolution 219 adopted as amended in lieu
of Resolutions 222 and 261 with a change of title.

PHYSICIAN-OWNED HOSPITALS
Resolution 219:

RESOLVED, That our American Medical Association advocate for policies that alleviate any restriction upon physicians from owning, constructing, and/or expanding any hospital facility type - in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment of physicians dedication to patient care (Directive to Take Action); and be it further.

RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to ensure that physician-owned hospitals are operating in the best interests of patients (Directive to Take Action); and be it further.

RESOLVED, That our AMA encourage further study and research into the benefits and drawbacks of physician-owned hospitals and their impact on patient care, as well as the potential impact of regulatory safeguards to ensure transparency and accountability in physician-owned hospitals (New HOD Policy); and be it further.

RESOLVED, That our AMA work with policymakers to develop regulations that promote transparency and accountability in physician-owned hospitals, and protect against any potential conflicts of interest, while also fostering competition and innovation in the healthcare market (Directive to Take Action); and be it further.

RESOLVED, That our AMA continue to support physician leadership in healthcare and advocate for policies that enable physicians to provide the highest quality care to their patients, including policies that remove unnecessary barriers to physician ownership of hospitals (Directive to Take Action); and be it further.

RESOLVED, That our AMA work to educate its members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership (Directive to Take Action); and be it further.

RESOLVED, That our AMA collaborate with other stakeholders, including hospital associations, patient advocacy groups, and government agencies, to develop and promote policies that support physician ownership of hospitals (Directive to Take Action); and be it further.

RESOLVED, That our AMA direct the appropriate stakeholders to report back to the AMA on the progress made in implementing these resolutions, with recommendations for future action as appropriate. (Directive to Take Action)

Resolution 222:

RESOLVED, That our American Medical Association explore and report back to the House of Delegates at the 2024 Annual Meeting, the feasibility of filing judicial or legislative challenges to the ban on physician ownership of new hospitals under the relevant provisions of the Affordable Care Act. (Directive to Take Action)
Resolution 261:

RESOLVED, That our American Medical Association study the patient selection practices of both physician-owned and non-physician-owned hospitals to better understand the impact of hospital ownership status on access to care through:

1. A thorough review of the existing literature;
2. Analyzing patient characteristics across both physician-owned and non-physician-owned hospitals to elucidate whether there are any meaningful differences between these 2 populations. This study should take into account that half of physician-owned hospitals are community hospitals and half are specialty hospitals focused on cardiac, orthopedic, or surgical care;
3. Proposing solutions if there are meaningful differences in these patient populations to ensure equitable access to care (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association conduct a comprehensive study into the impact of Section 1877 of the Social Security Act, the Physician Self-Referral Law (also called the Stark Law), on physician-owned hospitals and market-wide consolidation, including the following:

1. Analyzing the impact that restrictions on physician-owned hospitals enacted by the Stark Law have had on patient access to care, in terms of both cost and quality;
2. Examining the impact of the Stark Law on physician practices, especially those that are integrated or affiliated with physician-owned hospitals;
3. Understanding the extent to which the Stark Law has driven market consolidation and, in doing so, impacted healthcare costs, quality, and patient access to care;
4. Proposing alternative approaches to the Stark Law, including consideration of repeal of relevant provisions, that would promote competition and improve patient access to high-quality care (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association study the impact of Section 6001 of the Patient Protection and Affordable Care Act on physician hospital ownership metrics, physician fiscal health and retirement, physician burnout, patient continuity of care, physician turnover within hospitals, and most importantly physicians’ empowerment to advocate for the health and wellbeing of their patients (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association report the initial findings of studies into Section 1877 of the Social Security Act and/or Section 6001 of the Patient Protection and Affordable Care Act to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

RESOLVED, That our American Medical Association work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of the repeal of the ban on physician-owned hospitals on patients, physicians, and hospital prices. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning Resolutions 219, 222, and 261. Testimony urged that our AMA provide additional advocacy support for physician-owned hospitals. Your Reference Committee heard that advocacy surrounding physician-
owned hospitals is ultimately in the best interest of patients. Your Reference Committee heard that our AMA should continue to educate AMA members and the public on the potential benefits of physician ownership of hospitals and the need for policies that support such ownership. Your Reference Committee also heard that Resolutions 219, 222, and 261 were very similar. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended in lieu of Resolutions 222 and 261.

(33) RESOLUTION 237 - PROHIBITING COVENANTS NOT-TO-COMPETE IN PHYSICIAN CONTRACTS
RESOLUTION 263 - ELIMINATION OF NON-COMPETE CLAUSES IN EMPLOYMENT CONTRACTS

RECOMMENDATION:

Resolution 237 be adopted in lieu of Resolution 263.

HOD ACTION: Resolution 237 adopted in lieu of Resolution 263.

Resolution 237:

RESOLVED, That our American Medical Association support policies, regulations, and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing company employers (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the use of restrictive covenants not-to-compete as a contingency of employment for any physician-in-training, regardless of the ACGME accreditation status of the residency/fellowship training program (New HOD Policy), and be it further

RESOLVED, That our AMA study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care - such recommendations to include the appropriate regulation or restriction of 1) Covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and 2) De facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination. (Directive to Take Action)

Resolution 263:

RESOLVED, That our AMA support the elimination of restrictive not-to-compete clauses within contracts for all physicians in clinical practice, regardless of the for-profit or not-for-profit status of the employer; and be it further

RESOLVED, That our AMA strongly advocate for policies that enable all physicians, including residents and fellows currently in training, to have greater professional mobility and the ability to serve multiple hospitals, thereby increasing specialist coverage in communities and improving overall patient care; and be it further