

AMERICAN MEDICAL ASSOCIATION PRIVATE PRACTICE PHYSICIAN SECTION

Resolution: 4
(NOV-22)

Introduced by: Medical Society of the District of Columbia
Subject: Minimal Sustainable Reimbursement for Community Practices
Referred to: PPPS Reference Committee
(xxxx, MD, Chair)

- 1 WHEREAS, Community-based private practices accept insurance reimbursement to provide
2 access to affordable service for people in need; and
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4 WHEREAS, Small private practices provide neighborhood-based care, often in communities
5 facing health disparities, that may not be readily available elsewhere; and
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7 WHEREAS, Medicare rates are collaboratively (by the AMA, government agencies, and
8 industry) based on the source-based relative values scale, created by Harvard University in
9 1985 and published in the *Journal of the American Medical Association* in 1988¹, which
10 incorporates physician work, practice expense, professional liability costs, and geographic
11 variations, with extensive input from physicians and specialty societies; and
12
13 WHEREAS, There are currently no lower limits regarding the reimbursement rates insurers pay
14 to medical practices and no legal requirements that insurers negotiate with practices, provide
15 fair reimbursement, or consider the needs of patients served by community practices; and
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17 WHEREAS, Reimbursement from private insurers to small practices is often well below
18 Medicare rates and below the level required to cover fixed costs and accompanied by a
19 dramatic increase in required reporting by physician offices; and
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21 WHEREAS, Payers may refuse to negotiate appropriate reimbursement rates with small private
22 practices; and
23
24 WHEREAS, AMA policy supports a pluralistic approach to health care utilization to include
25 small, solo, and medium-sized practices. Despite the well documented outcome-based
26 evidence of the benefit of these treatment options, third-party insurers are forcing market
27 consolidation with unsustainable reimbursement models that are below Medicare
28 reimbursement rates; and
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30 WHEREAS, Private practices are prohibited from collaborating with each other to request fair
31 reimbursement due to prior antitrust legal interpretations; and
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33 WHEREAS, Private practices are rapidly disappearing, either going out of business or being
34 absorbed by large institutional practices that are able to negotiate with payers (as of January

¹ Janower ML. The Resource-Based Relative Value Scale. JAMA. 1988 Mar 4;259(9):1329. PMID: 3339834

1 2021², nearly 70 percent of U.S. physicians reportedly worked for hospitals or corporate
2 entities); and
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4 WHEREAS, The future of health care is trending towards the concepts of population health
5 management, outcome evidence-based care, and value-based purchasing of health care.
6 These models favor large groups and hospitals, once again excluding private practice
7 physicians in small and medium-sized groups, thus action is needed now to establish both
8 access to patients and appropriate floors for reimbursement which will address these health
9 care models and their potentially deleterious effects on private practice physicians in small and
10 medium-sized groups going forward; and
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12 WHEREAS, In the same way individuals are protected through the Fair Labor Standards Act of
13 1938 (29 USC § 203), which set a minimum wage, and states and municipalities have enacted
14 similar measures, governments have the authority to establish minimum levels of
15 reimbursement for medical practices; therefore be it
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17 RESOLVED, That our American Medical Association study small primary practices in the
18 country to better understand reimbursement rates from major insurers and how these practices
19 experience them (Directive to Take Action); and be it further
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21 RESOLVED, That our AMA study and report back by the Annual 2023 meeting appropriate
22 remedies for reimbursement rates for physician practices that are minimally tied to Medicare
23 rates, sch as a reimbursement floor tied to Medicare rates or above, such that insurers would be
24 encouraged to conduct good faith negotiations with small and medium-sized practices along
25 existing AMA policy (Directive to Take Action); and be it further
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27 RESOLVED, That our AMA study the impacts of concepts of population health management,
28 outcome evidence-based care, and value-based purchasing of health care on small and
29 medium-sized physician practices (Directive to Take Action); and be it further
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31 RESOLVED, That our AMA will develop options for model legislation for states and
32 municipalities seeking to correct reimbursement rates for medical practices that are below those
33 required to meet fixed costs by Annual 2023 (Directive to Take Action).

Fiscal Note: Modest: Between \$1,000 and \$5,000 to implement

Received: 9/12/2022

² Physician Advocacy Institute. COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020. Accessed 9/22/2022:

http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PA-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3d%3d

RELEVANT AMA POLICY

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors (D-400.990)

Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.

Citation: Res. 137, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 103, A-13; Reaffirmed: A-19

National Mandatory Fee Schedule (H-385.986)

The AMA opposes any type of national mandatory fee schedule.

Citation: Res. 27, A-85; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of: Res 127, A-10; Reaffirmed: A-15

Definition of “Usual, Customary and Reasonable” (UCR) (H-385.923)

1. Our AMA adopts as policy the following definitions:

- (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);
- (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
- (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.

2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.

Citation: Res. 109, A-07; Appended: Res. 107, A-13

Physician Choice of Practice (H-385.926)

Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon

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

Citation: BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: Sub. Res. 701, A-93; Reaffirmed: A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 107, I-93 Res. 124, I-93; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed: A-96; Reaffirmed: I-96; Reaffirmed: A-97; Reaffirmed: I-98; Reaffirmed: A-99; Appended: Res. 127, A-98; Reaffirmed: CMS Rep. 6, A-99; reaffirmed: A-00; Reaffirmed: Sub Res. 116, I-00; reaffirmed: Res. 217, A-01; Reaffirmed: A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: A-07; Reaffirmed: A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: I-13; Reaffirmed: A-15; Reaffirmed: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 09, A-16; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 6, A-21; Reaffirmed: CMS Rep. 2, A-22

Payment for Physicians Services (H-385.989)

Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by 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.

Citation: CMS Rep. A, A-84; Reaffirmed: CLRPD Rep. 3, A-94; Reaffirmed: Sub Res. 716, A-00; Reaffirmed: A-02; Reaffirmed: A-07; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: I-13; Reaffirmed: A-15